Department of Behavioral Health
Dawan Utecht, Mental Health Director/Public Guardian

Providing Quality Mental Health and Substance Abuse Services for the People of Fresno County

April 18, 2016

Autumn Boylan Valerio, MPH
Chief, Compliance Section
Program Oversight and Compliance Branch
Mental Health Services Division
Department of Health Care Services
P.O. Box 997413, MS 2703
Sacramento, CA 95899-7413

Dear Ms. Boylan Valerio:

The Fresno County Mental Health Plan (MHP) submits the attached Plan of Correction (POC) for the out-of-compliance items that were identified during the Medi-Cal Oversight onsite review conducted on May 4-7, 2015. The final report was received on February 24, 2016.

The POC will serve as the roadmap to help Fresno County's MHP achieve full compliance with the standards set forth in the agreement between the MHP and the Department of Health Care Services. The MHP welcomes your feedback on the POC and any technical assistance that is available from the Program Oversight and Compliance Branch. Betty Brown, Managed Care Division Manager, is the MHP's designee to implement the changes required by this POC, and can be reached at (559) 600-4645 or by e-mail to bbrown2@co.fresno.ca.us should you have questions or require additional information.

Thank you for your guidance during this process. We truly appreciate the feedback to help in our efforts to better serve the community.

Sincerely,

Maryam Le for

Dawan Utecht, Director
Fresno County Department of Behavioral Health

DU:BB:DY:lo

Attachments

4441 E. Kings Canyon Road / Fresno, California 93702-3604
(559) 600-9180 ◆ FAX (559) 600-7674
Equal Employment Opportunity ◆ Affirmative Action ◆ Disabled Employer
www.co.fresno.ca.us ◆ www.fresno.networkofcare.org

FRESNO COUNTY MENTAL HEALTH PLAN

PLAN OF CORRECTION

Consolidated Specialty Mental Health Services
Fiscal Year 2014-2015

May 4-7, 2015

Dawan Utecht, Director
Fresno County Mental Health Plan
Department of Behavioral Health

Inquiries:
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FRESNO COUNTY MENTAL HEALTH PLAN
Plan of Correction

Consolidated Specialty Mental Health Services
Fiscal Year 2014-2015

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CONSOLIDATED SPECIALTY MENTAL HEALTH SERVICES FISCAL YEAR 2014-2015 FRESNO COUNTY MENTAL HEALTH PLAN REVIEW MAY 4-7, 2015 FINAL REPORT

ITEMS OUT OF COMPLIANCE – PLAN OF CORRECTION

ATTESTATION

FINDINGS:
The Department of Health Care Services (DHCS) reviewed Attestation Items 1, 5, 15, 18 and 23. All were found in compliance.

PLAN OF CORRECTION:
None

ITEM NO. 1, Section A, "Access," Questions 9a-2, 9a-3, 9a-4:

9. Regarding the statewide, 24 hours a day, 7 days a week (24/7) toll-free telephone number:

9a-2. Does the toll-free telephone number provide information to beneficiaries about how to access specialty mental health services, including specialty mental health services required to assess whether medical necessity criteria are met?

9a-3. Does the toll-free telephone number provide information to beneficiaries about services needed to treat a beneficiary's urgent condition?

9a-4. Does the toll-free telephone number provide information to beneficiaries about how to use the beneficiary problem resolution and fair hearing processes?

CCR, title 9, chapter 11, sections 1810.405(d) and 1810.410(e)(1);
CFR, title 42, section 438.406 (a)(1)
DMH Information Notice No. 10-02, Enclosure, Page 21, and
DMH Information Notice No. 10-17, Enclosure, Page 16
MHP Contract, Exhibit A, Attachment I

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

Test call #1 was placed on Sunday, April 5, 2015, at 12:22 pm. The call was initially answered after one (1) ring via recorded message. The recording advised the caller that all lines were busy and if this was an emergency to please hang up and dial 911. After four (4) minutes on hold, a live operator answered the line and advised the caller to hold for an additional three (3) minutes. The caller requested information about mental health services. The operator asked for the caller's name and telephone number. The caller responded to the operator that he/she was unable to provide the requested identifying

information and again requested information about mental health services. The operator told the caller to call back during business hours. The caller was not provided information on how to access SMHS, including SMHS required to assess whether medical necessity criteria is met nor was the caller provided with information about services needed to treat an urgent condition. This call was deemed OOC with the regulatory requirements for protocol questions 9a-2 and 9a-3.

Test call #2 was placed on Sunday, May 3, 2015, at 8:30 pm. The call was initially answered after one (1) ring via recorded message. The recording advised the caller that all lines were busy and if this was an emergency to please hang up and dial 911. After a brief wait, a live operator answered the call. The caller requested information about mental health services and was told by the operator that he/she had reached an after-hours emergency line. The operator asked for the caller's name and telephone number and advised the caller that someone would call back within three (3) days. The caller was also told he/she could call back during business hours. The caller inquired if it was necessary to submit personal information as he/she felt uncomfortable giving personal information. The caller then inquired if there was a walk-in clinic available to obtain services. The operator responded by again asking for the caller's information and reiterated that someone would call him/her back if the information was provided. After asking again about services, the operator provided the caller with the number to Exodus Recovery. The caller was not provided information on how to access SMHS, including SMHS required to assess whether medical necessity criteria is met. After several requests, the caller was eventually provided with information about services needed to treat a beneficiary's urgent condition. This call was deemed OOC with regulatory requirements for protocol questions 9a-2 and 9a-3.

Test call #3 was placed on Thursday, April 16, 2015, at 3:21 pm. The call was initially answered after one (1) ring by a live operator. The caller requested information about mental health services. The operator asked for the caller's name and telephone number and advised the caller that someone would return the call within three (3) days. The operator also advised the caller that upon receipt of the caller's personal information that he/she could provide the caller with emergency numbers that the caller could use to contact urgent care providers. The caller provided the operator with the requested personal information and the operator advised the caller how to obtain services from either of the two urgent care wellness centers that are available to provide immediate services. The caller was not provided information on how to access SMHS, including SMHS required to assess whether medical necessity criteria is met. However, after identifying information was provided to the operator, the caller was given information about services needed to treat a beneficiary's urgent condition. This call was deemed OOC with regulatory requirements for protocol question 9a-2 but in compliance with protocol question 9a-3.

Test call #4 was placed on Thursday, April 16, 2015, at 3:10 pm. The call was initially answered immediately via a recorded message indicating that all lines were busy. After being placed on hold for approximately thirty (30) seconds, a live operator answered the phone and inquired if the caller was currently experiencing an emergency situation. After responding in the negative, the caller requested information about mental health services. The operator provided the caller with a telephone number to contact mental

health urgent care to obtain immediate services and advised the caller to contact Exodus to initiate SMHS in Fresno County. The caller was provided information on how to access SMHS, including SMHS required to assess whether medical necessity criteria is met and information about services needed to treat a beneficiary's urgent condition. This call was deemed in compliance with regulatory requirements for protocol questions 9a-2 and 9a-3.

Test call #5 was placed on Friday, April 24, 2015, at 7:10 am. The call was initially answered after one (1) ring via recorded message. The recording advised the caller that all lines were busy and to hang up and dial 911 if it was an emergency. The call was then answered by a live operator. The caller requested information about how to access mental health services. The operator advised the caller that he/she had reached the exchange line and offered to have someone call back during business hours. The operator requested personal identifying information from caller and advised that the information will be placed in the system, which would trigger the call back. The caller inquired if there was anyone available immediately and was provided with information about the Wellness Center. The caller was not provided information on how to access SMHS, including SMHS required to assess whether medical necessity criteria is met (i.e., clinic locations and/or hours of operation, etc.); however, the caller was provided with information about services needed to treat a beneficiary's urgent condition. This call was deemed OOC with regulatory requirements for protocol question 9a-2, but in compliance with protocol question 9a-3.

Test call #6 was placed on Thursday, March 19, 2015, at 7:36 am. The call was initially answered after one (1) ring via recorded message. The recording advised the caller that all lines were busy and to hang up and dial 911 if it was an emergency. After being placed on hold for approximately thirty (30) seconds, a live operator answered from the county's answering service. The caller requested information about SMHS. The operator advised the caller that he/she would need to call back during business hours to speak with someone about SMHS. The caller then asked where they should go to obtain services and was provided with contact information and hours of operation for the MHP. The operator advised the caller to provide his/her personal information and someone would call him/her back within three (3) days. The caller was provided information on how to access SMHS, including SMHS required to assess whether medical necessity criteria is met; however, the caller was not provided with information about services needed to treat a beneficiary's urgent condition. This call was deemed in compliance with regulatory requirements for protocol question 9a-2 but OOC with protocol requirements for question 9a-3.

Test call #7 was placed on Friday, April 24, 2015, at 9:22 am. The call was initially answered after two (2) rings via a recorded message. The call was subsequently transferred to a live operator. The operator immediately requested the name and telephone number of the caller advising the caller that someone would call him/her back within three (3) days. The caller asked if there was any place to go to pick up information and/or file a grievance and the operator responded that "I guess you can go to any county to pick it up" and provided the address. The caller was not provided with appropriate information about how to use the beneficiary problem resolution and fair hearing processes. This call was deemed not in compliance with regulatory

requirements for protocol question 9a-4.

FINDINGS:

Protocol Question	Test Call Findings							Compliance Percentage
	#1	#2	#3#4	#4	#5	#6	#7	
9a-1	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**Not Applicable**
9a-2	OOC	OOC	OOC	IN	OOC	IN	n/a	**33.3%**
9a-3	OOC	OOC	IN	IN	IN	OOC	n/a	**50%**
9a-4	n/a	n/a	n/a	n/a	n/a	n/a	OOC	**0%**

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

Please note: In the previous triennial review, on April 2-5, 2012, this protocol item was found OOC.

FRESNO'S RESPONSE:

1. **Toll Free Number**
   The Fresno County Department of Behavioral Health Mental Health Plan (MHP) does provide a Toll Free, consumer Access Line, available 24 hours/day, seven (7) days/week with language capability for all languages spoken within the County; specifically, threshold languages spoken (English, Spanish, and Hmong). The Toll Free Access Line, (800) 654-3937, is designed to meet the CCR, Title 9, Chapter 11, Sections 1810.405(d) and 1810.410(e)(1); CFR, Title 42, Section 438.406(a)(1); and CCR, Title 9, Chapter 11, Sections 1850.205. The purpose of the Access Line is to make available information on how to access Specialty Mental Health Services (SMHS), including SMHS required to assess whether medical necessity criteria are met; information about services needed to treat a beneficiary's urgent condition; and information about how to use the beneficiary problem resolution and fair hearing process.

2. **Address how corrective action will be accomplished.**
   In addition to the Medi-Cal Triennial Audit's findings, the County's MHP acknowledges deficiencies in the current Toll Free Access Line (State goal at 100% for all categories). In Calendar Year 2015, a total number of 66 test calls were completed, of which 67% of test calls were logged. Of the calls logged, the

MHP monitors the call log for accuracy of: *Names* (61%); *Dates* (61%); *Phone Number* (59%); *Reason/Request* (53%); *Calls Assessed for Crisis* (83%), *How to access SMHS* (72%); and test calls in a *foreign language* (61%).

Corrective Action (New Contractor): Due to monthly test call monitoring results not meeting State goals, the Department's leadership team supports seeking a new contractor to operate and improve Access Line services. The existing contract provider, Professional Exchange Services (PESC), contract for services will end June 30, 2016. Search for a new contract provider has been processed through the County's Request for Proposal (RFP) competitive bid process. The RFP delegates the Access Line to the new contractor to abide by State and Federal Regulations. Anticipated start date for new vendor is July 1, 2016. Department of Behavioral Health Staff will work closely with the new vendor to provide technical assistance and require vendor to periodically participate in the monthly Access and Quality Improvement Committee meetings. In collaboration with a contract provider with a multi-disciplinary staffing pattern focusing on mental health crisis and operating the County's Crisis program, the MHP anticipates positive outcome test call results benefiting callers.

Until July 1, 2016, the County will continue to work with its contract with Professional Exchange Services (PESC) to operate its Access Line. The Department's Quality Improvement (QI) team continues to communicate with the vendor to resolve issues and improve deficiencies on a monthly basis. On December 16, 2015, QI team members met with PESC management to discuss improvement to existing Access Line services. Discussion included: Refresher training for PESC and Test Callers; Transferring calls received during business hours to appropriate adult and children's divisions for SMHS and Managed Care for problem resolution and fair hearing process, rather than telling the caller someone will call back within 3 days. The meeting discussion also included the importance of meeting State goals in regards to test calls/calls logged and the release of the RFP for Access Line services. The MHP continues to communicate with PESC on a monthly basis for Plan of Correction follow up.

3. **Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.**
   As of 2012, the MHP has monitored test calls on a monthly basis and has made available these results to the Department's Access and QI committees, Department's leadership team, contracted provider overseeing the Access Line operations, and the State Department of Health Care Services (DHCS) – 24/7 Test Call Quarterly Update Report Form. In addition, the MHP anticipates the availability of test call results, via the Department's web site Dashboard, prior to September 1, 2016. See Attachment A for test call results for Calendar Year 2015.

4. **Include dates when corrective action will be completed.**
   May 2015 – June 30, 2016:

   - Continue to collaborate with existing Contracted Provider

   New Contract:

   - RFP Release Date: December 10, 2105
   - Closing Date: January 26, 2016
   - Board of Supervisors: May-June 2016 (no scheduled date set)
   - Service Start Date: July 1, 2016

ITEM NO. 2, Section A, "Access," Questions 10a, 10b, 10c:

10. Regarding the MHP maintaining a written log of initial requests that meets title 9 requirements:

10a. Does the written log contain the name of the beneficiary?

10b. Does the written log contain the date of the request?

10c. Does the written log contain the initial disposition of the request?

CCR, title 9, chapter 11, section 1810.405(f)

FINDING:
The MHP did not provide evidence that its written log(s) of initial requests for SMHS was in compliance with title 9 regulations. Specifically, DHCS found three (3) of the six (6) test calls documented on the written log (with all required elements). The MHP was found in partial compliance (50%) with regulatory requirements for protocol questions 10a, 10b and 10c.

PLAN OF CORRECTION:
The MHP will submit a POC addressing the OOC findings for these requirements. The MHP is required to provide evidence to DHCS to substantiate its POC and to demonstrate that its written log of initial requests for SMHS (including requests made via telephone, in person or in writing) complies with title 9 regulatory requirements.

Please note: In the previous triennial review on April 2-5, 2012, this protocol item was found OOC.

FRESNO'S RESPONSE:

1. **Address how corrective action will be accomplished.**
   The Fresno County Department of Behavioral Health Mental Health Plan (MHP) does have a written Call Log in place. The Call Log, a database (https://www.fcmhpaccessline.com), is designed to meet the CCR, Title 9, Chapter 11, Section 1810.405(f). The purpose of the written log is to track and validate beneficiaries Name, Date of Request and Initial Disposition.

Three (3) of the six (6) test calls were not logged by the operator due to callers declining to state their name. Fresno MHP has instructed the contracted provider, PESC, to record all calls including calls from individuals who declined to state their name. PESC operator will note on the Access Log that the caller either refused to provide name or note "no name" on the log, when identifying the caller.

In order to test and remedy the issue, the Fresno MHP will include in its monthly test call script a "*No Name*" scenario to ensure that phone operators record these types of calls. The MHP implemented this procedure as of January 2016, and will continue to test on a monthly basis.

2. **Address what measures will be put in place or systemic changes made to ensure that the deficient practice will not recur.**
Within a 24 hour period (business day), Department of Behavioral Health Staff will follow up on the Access Line Call Log to confirm test calls have been entered. As of January 2016, the Fresno MHP monitors the call log system to ensure that the callers who declined-to-state his/her name are logged appropriately. Once a test call has been logged, staff will confirm the log's accuracy of callers *Name*, *Date of Request*, and *Initial Disposition of the Request*. If a test was completed and not logged onto the web-based access log, Department staff will follow up with the Department's Adult – Urgent Care Wellness Center and Children's Outpatient Division to confirm whether or not a FAX was received from the contractor due to the access log not being available to the contracted provider. Once monthly test calls have been confirmed and completed, a Plan of Correction and Caller Feedback form are sent to the contracted provider for follow-up. In addition the Fresno MHP will continue to provide the evidence of calls logged results quarterly to DHCS, as mandated.

3. **Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.**
Test Calls written Call Log will be monitored on a monthly basis and will be made available to Department Access and QI Committees, Department Leadership team, contracted provider overseeing the Access Line operations, and the State Department of Health Care Services (DHCS) – 24/7 Test Call Quarterly Update Report Form. In addition, the MHP anticipates the availability of test call results, via the Department's web site, Dashboard prior to September 1, 2016.

4. **Include dates when corrective action will be completed.**
May 2015 – June 30, 2016:

- Continue to collaborate with existing Contracted Provider
- January 1, 2016 – Test Script will include callers with no name
  Follow up on calls not logged via Faxes sent to DBH

New Contract:

- RFP Release Date: December 10, 2105

- Closing Date: January 26, 2016
- Board of Supervisors: May-June 2016 (no scheduled date set)
- Service Start Date: July 1, 2016

ITEM NO. 3, Section B, "Authorization," Question 1c:

1. Regarding the Treatment Authorization Requests (TARs):

1c. Does the MHP approve or deny TARs within 14 calendar days of the receipt of the TAR and in accordance with title 9 regulations?

CCR, title 9, chapter 11, sections 1810.242, 1820.220(c),(d), 1820.220 (f), 1820.220 (h), and 1820.215
CFR, title 42, section 438.210 (d)

FINDING:
The MHP did not provide evidence that it approves or denies all TARs within 14 calendar days of the receipt of the TAR, in accordance with title 9 regulations. Specifically, the DHCS review team found three (3) of the one hundred (100) TARs that were not approved or denied within fourteen (14) calendar days of the receipt of the TAR. The MHP was found in partial compliance (97%) with regulatory requirements for protocol question 1c.

PLAN OF CORRECTION:
The MHP will submit a POC addressing the OOC finding for this requirement. The MHP is required to provide evidence to DHCS to substantiate its POC and to demonstrate that it approves or denied TARs within 14 calendar days of receipt of the TAR in accordance with title 9 regulations.

FRESNO'S RESPONSE:
Policy and Procedure Guideline (PPG) 4-3-1 (Claims Processing, Inpatient Psychiatric Hospital Services) has been revised to include the TAR Denial Worksheet as an attachment to the PPG. See Attachment B for revised PPG. The TAR Denial Worksheet has been revised to include a "due by" date to notice the reviewing psychiatrist of a return date to Managed Care to ensure the fourteen (14) calendar date timeline is met.

On, 3/29/16, training was provided to the appropriate staff to review the protocol for receiving and reviewing TARS in a timely manner to meet the requirement of approving or denying TARs within 14 calendars days of receipt of the TAR and in accordance with title 9 regulations. See Attachment B-1 for training sign-in sheet.

ITEM NO. 4, Section B, "Authorization," Question 3:

3. Does the MHP have a payment authorization system in place that meets the requirements regarding Day Treatment Intensive and Day Rehabilitation in accordance with title 9 regulations?

CCR, title 9, chapter 11, sections 1830.215(e) and 840.318
DMH Information Notice 02-06, Enclosures, Pages 1-5

DMH Letter No. 03-03

FINDING:
The MHP did not furnish evidence it has a payment authorization system in place that meets requirements for Day Treatment Intensive (DTI) and Day Rehabilitation (DR). The MHP's policies and procedures do not specify that providers are required to request advance payment authorization for DTI and DR in advance of service delivery when services will be provided for more than five (5) days per week. The MHP is OOC with the requirements of the MHP contract.

PLAN OF CORRECTION:
The MHP will submit a POC addressing the OOC finding for this requirement. The MHP is required to provide evidence to DHCS to substantiate its POC and to demonstrate that it has a payment authorization system in place that meets the requirements regarding DTI and DR in accordance with regulatory and MHP contract requirements.

FRESNO'S RESPONSE:
PPG 4-2-4 (Authorization of Day Treatment Intensive, Day Rehabilitation, and Designated Specialty Mental Health Services for Out of County Providers) has been revised to include the requirement for those DTI and/or DR service requests that extend beyond 5-days per week. See Attachment C for revised PPG.

On, 3/29/16, training was provided to appropriate staff to review the revision to PPG 4-2-4 regarding the requirement that providers must request advance payment authorization for DTI and DR in advance of service delivery when services will be provided for more than five (5) days per week. See Attachment C-1 for training sign-in sheet.

ITEM NO. 5, Section B, "Authorization," Question 4a:

4. Regarding authorization timeframes:

4a. For standard authorization decisions, does the MHP make an authorization decision and provide notice as expeditiously as the beneficiary's health condition requires and within 14 calendar days following receipt of the request for service with a possible extension of up to 14 additional days?

CFR, title 42, section 438.210(d)(1)(2)

FINDING:
The MHP did not provide evidence that it makes an authorization decision and provides notice as expeditiously as the beneficiary's health condition requires and within fourteen (14) calendar days following receipt of the request for service with a possible extension of up to fourteen (14) additional days. Specifically, the DHCS team reviewed 25 standard requests for payment authorization decisions. Two (2) of the 25 standard authorization decisions were not authorized within 14 calendar days. The MHP was found in partial compliance (92%) with this regulatory requirement.

PLAN OF CORRECTION:
The MHP will submit a POC addressing the OOC findings for these requirements. The MHP is required to provide evidence to DHCS to substantiate its POC and to demonstrate that it makes authorization decisions and provides notice as expeditiously as the beneficiary's health condition requires and within 14 calendar days following receipt of the request for service with a possible extension of up to 14 additional days.

FRESNO'S RESPONSE:
Review of PPG 4-2-4 (Authorization of Day Treatment Intensive, Day Rehabilitation, and Designated Specialty Mental Health Services for Out of County Providers) was provided to appropriate staff to emphasize the timelines for standard authorization decisions and providing notice as expeditiously as the beneficiary's health condition requires and within 14 calendar days following receipt of the request for service with a possible extension of up to 14 additional days.

Review of PPG 4-2-4 was provided to the appropriate Department staff on 3/29/16. See Attachment C-1 for training sign-in sheet.

ITEM NO. 6, Section B, "Authorization," Questions 6c:

6. Regarding Notices of Action (NOAs):

6c. NOA-C: Is the MHP providing 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?

CFR, title 42, section 438.10 (c), 438.400(b) and 438.404(c)(2)
CCR, title 9, chapter 11, sections 1830.205(a),(b)(1),(2),(3), 1850.210 (a)-(j)and 1850.212
DMH Letter No. 05-03
MHP Contract, Exhibit A, Attachment I

FINDING:
The MHP did not furnish evidence that Notices of Action (NOA) were provided to beneficiaries in accordance with title 9 regulations. Specifically, DHCS reviewed seventy-five (75) NOA-C's; 25 of the NOA-Cs in this sample were not mailed to the beneficiaries within three (3) working days of taking action. The MHP is in partial compliance (67%) with regulatory requirements for protocol question 6c.

PLAN OF CORRECTION:
The MHP will submit a POC indicating how it will address the OOC finding for this requirement. The MHP must provide evidence to DHCS with evidence of correction for the POC to ensure the MHP, in accordance with title 9 regulations, provides a written NOA-C to the beneficiaries when the MHP denies payment authorization of a service that has already been delivered to the beneficiaries as a result of retrospective payment determination.

FRESNO'S RESPONSE:
PPG 1-2-12 (Notice of Action/Fair Hearing/Aid Paid Pending for Medi-Cal Beneficiaries)

has been revised to include the "3 working day deadline" to provide a written NOA-C to the beneficiaries when the MHP denies payment authorization of a service that has already been delivered to the beneficiaries as a result of retrospective payment determination. See Attachment D for revised PPG.

Staff training was conducted on 3/29/16 to emphasize the practice of notifying the beneficiary within 3 working days of denial or modification of a request for payment authorization of a specialty mental health service. See Attachment D-1 for training sign in sheet.

ITEM NO. 7, Section C, "Beneficiary Protection," Question 4a, 4b, 4c:

4. Does the MHP provide written acknowledgement:

4a. Of each grievance to the beneficiary in writing?

4b. Of each appeal to the beneficiary in writing?

4c. Of each expedited appeal to the beneficiary in writing?

CFR, title 42, section 438.406(a)(2)
CCR, title 9, chapter 11, section 1850.205(d)(4)

FINDING:
The MHP did not provide evidence that the MHP provided written acknowledgement to beneficiaries of each grievance, appeal or expedited appeal in compliance with title 9 regulations. The DHCS review team reviewed five (5) grievances. Four (4) of the five (5) reviewed grievances were in compliance as the MHP presented evidence showing written acknowledgement of each grievance was provided to the beneficiaries in writing. There was one (1) grievance that was not in compliance because the MHP placed a form letter into beneficiary's file instead of appropriately sending written acknowledgement to the beneficiary. The MHP was in partial compliance (80%) with regulatory requirements for protocol question 4a.

PLAN OF CORRECTION:
The MHP will submit a POC indicating how it will address the OOC finding for this requirement. The MHP must provide evidence to DHCS with evidence of correction for the POC to ensure the MHP is providing beneficiaries with written acknowledgement of each grievance, appeal and expedited appeal.

FRESNO'S RESPONSE:
PPG 1-2-11 (Consumer Grievance Resolution Process) and PPG 1-2-18 (Consumer Appeal and Expedited Appeal Process) were revised to clarify current practice to ensure beneficiaries are provided written acknowledgement of each grievance, appeal and expedited appeal. See Attachments E and F, respectively.

Training to the revisions to PPGs 1-2-11 and 1-2-18 and review of the policies was provided to the appropriate Department staff on 3/29/16. See Attachments E-1 and F-1 for training sign in sheets.

ITEM NO. 8, Section C, "Beneficiary Protection," Question 5a:

5. Is the MHP notifying beneficiaries, or their representatives:

5a. Of the grievance disposition and is this being documented?

CFR, title 42, section 438.408 (d
CCR, title 9, chapter 11, sections 1850.206(b)(c), 1850.207 (c)(h) and 1850.208 (d) (e) DMH Letter No. 05-03

FINDING:
The MHP did not provide evidence that it is notifying beneficiaries, or their representatives, of the grievance disposition and that this is being documented in accordance with title 9 regulations. The DHCS review team reviewed five (5) grievances. Four (4) of the five (5) reviewed grievances were in compliance as the MHP presented evidence showing the MHP is notifying beneficiaries or their representatives of the grievance disposition. There was one (1) grievance that was not in compliance because the MHP did not properly notify the beneficiary of the grievance disposition. The MHP was in partial compliance (80%) with regulatory requirements for protocol question 5a.

PLAN OF CORRECTI ON:
The MHP will submit a POC indicating how it will address the OOC finding for this requirement. The MHP must provide evidence to DHCS with evidence of correction for the POC to ensure the MHP is notifying beneficiaries or their representative of the grievance disposition and this is being documented.

FRESNO'S RESPONSE:
PPG 1-2-11 (Consumer Grievance Resolution Process) has been revised to clarify current practice of notifying beneficiaries or their representatives of the grievance disposition and that it is being documented. See Attachment G.

Review of PPG 1-2-11 was provided to the appropriate Department staff on 3/29/16 with emphasis to revisions clarifying current practice of notifying beneficiaries or their representatives of the grievance disposition and that it is being documented. See Attachment G-1 for training sign in sheet).

ITEM NO. 9, Section G, "Provider Relations," Question 2:

2. Does the MHP have an ongoing monitoring system in place that ensures contracted organizational providers are certified and recertified as per title 9 regulations?

CCR, title 9, chapter 11, section 1810.435 (d)(e)
MHP Contract, Exhibit A, Attachment I

FINDING:
The MHP did not provide evidence that it has an ongoing monitoring system in place that ensures contracted organizational providers are certified and recertified in

compliance with title 9 regulations. Specifically, the MHP had a policy which met the requirements of this question; however, in practice, at the time of the triennial review, the MHP had twenty-seven (27) providers that were overdue for re-certifications. The MHP was found in partial compliance (55%) with regulatory requirements for protocol question 2.

PLAN OF CORRECTION:

The MHP will submit a POC indicating how it will address the OOC finding for this requirement. The MHP must provide evidence to DHCS with evidence of correction for the POC to ensure that the MHP has an ongoing monitoring system in place that ensures contracted organizational providers are certified and recertified per title 9 regulations.

FRESNO'S RESPONSE:

In order to ensure that contracted organizational providers are certified and recertified per Title 9 regulations, the MHP policy for an ongoing monitoring system includes:

1. Information regarding Medi-Cal Provider certification is now maintained and updated as appropriate on the "Fresno Provider Report" (See Attachment H).
2. The Fresno Provider Report is reviewed and site certifications/re-certifications are scheduled as needed at regular DBH Utilization Review Specialist meetings (See Attachment H).

The MHP has reconciliation of all previously identified overdue providers from the triennial review, bringing the MHP into compliance.

Section K, "Chart Review – Non-Hospital Services"

The medical records of five (5) adult and five (5) child/adolescent Medi-Cal specialty mental health beneficiaries were reviewed for compliance with state and federal regulations, for adherence to the terms of the contract between the Fresno County Mental Health Plan (MHP) and the California Department of Health Care Services (DHCS), and for consistency with the MHP's own documentation standards and policies and procedures regarding medical records documentation. The process included a review of **395** claims submitted for the months of April, May, and June of 2014.

ITEM No. 10, Section K, "Chart Review – Non-Hospital Services," Questions 1a-1c:

1. **Does the beneficiary meet all three (3) of the following medical necessity criteria for *reimbursement (1a, 1b, and 1c, below?)***
   - **1a. The beneficiary has a DMS diagnosis contained in the CCR, title 9, section 1830.205(b)(1)(A-R).**
   - **1b. The beneficiary, as a result of a mental disorder listed in 1a, must have, at least one (1) of the following criteria (1-4 below):**
     1) **A significant impairment in an important area of life functioning.**
     2) **A probability of significant deterioration in an important area of life functioning.**

3) **A probability that the child will not progress developmentally as individually appropriate.**

4) **For full-scope MC beneficiaries under the age of 21 years, a condition as a result of the mental disorder that the SMHS can correct or ameliorate.**

1c. Must meet each of the intervention criteria listed below:

1) **The focus of the proposed intervention is to address the condition identified in No. 1b (1-3) above, or for full-scope MC beneficiaries under the age of 21 years, a condition as a result of the mental disorder that SMHS can correct or ameliorate per No. 1b. (4).**

2) **The expectation is that the proposed intervention will do, at least one (1) of the following (A, B, C, or D);**

   A. **Significantly diminish the impairment.**
   B. **Prevent significant deterioration in an important area of life functioning.**
   C. **Allow the child to progress developmentally as individually appropriate.**
   D. **For full-scope MC beneficiaries under the age of 21 years, correct or ameliorate the condition.**

- *CCR, title 9, chapter 11, section 1830.205(b)(c)*
- *CCR, title 9, chapter 11, section 1830.210*
- *CCR, title 9, chapter 11, section 1810.345(c)*
- *CCR, title 9, chapter 11, section 1840.112(b)(1) and (4)*
- *CCR, title 9, chapter 11, section 1840.314(d)*
- *CCR, title 22, chapter 3, section 51303(a)*

FINDING:

1c-1. Reason for Recoupment #3 - One or more claims associated with the following Line #s did not meet the medical necessity criteria since the focus of the interventions documented on the progress notes did not address the mental health condition as specified in the CCR, title 9, chapter 11, section 1830.205(b)(3)(A): Line #2 and Line #15.

Refer to the enclosed Recoupment Summary for additional details concerning any disallowance indicated above.

PLAN OF CORRECTION:

1c-1. The MHP shall submit a Plan of Correction (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).

FRESNO'S RESPONSE:

In order to ensure that interventions are focused on a significant functional impairment that is directly related to the mental health condition, Fresno County has mutually

emphasized this in trainings and has revised its chart review standards, including:

1. The *FCMHP Audit Summary Tool,* items 26b and 36 (See Attachment I) have been reviewed and updated as necessary to capture appropriate interventions that meet medical necessity criteria for utilization of all MHP chart reviews.
2. For contracted provider programs, each provider of services reviewed was contacted and each provided a collaborative Plan of Correction response to address specific findings that were identified (See Attachment J). Provider 10DP has adequately addressed through training and documented procedures as demonstrated in the Attachment J-5.
3. For county-operated programs, the Division Managers will require that all Clinical Supervisors with programs providing outpatient specialty mental health services will review the findings identified and the plan of correction with their subordinate direct service employees by May 2016.
4. The MHP provides documentation and billing training for new employees and annually includes these requirements in the training.
5. This will also be a component of the current and ongoing chart audit process performed by Clinical Supervisors (approximately 5 charts per quarter per clinician) and reviewed with the clinician for continuous quality improvement. Clinical Supervisors will also present examples of good documentation, an object lesson to their team(s) and perform a periodic consistency monitoring between the supervisors for inter-rater reliability.
6. The Plan of Correction (POC) will be reviewed with all appropriate staff within 30 days of submission to DHCS with ongoing training, chart audits and continuous quality improvement thereafter.

FINDING:

1c-2. Reason for Recoupment #4 - One or more claims associated with the following Line #s did not meet the medical necessity criteria since there was no expectation that the documented intervention would meet the intervention criteria as specified in the CCR, title 9, chapter 11, section 1830.205(b)(3)(B)(1-4): Line #11 and Line #17.

Refer to the enclosed Recoupment Summary for additional details concerning any disallowance indicated above.

PLAN OF CORRECTION:

1c-2. 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).

FRESNO'S RESPONSE:

In order to ensure that interventions provided meet the intervention criteria, Fresno County has mutually emphasized this in trainings and revised its chart review standards, including:

1. The *FCMHP Audit Summary Tool,* items 36 and 49-61 (See Attachment I) have been reviewed and updated as necessary to capture appropriate interventions that meet intervention criteria for utilization of all MHP chart reviews.
2. For contracted provider programs, each provider of services reviewed was contacted and each provided a collaborative Plan of Correction response to

address specific findings that were identified (See Attachment J). Provider 10CY has adequately addressed through training and documented procedures as demonstrated in the Attachment J-3.

3. For county-operated programs, the Division Managers will require that all Clinical Supervisors with programs providing outpatient specialty mental health services will review the deficiencies identified during this audit and the plan of correction with their subordinate direct service employees.
4. The MHP provides documentation and billing training for new employees and annually includes these requirements in the training.
5. This will also be a component of the current and ongoing chart audit process performed by Clinical Supervisors (approximately 5 charts per quarter per clinician) and reviewed with the clinician for continuous quality improvement. Clinical Supervisors will also present examples of good documentation, an object lesson to their team(s) and perform a periodic consistency monitoring between the supervisors for inter-rater reliability.
6. The Plan of Correction (POC) will be reviewed with all appropriate staff within 30 days of submission to DHCS with ongoing training, chart audits and continuous quality improvement thereafter.

ITEM NO. 11, Section K, "Chart Review – Non-Hospital Services," Questions 2a-2f:

2. Regarding the Assessment, are the following conditions met:

2a. Has the Assessment been completed in accordance with regulatory and contractual requirements.

2b. Has the Assessment been completed in accordance with the MHP's established written documentation standards for timeliness and frequency?

2c. Does the Assessment include the areas specified in the MHP Contract with the Department?

1) **Presenting Problem,** The beneficiary's chief complaint, history of presenting problem(s), including current level of functioning, relevant family history, and current family information;
2) **Relevant conditions and psychosocial factors affecting the beneficiary's physical health and mental health;** including as applicable, living situation, daily activities, social support, cultural and linguistic factors and history of trauma or exposure to trauma;
3) **Mental Health History,** Previous treatment, including providers, therapeutic modality (e.g. medications, psychosocial treatment(s) and response, and inpatient admissions. If possible, include information from other sources of clinical data, such as previous mental health records, and relevant psychological testing or consultation reports;
4) **Medical History,** Relevant physical health conditions reported by the beneficiary or a significant support person. Include name and address of current source of medical treatment. For children and adolescents, the history must include prenatal and perinatal events and relevant/significant development history. If possible, include other medical information from medical records or relevant consultation reports;

5) **Medications,** Information about medications the beneficiary has received, or is receiving, to treat mental health and medical conditions, including duration of medical treatment. The assessment shall include documentation of the absence or presence of allergies or adverse reactions to medications, and documentation of an informed consent for medications;
6) **Substance Exposure/Substance Use**, Past and present use of tobacco, alcohol caffeine, CAM (complementary and alternative medications) and over-the-counter drugs, and illicit drugs;
7) **Client Strengths,** Documentation of the beneficiary's strengths in achieving client plan goals related to the beneficiary's mental health needs and functional impairments as a result of the mental health diagnosis;
8) **Risks,** Situations that present a risk to the beneficiary and/or others, including past or current trauma;
9) **A mental status examination;**
10) **A complete five-axis diagnosis** from the most current DSM, or a diagnosis from the most current ICD-code shall be documented, consistent with the presenting problems, history, mental status examination and/or other clinical data, and;
11) **Additional clarifying formulation information,** as needed.

2d. Did the provider obtain and retain a written medication consent form signed by the beneficiary agreeing to the administration of psychiatric medication?

2e. Did the documentation include, but not limited to:

1) **The reasons for taking such medications;**
2) **Reasonable alternative treatments available, if any;**
3) **The type, range of frequency and amount, methods (oral or injection), and duration of taking the medications, probable side effects, possible additional side effects which may occur to beneficiaries taking such medication beyond three (3) months, and;**
4) **That the consent, once given, may be withdrawn at any time by the beneficiary.**

2f. Is the documentation legible?

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

FINDING:

2a. Initial and Updated assessments were not completed in accordance with regulatory and contractual requirements:

1) Initial and Updated assessments were not always completed within the timeliness and frequency requirements specified in the MHP's written documentation standards.

2) Assessments did not include all of the required elements specified in the MHP Contract with the Department.

PLAN OF CORRECTION:

2a. The MHP shall submit a POC that:

1) 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.
2) Indicates how the MHP will ensure that assessments include the required elements and are completed in accordance with regulatory and contractual requirements.

FRESNO'S RESPONSE:

The *FCMHP Audit Summary Tool* (See Attachment I) has been reviewed and updated as necessary to ensure that both initial and updated assessments are completed in accordance with the timeliness and frequency requirements (item 4 of tool) and that assessments contain all of the required elements (item 5a-j of tool) for utilization at all MHP chart reviews. In addition:

1. For county-operated programs, the Division Managers will require that all Clinical Supervisors with programs providing outpatient specialty mental health services will review the deficiencies identified during this audit and the plan of correction with their subordinate direct service employees.
2. Ensuring that assessments include the required elements and completed in accordance with regulatory and contractual requirements will be a component of the current and ongoing chart audit process performed by Clinical Supervisors (approximately 5 charts per quarter per clinician) and reviewed with the clinician for continuous quality improvement. Clinical Supervisors will also present examples of good documentation, an object lesson to their team(s) and perform a periodic consistency monitoring between the supervisors for inter-rater reliability.
3. In addition, the Avatar system implemented in the core assessment form in April 2015 as part of the electronic client record. This enabled online access to the assessment form, and the development of an automated system report that identifies when an assessment is incomplete, remains in draft or otherwise not finalized. Every clinical staff has access to the "Expiring Clinical Documents Report" (See Attachment K) that has a list of expiration dates for assessments and treatment plans for clients on their caseload. There is another system alert that is provided two-months in advance of the due date for the reassessment to the treating staff member. This increased functionality in the Avatar system will assist in meeting the timeliness and frequency requirements specified in the MHP's written documentation standards.
4. The MHP provides documentation and billing training for new employees and annually and includes these requirements in the training
5. In addition, targeted training will be provided to direct services providers by May 2016 on the required elements of an assessment per regulatory/contractual requirements as well as the timeliness and frequency of the initial and updated assessment.

FINDING:

2b. Assessments were not completed in accordance with the MHP's written documentation standards for timeliness and frequency:

- Line #5: There was no initial assessment found in the medical record. During the review, MHP staff was given the opportunity to locate the missing assessment but could not locate the document in the medical record.
- Line #1, Line #6, Line #11 and Line #20: The initial assessment was completed late. In addition, for Line #19, the second provider completed an assessment that was late.
- Line #2, Line #7, Line #12, and Line #13: The updated assessment was completed late.

PLAN OF CORRECTION:

2b. The MHP shall submit a POC that indicates how the MHP will ensure that assessments are completed in accordance with the MHP's written documentation standards for timeliness and frequency.

FRESNO'S RESPONSE:

In order to ensure that assessments are completed in accordance with the MHP's written documentation standards for timeliness and frequency, Fresno County has mutually emphasized this in trainings and revised its chart review standards, including:

1. The *FCMHP Audit Summary Tool,* item 4 (See Attachment I) has been reviewed and updated as necessary for all MHP chart reviews.
2. For contracted provider programs, each provider of services reviewed was contacted and each provided a collaborative Plan of Correction response to address specific findings that were identified (See Attachment J). Providers 10DP, 10CY, 10CI, and10C9 have adequately addressed through training and documented procedures that ensure assessments are completed in accordance with MHP's written standards for timeliness and frequency as demonstrated in the Attachments J-1 through J-3 and J-5.
3. For county-operated programs, the Division Managers will require that all Clinical Supervisors with programs providing outpatient specialty mental health services will review the deficiencies identified during this audit and the plan of correction with their subordinate direct service employees.
4. In addition, the Avatar system implemented in the core assessment form in April 2015 as part of the electronic client record. This enabled online access to the assessment form, and the development of an automated system report that identifies when an assessment is incomplete, remains in draft or otherwise not finalized. Every Clinical Supervisor and clinical staff has access to the "Expiring Clinical Documents Report" (See Attachment K) that lists two months in advance of the due date when a reassessment is due for clients on the staff's caseload. The Clinical Supervisor can run this report to show all of their staff and their respective caseloads on one report. In addition, the Clinical Supervisors are provided with a monthly "QA – Fresno Treatment Plans/Core Assessments Not in Final Status Report" (See Attachment L) in order to

monitor and readily address timeliness issues. This increased functionality in the Avatar system will assist the MHP to meet the timeliness and frequency requirements for reassessments as specified in the MHP's standards for timeliness and frequency.

5. The MHP provides documentation and billing training for new employees and annually and includes these requirements in the training.
6. Ensuring that assessments are completed in accordance with the MHP's written documentation standards for timeliness and frequency will be included in the current and ongoing chart audit process performed by Clinical Supervisors (approximately 5 charts per quarter per clinician) and reviewed with the clinician for continuous quality improvement. Clinical Supervisors will also present examples of good documentation, an object lesson to their team(s) and perform a periodic consistency monitoring between the supervisors for inter-rater reliability.
7. The Plan of Correction (POC) will be reviewed with all appropriate staff within 30 days of submission to DHCS with ongoing training, chart audits and continuous quality improvement thereafter.

FINDING:

2c. One or more of the assessments reviewed did not include all of the required elements as specified in the MHP Contract with the Department.

The following required elements were missing:

1) Medical History: Line #19 (2nd provider's assessment)
2) Substance Exposure/Substance Use: Line #1 and Line #19.
3) Client Strengths: Line #1, Line #4, Line #7, Line #10, Line #13, Line #18 and Line #19.
4) Risks: Line #1, Line #2, Line #6 and Line #7.

PLAN OF CORRECTION:

2c. 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.

FRESNO'S RESPONSE:

In order to ensure that every assessment contains all of the required elements specified in the MHP Contract, Fresno County has mutually emphasized this in trainings and revised its chart review standards, including:

1. The *FCMHP Audit Summary Tool,* item 5a-j (See Attachment I) has been reviewed and updated as necessary for all MHP chart reviews specific to each required element of a clinical assessment.
2. For contracted provider programs, each provider of services reviewed was contacted and each provided a collaborative Plan of Correction response to address specific findings that were identified (See Attachment J). Providers 10CI, 10DP, and10CY have adequately addressed through training and documented procedures that ensure all assessments contain the required elements as demonstrated in the Attachments J-1 through J-3 and J-5.

3. For county-operated programs, the Division Managers will require that all Clinical Supervisors with programs providing outpatient specialty mental health services will review the deficiencies identified during this audit and the plan of correction with their subordinate direct service employees.
4. A targeted training was presented by Managed Care to Children's Mental Health clinicians in September 2015 that focused on the required elements of assessments (See Attachment M). In that training, the Strengths, Needs, Abilities and Preferences (SNAP) form was incorporated to assist in identifying client strength. The Division Manager will ensure that this training is provided to the adult programs by May 2016.
5. The MHP provides documentation and billing training for new employees and annually and includes these requirements in the training.
6. Ensuring that assessments include all of the requirement elements to establish medical necessity are included in the current and ongoing chart audit process performed by Clinical Supervisors (approximately 5 charts per quarter per clinician) and reviewed with the clinician for continuous quality improvement. Clinical Supervisors will also present examples of good documentation, an object lesson to their team(s) and perform a periodic consistency monitoring between the supervisors for inter-rater reliability.
7. The Plan of Correction (POC) will be reviewed with all appropriate staff within 30 days of submission to DHCS with ongoing training, chart audits and continuous quality improvement thereafter.

FINDING:

2d. The provider did not obtain and retain a written medication consent signed by the beneficiary agreeing to the administration of psychiatric medication, and there was no documentation in the medical record of a written explanation regarding the beneficiary's refusal or unavailability to sign the medication consent:

- Line #1, Line #5 and Line #16: There was no written medication consent form found in the medical record. *During the review, MHP staff was given the opportunity to locate the missing medication consent form but was unable to locate it in the medical record.*
- Line #12 and Line #18: Although there was a written medication consent form in the medical record, there was no medication consent for all of the medications prescribed. *During the review, MHP staff was given the opportunity to locate the medication consents in question but was unable to locate them in the medical record.*

PLAN OF CORRECTION:

2d. The MHP shall submit a POC that indicates how the MHP will ensure that:

1) A written medication consent form is obtained and retained for each medication prescribed and administered under the direction of the MHP.
2) Written medication consent forms are completed in accordance with the timeliness and frequency standards specified in the MHP's written documentation standards.

FRESNO'S RESPONSE:

To ensure that a written medication consent form is obtained and retained for each medication prescribed and administered under the direction of the MHP and that written consent forms are completed in accordance with the timeliness and frequency standards in the MHP's written documentation standards:

1. For county-operated programs, the Medication Consent form has been incorporated in the Avatar system since January 2011 that includes the electronic signatures of the client or legal guardian.
2. The current medication consent form has be revised to include all of the required elements (See Attachment N). Training on this revised form for accuracy and timeliness will be provided to the medical, nursing and all applicable staff no later than May 2016.
3. The MHP provides documentation and billing training for new employees and annually and includes these requirements in the training
4. The medication monitoring review conducted by MHP will provide ongoing monitoring for compliance of the content within the medication consent form and that it meets the MHP's standards for the timeliness and frequency (See Attachment N).
5. For the contracted provider program identified in 2d, the provider of services reviewed was contacted and provided a collaborative Plan of Correction response to address specific findings that were identified (See Attachment J). Provider 10DP has adequately addressed through training and documented procedures that medication consent form requirements are met as demonstrated in Attachment J-5.
6. The *FCMHP Audit Summary Tool,* item 68 (See Attachment I) has been reviewed and updated as necessary for all MHP chart reviews to include compliance of medication consent form requirements.
7. The Plan of Correction (POC) will be reviewed with all appropriate staff within 30 days of submission to DHCS with ongoing training, chart audits and continuous quality improvement thereafter.

FINDING:

2e. Written medication consents did not contain all of the required elements specified in the MHP Contract with the Department:

- For Line #2, Line #3, Line #4, Line #6, Line #7, Line #8, Line #9, Line #11, Line #12, Line #13, Line #14, Line #15, Line #18 and Line #20, one or more of the following required elements were not documented on the medication consent forms found in the beneficiary's medical record:

  Reason for taking each medication; reasonable alternative treatment available, if any; range of frequency and amount, method of administration (oral or injection); duration of taking each medication; additional side effects which may occur when taking the medication beyond three (3) months.

PLAN OF CORRECTION:

2e. The MHP shall submit a POC that indicates how the MHP will ensure that every medication consent includes documentation of all of the required elements specified in the MHP Contract with the Department.

FRESNO'S RESPONSE:
To ensure that every medication consent includes documentation of all the required elements as specified in the MHP Contract, Fresno County has implemented the following:

1. For county-operated programs, the Medication Consent form has been incorporated in the Avatar system since January 2011 that includes the electronic signatures of the client or legal guardian.
2. The current medication consent form has been revised to include all of the required elements (See Attachment N). Training on this revised form will be provided to the medical, nursing and all applicable staff no later than May 2016.
3. The medication monitoring review conducted by the MHP will review the medication consent forms to identify those instances when the content does not include all of the required elements specified in the MHP Contract with the State and provide feedback to the appropriate staff for ongoing quality improvement when needed (See Attachment N).
4. For the contracted provider programs identified, each provider of services reviewed was contacted and provided a collaborative Plan of Correction response to address specific findings that were identified (See Attachment J). Providers 10DP, 10C9, 10AD, 10CY, and 10CI have adequately addressed through training and documented procedures that medication consent form requirements are met as demonstrated in Attachments J-1 through J-5.
5. The *FCMHP Audit Summary Tool,* item 69 (See Attachment I) has been reviewed and updated as necessary for all MHP chart reviews to include compliance with all elements of medication consent forms.
6. The Plan of Correction (POC) will be reviewed with all appropriate staff within 30 days of submission to DHCS with ongoing training, chart audits and continuous quality improvement thereafter.

ITEM NO. 12, Section K, "Chart Review – Non-Hospital Services," Questions 3a-3h:

3a. Has the client plan been completed in accordance with regulatory and contractual requirements?

3b. Has the client plan been updated at least annually, or when there are significant changes in the beneficiary's condition?

3c. Does the client plan contain the following items specified in the MHP Contract with the Department?

1) **Specific, observable, and/or specific quantifiable goals/treatment objectives related to the beneficiary's mental health needs and functional impairments as a result of the mental health diagnosis.**
2) **The proposed type(s) of intervention/modality including a detailed description of the intervention to be provided.**
3) **The proposed frequency and duration of intervention(s).**
4) **Interventions that focus and address the identified functional impairments as a result of the mental disorder.**

5) Interventions that are consistent with client plan goal(s)/treatment objective(s).
6) Be consistent with the qualifying diagnoses.

3d. Is the client plan signed (or electronic equivalent) by, at least, one of the following (1, 2, or 3):
1) A person providing the services.
2) A person representing a team or program providing the service(s).
3) A person representing the MHP providing services.

By one of the following as a co-signer, if the client plan is used to establish that services are provided under the direction of an approved category of staff, and if the signing staff is not of the approved categories, one (1) of the following must sign:
1) A physician
2) A Licensed/Waivered Psychologist
3) A Licensed/Registered/Waivered Social Worker
4) A Licensed Registered/Waivered Marriage and Family Therapist
5) Licensed/Registered/Waivered Professional Clinical Counselor (pending Centers for Medicare and Medicaid Services (CMS) approval
6) A Registered Nurse, including, but not limited to nurse practitioners and clinical nurse specialists.

3e. Is there documentation of the beneficiary's degree of participation and agreement with the client plan as evidenced, but not limited to:
1) Reference to the beneficiary's participation in and agreement in the body of the client plan or
2) The beneficiary's signature on the client plan; or

The beneficiary's signature or the signature of the beneficiary's legal representative is required on the client plan when:
1) The beneficiary is expected to be in a long-term treatment, as determined by the MHP, and,
2) The client plan provides that the beneficiary will be receiving more than one (1) type of SMHS.

When the beneficiary's signature, or the signature of the beneficiary's legal representative is required on the client plan and the beneficiary refuses or is unavailable for signature, the client plan shall include a written explanation of the refusal or unavailability.

3f. Does the MHP have a written definition of what constitutes long term care beneficiary?

3g. Is there documentation that the contractor offered a copy of the client plan to the beneficiary?

3h. Is the documentation legible?

- *CCR, title 9, chapter 11, section 1810.205.2*

- *CCR, title 9, chapter 11, section 1810.254*
- *CCR, title 9, chapter 11, section 1840.314*
- *CCR, title 9, chapter 11, section 1810.440(c)*
- *CCR, title 9, chapter 11, section 1840.112(b)(5)*
- *DMH Letter 02-01, Enclosure A*
- *W&IC section 5751.2*

FINDING:

3a. The client plan was not completed in accordance with regulatory and contractual requirements.

1) The MHP was not always following contractual requirements and/or its own written documentation standards for timeliness and frequency, goal and intervention requirements on its client plans.

PLAN OF CORRECTION:

3a. The MHP shall submit a POC that indicates how the MHP will ensure that client plans:

1) Are completed in accordance with the timeliness and frequency requirements specified in the MHP's written documentation standards.
2) Contain goals/objectives and proposed interventions in accordance with regulatory and contractual requirements.
3) Are updated at least annually or when there are significant changes in the beneficiary's condition in accordance with regulatory and contractual requirements.

FRESNO'S RESPONSE:

The *FCMHP Audit Summary Tool* (See Attachment I) has been reviewed and updated as necessary to ensure that all Plans of Care are completed in accordance with the timeliness and frequency requirements (item 10 of tool), that the goals/objectives and proposed interventions are in accordance with MHP documentation standards (items 12-17 of tool), and is updated at least annually or when significant changes occur (item 11 of tool) for utilization at all MHP chart reviews. In addition:

1. For county-operated programs, the Division Managers will require that all Clinical Supervisors with programs providing outpatient specialty mental health services will review the deficiencies identified during this audit and the plan of correction with their subordinate direct service employees.
2. Ensuring that treatment plans adhere to findings 1-4, those requirements are included in the current and ongoing chart audit process performed by Clinical Supervisors (approximately 5 charts per quarter per clinician/case manager) and reviewed with clinicians/case managers for continuous quality improvement. Clinical Supervisors will also present examples of good documentation, an object lesson to their team(s) and perform a periodic consistency monitoring between the supervisors for inter-rater reliability.
3. In addition, the treatment plans were added to the electronic health record in Avatar in June 2014. In order to address items #1 and #3 regarding timeliness and frequency requirements, there is now a compliance alert in Avatar for expired treatment plans, The "Expiring Treatment Plan" report is generated by the Quality Improvement staff (See Attachment O) and can also

be run by the Clinical Supervisors. This report identifies when the treatment plan has expired in red and yellow when it is due in the next 60 days.

4. A targeted training was presented by Managed Care to Children's Mental Health clinicians in June 2015 that focused on the required elements of Plans of Care (See Attachment M). The Division Manager will ensure that this training is provided to the adult programs by May 2016.
5. The MHP provides documentation and billing training for new employees and annually and includes these requirements in the training.
6. The Plan of Correction (POC) will be reviewed with all appropriate staff within 30 days of submission to DHCS with ongoing training, chart audits and continuous quality improvement thereafter.
7. For the contracted provider program identified in 3a, the provider of services reviewed was contacted and provided a collaborative Plan of Correction response to address specific findings that were identified (See Attachment J). Provider 10CI has adequately addressed through training and documented procedures that ensure initial client plans are completed within the time period specified in the MHP documentation standards as demonstrated in Attachment J-2.
8. MHP staff reviewed all services and claims during which there was no initial client plan in effect outside of the audit review period, identified in Line #19 and Line #5 of the Recoupment Summary. The remaining service claims were found to be in compliance and no further disallowances were identified.

FINDING:

3a. **Reason for Recoupment #5** – The initial client plan was not completed within the time period specified in the MHP's documentation standards, with no evidence supporting the need for more time:

- Line #19: The initial client plan was not completed within the time period specified in the MHP's documentation standards, and therefore, there was no client plan in effect during part of the audit review period. *The MHP should review all services and claims during which there was no initial client plan in effect and disallow those claims as required.*
- Line #5: There was no initial client plan in the medical record within the time period specified in the MHP's written documentation standards. However, this occurred prior to the audit review period. *The MHP should review all the services and claims during which there was no initial client plan in effect and disallow those claims as required.*

PLAN OF CORRECTION:

3a. The MHP shall submit a POC that indicates how the MHP will:

1) Ensure that initial client plans are completed in accordance with the MHP's written documentation standards.
2) Ensure that the interventions/modalities on the client plans are clear, specific, detailed and address the beneficiary's identified functional impairments as a result of the mental disorder.
3) Ensure that services are not claimed:

a) When an initial client plan has not been completed.

b) When not indicated on the initial client plan.

4) Provide evidence that those services claimed outside of the audit review period for which there were no client plans in effect are disallowed.

FRESNO'S RESPONSE:

The *FCMHP Audit Summary Tool* (See Attachment I) has been reviewed and updated as necessary to ensure that all Plans of Care are completed in accordance with the timeliness and frequency requirements (item 10 of tool), that the goals/objectives and proposed interventions are in accordance with MHP documentation standards (items 12-17 of tool), and is updated at least annually or when significant changes occur (item 11 of tool) for utilization at all MHP chart reviews. In addition:

1. For county-operated programs, the Division Managers will require that all Clinical Supervisors with programs providing outpatient specialty mental health services will review the deficiencies identified during this audit and the plan of correction with their subordinate direct service employees.
2. The client treatment plan was added to the electronic health record in Avatar in June 2014. This should avoid the occurrence of a paper treatment plan missing from the client's medical records chart. The treatment plan is now required to be completed at the time of the assessment. There is now an alert (flag) in Avatar on the client's account to indicate the treatment plan has expired. The "Expiring Treatment Plan" report is generated by the Quality Improvement staff and can also be run by the Clinical Supervisors (See Attachment O). This report identifies when the treatment plan has expired in red and yellow when it is due within the next 60 days.
3. The MHP provides documentation and billing training for new employees and annually and includes these requirements in the training.
4. The Plan of Correction (POC) will be reviewed with all appropriate staff within 30 days of submission to DHCS with ongoing training, chart audits and continuous quality improvement thereafter.
5. For the contracted provider program identified in 3a, the provider of services reviewed was contacted and provided a collaborative Plan of Correction response to address specific findings that were identified. (See Attachment J). Provider 10CI has adequately addressed through training and documented procedures that ensure initial client plans are completed within the time period specified in the MHP documentation standards as demonstrated in Attachment J.2.
6. MHP staff reviewed all services and claims during which there was no initial client plan in effect outside of the audit review period, identified in Line #19 and Line #5 of the Recoupment Summary. The remaining service claims were found to be in compliance and no further disallowances were identified.

FINDING:

3a, 3b. Reason for Recoupment #6 - The client plan was not updated at least annually, as required in the MHP Contract with the Department and/or as specified in the MHP's documentation standards:

- Line #10: There was no updated client plan in the medical record. During the

review, MHP staff was given the opportunity to locate the document in question but could not find written evidence of it in the medical record. *The MHP should review all services and the claims during which there was no client plan in effect and disallow those claims as required.*

- Line #1: There was no updated client plan for one or more type of service being claimed. During the review, MHP staff was given the opportunity to locate the services in question on a client plan but could not find written evidence of it. *The MHP should review all services and claims during which there was no client plan for the services in question and disallow those claims as required.*
- Line #15: There was a lapse between the prior and current client plans and therefore, there was no client plan in effect during a portion or all of the audit review period. *The MHP should review all services and claims during which there was no client plan in effect and disallow those claims as required.*
- Line #1 and Line #16: There was a lapse between the prior and current client plans. However, this occurred outside of the audit review period. *The MHP should review all services and claims outside of the audit review period during which there was no client plan in effect and disallow those claims as required.*

Refer to the enclosed Recoupment Summary for additional details concerning any disallowance indicated above.

PLAN OF CORRECTION:

3a, 3b. 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.
2) Ensure that all types of interventions/service modalities provided and claimed are recorded as proposed interventions on a current client plan.
3) Ensure that all interventions/modalities recorded on client plans are clear, specific, detailed and address the beneficiary's identified functional impairments as a result of the mental disorder.
4) Ensure that non-emergency services are not claimed when:
    a) A client plan has not been completed.
    b) The service provided is not included on the current client plan.
5) Provide evidence that all services claimed outside of the audit review period for which no client plan was in effect are disallowed.

FRESNO'S RESPONSE:

The *FCMHP Audit Summary Tool* (See Attachment I) has been reviewed and updated as necessary to ensure that all Plans of Care are updated at least annually and within the timeliness and frequency as required (item 11 of tool) for utilization at all MHP chart reviews. In addition:

1. For county-operated programs, the Division Managers will require that all Clinical Supervisors with programs providing outpatient specialty mental health

services will review the deficiencies identified during this audit and the plan of correction with their subordinate direct service employees.

2. The client treatment plan was added to the electronic health record in Avatar in June 2014. There is now an alert (flag) in Avatar on the client's account to indicate the treatment plan has expired. The "Expiring Treatment Plan" report is generated by the Quality Improvement staff and can also be run by the Clinical Supervisors (See Attachment O). This report identifies when the treatment plan has expired in red and yellow when it is due.
3. Targeted training was provided to the specific programs identified through this audit. These requirements are also included and will be emphasized in the Documentation and Billing training that is mandated for all new employees and annually for all direct service providers. In addition, targeted training will be provided throughout DBH by the end of the fiscal year.
4. The MHP provides documentation and billing training for new employees and annually and includes these requirements in the training.
5. Ensuring that treatment plans adhere to Findings 1-5, those standards and requirements are included in the current and ongoing chart audit process performed by Clinical Supervisors (approximately 5 charts per quarter per clinician/case manager) and reviewed with clinicians/case managers for ongoing quality improvement. Clinical Supervisors will also present examples of good documentation, an object lesson to their team(s) and perform a periodic consistency monitoring between the supervisors for inter-rater reliability.
6. The Plan of Correction (POC) will be reviewed with all appropriate staff within 30 days of submission to DHCS with ongoing training, chart audits and continuous quality improvement thereafter.
7. For the contracted provider program identified in 3a -3b, each provider of services reviewed was contacted and provided a collaborative Plan of Correction response to address specific findings that were identified (See Attachment J). Provider 10CY and 10DP have adequately addressed through training and documented procedures Findings 1-4 as demonstrated in Attachment J.
8. MHP staff reviewed all services and claims during which there was no initial client plan in effect outside of the audit review period, identified in Line #10, Line #15, and Line #16 of the Recoupment Summary. The service claims for these Line #s were found to be in compliance and no further disallowances were identified. MHP staff reviewed all services and claims for to medical record identified as Line #1 and did identify 6 services outside the audit period for which there was no client plan in effect. These additional services from Line #1 have been disallowed as evidenced by the MHP "Submitted Scarfs Report" (See Attachment P).

FINDING:

3a, 3b. The client plan was not updated when there was a significant change in the beneficiary's condition, as required in the MHP Contract with the Department:

- Line #5: The effective dates of the current client plan were 4/28/2014 to 4/27/2015. The medical record indicates that the beneficiary was seen in Crisis Intervention on multiple occasions during the effective dates of the current plan.

However, there was no documentation that the client plan was reviewed and updated in response to these emergency services.

- Line #6: The effective dates of the current client plan were 10/29/2013 to 10/28/2014. The medical record indicates that the beneficiary received both Crisis Intervention and Crisis Stabilization services during the effective dates of the current plan. However, there was no documentation that the client plan was reviewed and updated in response to these emergency services.

PLAN OF CORRECTION:

3a, 3b. The MHP shall submit a POC that indicates how the MHP will ensure that client plans are reviewed and updated whenever there is a significant change in the beneficiary's condition.

FRESNO'S RESPONSE:

The *FCMHP Audit Summary Tool* (See Attachment I) has been reviewed and updated to ensure that all Plans of Care are reviewed and updated as appropriate when there is a significant change in the beneficiary's condition (item 11 of tool) for utilization at all MHP chart reviews. In addition:

1. For county-operated programs, the Division Managers will require that all Clinical Supervisors with programs providing outpatient specialty mental health services will review the deficiencies identified during this audit and the plan of correction with their subordinate direct service employees. This will include a review of the expectation that when a client is new, seen for ongoing services, and/or receives crisis or acute psychiatric inpatient services, the clinician is required to review the client's treatment plan and make updates when there are significant changes.
2. The MHP provides documentation and billing training for new employees and annually and includes these requirements in the training.
3. Ensuring that treatment plans are updated whenever there is a significant change in the beneficiary's conditions is included in the current and ongoing chart audit process performed by Clinical Supervisors (approximately 5 charts per quarter per clinician/case manager) and reviewed with clinicians/case managers for ongoing quality improvement. Clinical Supervisors will also present examples of good documentation, an object lesson to their team(s) and perform a periodic consistency monitoring between the supervisors for inter-rater reliability.

FINDING:

3c-1-3. The following Line #s had client plans that did not include all of the items specified in the MHP Contract with the Department:

1) **3c-1.** Line #1, Line #2, Line #14, Line #18 and Line #19: One or more of the goals/treatment objectives were not specific, observable, and/or quantifiable and related to the beneficiary's mental health needs and identified functional impairments as a result of the mental health diagnosis.

2) **3c-2.** Line #1, Line #2, Line #7, Line #12, Line #13, Line #14, Line #15, Line #17, Line #18 and Line #19: One or more of the proposed interventions did not include a detailed description. Instead, only a "type" or "category" of intervention was

recorded on the client plan (e.g. "Medication Support Services," "Targeted Case Management," "Mental Health Services," etc.).

3) **3c-3.** Line #1, Line #4, Line #17 and Line #20: One or more of the proposed interventions did not indicate an expected frequency.

PLAN OF CORRECTION:

3c-1-3 The MHP shall submit a POC that indicates how the MHP will ensure that:

1) All client plan goals/treatment objectives are specific, observable and/or quantifiable and relate to the beneficiary's documented mental health needs and functional impairments as a result of the mental health diagnosis.
2) 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) All mental health interventions proposed on client plans indicate both an expected frequency and duration for each intervention.

FRESNO'S RESPONSE:

To ensure that all client plans meet the criteria per Findings 1-3, The *FCMHP Audit Summary Tool* (See Attachment I) has been reviewed and updated (Items 12, 13, and 14). In addition:

1. For county-operated programs, the Division Managers will require that all Clinical Supervisors with programs providing outpatient specialty mental health services will review the deficiencies identified during this audit and the plan of correction with their subordinate direct service employees. This will include that clinical staff have been instructed to complete the "Interventions" section on the treatment plan and ensure that they directly relate back to the client's mental health needs, functional impairments, consistent with the diagnoses and provide specificity of the interventions planned.
2. In Avatar, there are templates for both the SOAP and BIOP formats to help structure client documentation. Targeted training will be provided throughout DBH by the end of the fiscal year.
3. The MHP provides documentation and billing training for new employees and annually and includes these requirements in the training.
4. Ensuring that Findings #1 and 2 along with the expected frequency and duration for each intervention are present in client treatment plans; these are included in the current and ongoing chart audit process performed by Clinical Supervisors (approximately 5 charts per quarter per clinician/case manager) and reviewed with clinicians/case managers for ongoing quality improvement. Clinical Supervisors will also present examples of good documentation, an object lesson to their team(s) and perform a periodic consistency monitoring between the supervisors for inter-rater reliability.
5. For the contracted provider programs identified, each provider of services reviewed was contacted and provided a collaborative Plan of Correction response to address specific findings that were identified in 3c-1.3 (See Attachment J). Providers 10DP, 10C9, 10CW, and 10CI have adequately

addressed through training and documented procedures Findings 1-3 as demonstrated in Attachments J-1, J-2, and J-5.

6. The Plan of Correction (POC) will be reviewed with all appropriate staff within 30 days of submission to DHCS with ongoing training, chart audits and continuous quality improvement thereafter.

FINDING:

3g. There was inadequate documentation that the beneficiary or legal guardian was offered a copy of the client plan for the following Line #s: Line #1, Line #4 and Line #14.

PLAN OF CORRECTION:

3g. The MHP shall submit a POC that indicates how the MHP will:

1) Ensure that there is documentation substantiating that the beneficiary was offered a copy of the client plan.
2) Submit evidence that the MHP has an established process to ensure that the beneficiary is offered and whether or not he/she received a copy of the client plan.

FRESNO'S RESPONSE:

In order to ensure that there is documentation substantiating that the beneficiary was offered a copy of the client plan and evidence that the MHP has an established process to ensure that the beneficiary is offered and whether or not he/she received a copy of the client plan, Fresno County has mutually emphasized this in trainings and has revised its chart review standards, including:

1. For county-operated programs, the Division Managers will require that all Clinical Supervisors with programs providing outpatient specialty mental health services will review the deficiencies identified during this audit and the plan of correction with their subordinate direct service employees.
2. The treatment plan in Avatar includes a box (yes, no, refused) to note that the treatment plan was offered, not offered or refused and is a required field and space to provide additional information. Targeted training will be provided throughout DBH by the end of the fiscal year.
3. The MHP provides documentation and billing training for new employees and annually and includes these requirements in the training.
4. Ensuring that Findings 1 and 2 are included in the current and ongoing chart audit process performed by Clinical Supervisors (approximately 5 charts per quarter per clinician/case manager) and reviewed with clinicians/case managers for ongoing quality improvement. Clinical Supervisors will also present examples of good documentation, an object lesson to their team(s) and perform a periodic consistency monitoring between the supervisors for inter-rater reliability.
5. For the contracted provider program identified, the provider of services reviewed was contacted and provided a collaborative Plan of Correction response to address specific findings that were identified in 3g (See Attachment J). Provider 10DP has adequately addressed through training and documented procedures that ensure Findings 1-3 as demonstrated in Attachment J.1.

6. The *FCMHP Audit Summary Tool,* item 21 (See Attachment I) have been reviewed and updated as necessary to capture Findings 1-3 criteria for utilization of all MHP chart reviews.
7. The Plan of Correction (POC) will be reviewed with all appropriate staff within 30 days of submission to DHCS with ongoing training, chart audits and continuous quality improvement thereafter.

ITEM NO. 13, Section K, "Chart Review – Non-Hospital Services," Questions 4a-4d:

4. Do the progress notes describe how services provided reduced impairment,

4a. restored functioning, or prevented significant deterioration in an important area of life functioning outlined in the client plan?

4b. 1) Timely documentation of relevant aspects of client care, including documentation of medical necessity;

2) Documentation of client encounters, including relevant clinical decisions, when decisions are made, alternative approaches for future interventions;

3) Interventions applied, beneficiary's response to the interventions and the location of the interventions;

4) The date the services were provided;

5) Referrals to community resources and other agencies, when appropriate;

6) Documentation of follow-up care, or as appropriate, a discharge summary;

7) The amount of time taken to provide services;

8) The signature of the person providing the service (or electronic equivalent); the person's type of professional degree, licensure or job title; and the relevant identification number, if applicable.

9) The date the service was documented in the medical record by the person providing the service.

4c. Timeliness/frequency as follows:

1) Every service contact for:

A) Mental health services.
B) Medication support services.
C) Crisis intervention.
D) Targeted Case Management.

2) Daily for:

A) Crisis residential.
B) Crisis stabilization (one per 23/hour period).
C) Day treatment intensive.

3) Weekly for:

A) Day treatment intensive.
B) Day rehabilitation.
C) Adult residential.

4d. Is the documentation legible?

- *CCR, title 9, chapter 11, section 1810.254*
- *CCR, title 9, chapter 11, section 1810.440(c)*
- *CCR, title 9, chapter 11, section 1840.314*
- *CCR, title 9, chapter 11, section 1840.316-1840.322*
- *CCR, title 9, chapter 11, section 1840.112(b)(3)(6)*
- *CCR, title 22, chapter 3, section 51458.1*
- *CCR, title 22, chapter 3, section 51470*

NOTE:
4a-d: Multiple progress notes used for the purpose of claiming Federal Financial Participation
(FFP) Specialty Mental Health Services (SMHS) were disallowed.

Refer to the enclosed Recoupment Summary for additional details concerning any disallowance listed below.

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

1) One or more progress note was not completed within the timeliness and frequency standards in accordance with regulatory and contractual requirements.
2) The MHP was not following its own written documentation standards for timeliness of staff signatures on progress notes.

PLAN OF CORRECTION:
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) Provide evidence that the MHP has written documentation standards for progress notes, including required elements, timeliness and frequency as required in the MHP Contract with the Department.
3) Describe how the MHP will ensure that progress notes are completed in accordance with the timeliness and frequency requirements specified in the MHP's written documentation standards.

FRESNO'S RESPONSE:
In order to ensure that all progress notes meet timeliness, frequency and staff signature requirements as supported by the MHP written documentation standards for progress notes, Fresno County has mutually emphasized this in trainings and has revised its chart review standards to ensure progress notes are completed in accordance with these standards, including:

1. The *FCMHP Audit Summary Tool,* items 28a-f and 29a-c (See Attachment I) have been reviewed and updated as necessary to capture timeliness, frequency, and all other required progress note elements for utilization of all MHP chart reviews.
2. For county-operated programs, the Division Managers will require that all

Clinical Supervisors with programs providing outpatient specialty mental health services will review the deficiencies identified during this audit and the plan of correction with their subordinate direct service employees.

3. A targeted training will be provided to ensure that staff document attempts to contact client or parent/guardian to explain gaps in service. Timeliness is addressed through the "Progress Note Late Billing Report" in Avatar that gives a list by individual staff or by supervisor that shows the number of days that has lapsed between the service date and the completion of the note. The Quality Improvement staff also provide a trending report for administrative/management review (See Attachment Q).
4. The MHP will review the current policy and procedure guideline to establish timeliness expectations for the completion of progress notes.
5. The MHP provides documentation and billing training for new employees and annually and includes these requirements in the training.
6. The Findings 1-3 are included in the current and ongoing chart audit process performed by Clinical Supervisors (approximately 5 charts per quarter per clinician/case manager) and reviewed with clinicians/case managers for ongoing quality improvement. Clinical Supervisors will also present examples of good documentation, an object lesson to their team(s) and perform a periodic consistency monitoring between the supervisors for inter-rater reliability.
7. The Plan of Correction (POC) will be reviewed with all appropriate staff within 30 days of submission to DHCS with ongoing training, chart audits and continuous quality improvement thereafter.

FINDING:

4a, 4b. Reason for Recoupment #9:

- **4a, 4b.** Line #1: There was no progress note in the medical record for the service claimed.

  During the review, the MHP staff was given the opportunity to locate the documents in question but could not find written evidence of them in the medical record.

- **4b.** Line #5, Line #7 and Line #17: The type of SMHS documented on the progress note was not the same type of SMHS claimed.

During the review, MHP staff was given the opportunity to locate any missing document for any disallowance indicated above but could not find written evidence of the document in the medical record.

PLAN OF CORRECTION:

4a, 4b. 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.

e) Claimed to provider who actually provided the services.

2) Ensure that all progress notes are:

a) Accurate and meet the documentation requirements described in the MHP Contract with the Department.

b) 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.

FRESNO'S RESPONSE:

The *FCMHP Audit Summary Tool* (See Attachment I) has been reviewed and updated to ensure that all SMHS claimed meet all the progress note requirements outlined in Findings 1-2 (items 30 and 49 through 61 of tool) for utilization at all MHP chart reviews. In addition:

1. For county-operated programs, the Division Managers will require that all Clinical Supervisors with programs providing outpatient specialty mental health services will review the deficiencies identified during this audit and the plan of correction with their subordinate direct service employees.
2. A targeted training will be provided by the end of the fiscal year to ensure that documentation of specialty mental health services meet the MHP and State requirements and are claimed in accordance with Medi-Cal billing requirements.
3. The MHP provides documentation and billing training for new employees and annually and includes these requirements in the training.
4. The Findings 1a-e and 2a-b are included in the current and ongoing chart audit process performed by Clinical Supervisors (approximately 5 charts per quarter per clinician/case manager) and reviewed with clinicians/case managers for ongoing quality improvement. Clinical Supervisors will also present examples of good documentation, an object lesson to their team(s) and perform a periodic consistency monitoring between the supervisors for inter-rater reliability.
5. The Plan of Correction (POC) will be reviewed with all appropriate staff within 30 days of submission to DHCS with ongoing training, chart audits and continuous quality improvement thereafter.
6. For the contracted provider program identified, the provider of services reviewed was contacted and provided a collaborative Plan of Correction response to address specific findings regarding progress note requirements (See Attachment J). Provider 10DP has adequately addressed through training and documented procedures that ensure Findings 1-2 as demonstrated in Attachment J-5.

FINDING:

4b-1, 4b-8. Progress notes did not document thefollowing:

1) **4b-1.** Line #1, Line #2, Line #7, Line #13, Line #14, Line #15, Line #17, Line #18, Line #19 and Line #20: Timely documentation of relevant aspects of beneficiary care as specified by the MHP's documentation standards (i.e.,

progress notes completed late based on the MHP's written documentation standards in effect during the audit period).

2) **4b-8.** Line #18: The provider's professional degree, licensure or job title.

PLAN OF CORRECTION:

4b-1, 4b-8. The MHP shall submit a POC that indicates how the MHP will ensure that progress notes document:

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.
2) The provider's professional degree, licensure or job title.

FRESNO'S RESPONSE:

In order to ensure the timely completion of progress notes by the person providing the service, relevant aspects of the client care, and that the provider's professional degree, licensure or job title are included in the documentation, Fresno County has mutually emphasized this in trainings and has revised its chart review standards, including:

1. The *FCMHP Audit Summary Tool,* items 28a-f and 29a-c (See Attachment I) have been reviewed and updated as necessary to capture all required progress note elements for utilization of all MHP chart reviews.
2. For county-operated programs, the Division Managers will require that all Clinical Supervisors with programs providing outpatient specialty mental health services will review the deficiencies identified during this audit and the plan of correction with their subordinate direct service employees.
3. The MHP provides documentation and billing training for new employees and annually and includes these requirements in the training.
4. Timely completion of progress notes is monitored through the "Progress Note Late Billing Report" in Avatar that gives a list by individual staff or by supervisor that shows the number of days that has lapsed between the service date and the completion of the note. Quality Improvement staff also provide a trending report for administrative/management review.
5. A review of the process to ensure that the provider's professional degree, licensure or job title and the Avatar billing number which is the same as the employee's identification number will be reviewed, revised if needed and provided to appropriate staff no later than March 2016.
6. The Findings 1-2 are included in the current and ongoing chart audit process performed by Clinical Supervisors (approximately 5 charts per quarter per clinician/case manager) and reviewed with clinicians/case managers for ongoing quality improvement. Clinical Supervisors will also present examples of good documentation, an object lesson to their team(s) and perform a periodic consistency monitoring between the supervisors for inter-rater reliability.
7. The Plan of Correction (POC) will be reviewed with all appropriate staff within 30 days of submission to DHCS with ongoing training, chart audits and continuous quality improvement thereafter.
8. For the contracted provider programs identified, the providers of services reviewed were contacted and provided a collaborative Plan of Correction response to address specific findings regarding progress note requirements

(See Attachment J). Providers 10DP and 10CI have adequately addressed through training and documented procedures as demonstrated in Attachments J-2 and J-5.

FINDING:

4b-3, 4b-7. Reason for Recoupment #14 - The claim for a group activity was not properly apportioned to the beneficiary participating in the group:

- Line #7 and Line #12: There was an inaccurate calculation of time apportioned for the claim based on the information recorded on the progress note (i.e., based on direct service time, travel and documentation times and the identification of each group facilitator involved in the session).
- Line #7: Progress notes did not document the contribution, involvement or participation of each group facilitator as it relates to the identified functional impairment and mental health needs of the beneficiary.

PLAN OF CORRECTION:

4b-3, 4b-7. The MHP shall submit a POC that indicates how the MHP will ensure that:

1) The number of clients in the group, number of staff, units of time, type of service and dates of service (DOS) documented on the group progress notes are accurate and consistent with the documentation in the medical record and that services are not claimed when billing criteria are not met.
2) If group sessions involve more than a single facilitator, progress notes clearly identify each group facilitator and document the contribution, involvement or participation of each as it relates to the identified functional impairment and mental health needs of the beneficiary.
3) There is medical necessity for the use of multiple staff facilitators in the group setting.

FRESNO'S RESPONSE:

In order to ensure that progress notes for group activities include all required elements as outlined in Findings 1-3, Fresno County has mutually emphasized this in trainings and has revised its chart review standards, including:

1. The *FCMHP Audit Summary Tool,* items 51a-d and 52a-d (See Attachment I) have been reviewed and updated as necessary to capture all required group progress note elements for utilization of all MHP chart reviews.
2. For county-operated programs, the Division Managers will require that all Clinical Supervisors with programs providing outpatient specialty mental health services will review the deficiencies identified during this audit and the plan of correction with their subordinate direct service employees.
3. The electronic health record in Avatar has been updated and tested for group notes. Calculations and the documentation of necessary information that is required for the calculation will be correct and included on future group notes, as demonstrated by the "Group Note Entry Screen" and "Sample Group Note" (See Attachment S).
4. The staff have received additional training on group notes to include requested information. In addition, those group notes that are now required to be co-

signed by both therapists and staff have been trained in documenting each co-facilitator's interventions and necessity in the group more specifically.
5. The MHP provides documentation and billing training for new employees and annually and includes these requirements in the training.
6. The content and accuracy of the calculation of group therapy are included in the current and ongoing chart audit process performed by Clinical Supervisors (approximately 5 charts per quarter per clinician/case manager) and reviewed with clinicians/case managers for ongoing quality improvement. Clinical Supervisors will also present examples of good documentation, an object lesson to their team(s) and perform a periodic consistency monitoring between the supervisors for inter-rater reliability.
7. The Plan of Correction (POC) will be reviewed with all appropriate staff within 30 days of submission to DHCS with ongoing training, chart audits and continuous quality improvement thereafter.

FINDING:
Progress notes for the following Line #s indicate that the service provided was solely for:

1) **Reason for Recoupment #16** - Transportation: Line #17.
2) **Reason for Recoupment #17** - Clerical: Line #7.

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

1) Each progress note 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 transportation, clerical or payee related activities.
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).

FRESNO'S RESPONSE:
In order to ensure that progress notes describe all required elements as outlined in Findings 1-3, Fresno County has mutually emphasized this in trainings and has revised its chart review standards, including:

1. The *FCMHP Audit Summary Tool,* items 28a-f, 33, 36, and 37 (See Attachment I) have all been reviewed and updated as necessary to capture all required progress note elements for utilization of all MHP chart reviews.
2. For county-operated programs, the Division Managers will require that all Clinical Supervisors with programs providing outpatient specialty mental health services will review the deficiencies identified during this audit and the plan of correction with their subordinate direct service employees.
3. The MHP provides documentation and billing training for new employees and annually and includes these requirements in the training.
4. The Findings 1-3 are included in the current and ongoing chart audit process

performed by Clinical Supervisors (approximately 5 charts per quarter per clinician/case manager) and reviewed with clinicians/case managers for ongoing quality improvement. Clinical Supervisors will also present examples when transportation or clerical functions have been billed incorrectly and also good examples of documentation to provide an object lesson to their team(s) and perform a periodic consistency monitoring between the supervisors for inter-rater reliability.

5. The Plan of Correction (POC) will be reviewed with all appropriate staff within 30 days of submission to DHCS with ongoing training, chart audits and continuous quality improvement thereafter.

ITEM NO. 14, Section K, "Chart Review – Non-Hospital Services," Questions 5a-f:

5. Have *Day Treatment Intensive* and *Day Rehabilitation* services been provided in accordance with regulatory and contractual requirements?

5a. Service Components:

1) Do *Day Treatment Intensive* and *Day Rehabilitation* programs include all the following required service components:

A. Daily Community Meetings;
B. Therapeutic Milieu;
C. Process Groups;
D. Skill-building Groups; and
E. Adjunctive Therapies?

2) In addition:

A. Does *Day Treatment Intensive* include Psychotherapy?
B. Community meetings must occur at least once a day and have the following staffing:
C. For *Day Treatment Intensive*: Staff whose scope of practice includes psychotherapy
D. For *Day Rehabilitation*: Staff who is a physician, a licensed/waivered/registered psychologist, clinical social worker, or marriage and family therapist; a registered nurse, psychiatric technician, licensed vocational nurse or mental health rehabilitation specialist.

5b. Attendance:

1) Is there documentation of the total number of minutes/hours the beneficiary actually attended the program?
2) If the beneficiary is unavoidably absent:

A. Is the total time (number of hours and minutes) the beneficiary actually attended the program that day documented;
B. Is the beneficiary present for at least 50 percent of the scheduled hours of operation for that day; and
C. Is there a separate entry in the medical record documenting the reason for the unavoidable absence?

5c. Continuous Hours of Operation:

Did the provider apply the following when claiming for the continuous hours of operation of *Day Treatment Intensive* and *Day Rehabilitation* services?

A. For Half-Day: The beneficiary received face-to-face services a minimum of three (3) hours each day the program was open.
B. For Full-Day: The beneficiary received face-to-face services in a program with services available more than four (4) hours per day.

5d. Staffing Requirements:

1) Do *Day Treatment Intensive* and *Day Rehabilitation* meet the following staffing requirements:
   A. For *Day Treatment Intensive* Psychotherapy is provided by licensed, registered, or waivered staff practicing within their scope of practice.
   B. For all scheduled hours of operation: There is at least one staff person present and available to the group in the therapeutic milieu.

5e. Documentation Standards:

1) Is the required documentation timeliness/frequency for *Day Treatment Intensive* or *Day Rehabilitation* being met?
   A. For *Day Treatment Intensive* services:
      - Daily progress notes on activities; and
      - A weekly clinical summary.
   B. For *Day Rehabilitation* services:
      - Weekly progress note
2) Do all entries in the beneficiary's medical record include:
   A. The date(s) of service;
   B. The signature of the person providing the service (or electronic equivalent);
   C. The person's type of professional degree, licensure, or job title;
   D. The date of signature;
   E. The date the documentation was entered in the beneficiary record; and
   F. The total number of minutes/hours the beneficiary actually attended the program?

5f. Written Program Description:

1) Is there a Written Program Description for *Day Treatment Intensive* and *Day Rehabilitation*?
   A. Does the Written Program Description describe the specific activities of each service and reflect each of the required components of the services as described in the MHP Contract?
2) Is there a Mental Health Crisis Protocol?
3) Is there a Written Weekly Schedule?
   A. Does the Written Weekly Schedule:
      a) Identify when and where the service components will be provided, and by whom; and

b) Specify the program staff, their qualifications, and the scope of their services?

FINDING:

5a. Reason for Recoupment #19a - Documentation for the following Line # indicated that essential requirements for a Day Treatment Intensive (DTI) program were not met, as specified by the MHP Contract with the Department:

1) Line #1: Community meetings were not documented to have been provided and attended by the beneficiary at least once a day.
2) Line #1: Process groups were not documented to have been provided and attended by the beneficiary as part of the program milieu.

Refer to the enclosed Recoupment Summary for additional details concerning any disallowance indicated above.

PLAN OF CORRECTION:

5a. The MHP shall submit a POC that indicates how the MHP will ensure that all program requirements for *Day Rehabilitation (DR)* and *DTI* are provided in accordance with regulatory and contractual requirements. For example:

1) Ensure that all the required service components, including daily community meetings and process groups, are met and documented.
2) Ensure that the community meetings occur at least once a day
3) Ensure that staffing for *DTI* community meetings include staff whose scope of practice included psychotherapy.
4) Ensure that staffing for *DR* community meetings include a physician, a licensed/waivered/registered psychologist, clinical social worker, or marriage and family therapist; registered nurse, psychiatric technician, licensed vocational nurse, or a mental health rehabilitation specialist.
5) Provide evidence that all *DTI* claims outside the audit review period are recouped when the required service components are not met and when required frequency and staffing requirements for community meetings and all other required service components are not met.

FRESNO'S RESPONSE:

Fresno County will continue to use documentation and billing training (provided to all MHP providers within 30 days of hire and annually thereafter) to emphasize the importance of accurate documentation and filing of clinical services in the medical record. Chart reviews of all programs that provide DR and DTI, as provided under the MHP's *Master Children's Placement RCL 12-14 Agreement 14-313* have been reviewed and updated to ensure that the required elements are documented as identified in Findings 1-5, as demonstrated in the Sections 14 and 32 along with the Documentation Standards for Client Records in Exhibit F of the Agreement (See Attachment T). In addition, the process of review by the MHP is outlined in *Invoice Process for Children's Master Placement Agreement – RCL 12-14 Providers for Specialized Residential Mental Health Services* protocol (See Attachment T). As for the contracted provider program identified, the provider of services reviewed was contacted and provided a

collaborative Plan of Correction response to address specific findings regarding DR and DTI requirements (See Attachment J). Provider 10DP has adequately addressed through training and documented procedures that ensure Findings 1-5 as demonstrated in Attachment J-5. The DTI claims outside of the audit review period were reviewed and 6 claims were found to be out of compliance. These claims were disallowed as evidenced by the Submitted Scarfs Report from the MHP's Avatar system (See Attachment P).

FINDING:

5f-1. The Written Program Description for *DTI* did not clearly reflect all of the required service components - as described in the MHP Contract - for the following Line #: Line #1.

PLAN OF CORRECTION:

5f-1. The MHP shall submit a POC that indicates how the MHP will:

1) Ensure that the Written Program Description for any MHP-contracted *DTI* and *DR* program describes the specific activities of each service component required in the MHP Contract.
2) Provide evidence that there is a full and complete Written Program Description for any *DTI and DR* program under contract with, or provided by, the MHP.

FRESNO'S RESPONSE:

Fresno County will continue to use documentation and billing training (provided to all MHP providers within 30 days of hire and annually thereafter) to emphasize the importance of accurate documentation and filing of clinical services in the medical record. Chart reviews of all programs that provide DTI and DR, as provided under the MHP's *Master Children's Placement RCL 12-14 Agreement 14-313* have been reviewed and updated to ensure that the required elements are documented as identified in Findings 1-2, as demonstrated in the Sections 14 and 32 along with the Documentation Standards for Client Records in Exhibit F of the Agreement (See Attachment T). In addition, the process of review by the MHP is outlined in *Invoice Process for Children's Master Placement Agreement – RCL 12-14 Providers for Specialized Residential Mental Health Services* protocol (See Attachment T). As for the contracted provider program identified, the provider of services reviewed was contacted and provided a collaborative Plan of Correction response to address specific findings regarding DTI and DR requirements (See Attachment J). Provider 10DP has adequately addressed through training and documented procedures that ensure Findings 1-2 as demonstrated in Attachment J-5. The Written Program Description from the contractor covered under Agreement 14-313 was acquired (See Attachment U).

FINDING:

5f-3. The Written Weekly Schedule for *DTI* did not clearly identify:

1) **5f-3A-a.** Line #1: The provision of Process Groups and daily Community Meetings.
2) **5f-3A-b.** Line #1: All program staff and their qualifications for each service activity required by the MHP Contract with the Department.

PLAN OF CORRECTION:

5f-3. The MHP shall submit a POC that indicates how the MHP will:

1) Ensure that there is a Written Weekly Schedule for *DTI* programs with all required components.
2) Ensure that the Written Weekly Schedules for *DTI* programs identify when and where the service components will be provided and by whom;
3) Ensure that the Written Weekly Schedules for *DTI* programs identify all program staff and specifies their qualifications and scope of their services
4) Provide evidence that there are current Written Weekly Schedules for *DTI* programs that are updated whenever there is any change in program staff and/or schedule.

FRESNO'S RESPONSE:

Fresno County will continue to use documentation and billing training (provided to all MHP providers within 30 days of hire and annually thereafter) to emphasize the importance of accurate documentation and filing of clinical services in the medical record. Chart reviews of all programs that provide DTI, as provided under the MHP's *Master Children's Placement RCL 12-14 Agreement 14-313* have been reviewed and updated to ensure that the required elements including a written weekly schedule for DTI are documented as identified in Findings 1-4, as demonstrated in the Sections 14 and 32 along with the Documentation Standards for Client Records in Exhibit F of the Agreement (See Attachment T). In addition, the process of review by the MHP is outlined in *Invoice Process for Children's Master Placement Agreement – RCL 12-14 Providers for Specialized Residential Mental Health Services* protocol (See Attachment T). As for the contracted provider program identified, the provider of services reviewed was contacted and provided a collaborative Plan of Correction response to address specific findings regarding DTI requirements of a written weekly schedule (See Attachment J). Provider 10DP has adequately addressed through training and documented procedures that ensure Findings 1-4 as demonstrated in Attachment J-5. As provider 10DP is no longer contracted with the MHP to provide DTI (See Attachment V), and there are no other current DTI programs at this time, no current Written Weekly Schedules are provided with this response.

ITEM NO. 15, Section K, "Chart Review – Non-Hospital Services," Questions 6i-iii:

6. Do all entries in the beneficiary's medical record include:
   - **i. Date of service?**
   - **ii. The signature of the person providing the service or (electronic equivalent) with the person's professional degree, licensure or job title; AND**
   - **iii. The date the documentation was entered in the medical record?**

FINDING:

6-i. The entries in the beneficiary's medical record did not include the following:

1) 6-iii. Date the documentation was entered into the medical record:
   - Medication consent signature date: Line #5.

PLAN OF CORRECTION:

6-i. The MHP shall submit a POC that indicates how the MHP will ensure that all documentation includes the date the date of signature to identify when the document was completed and entered into the medical record.

FRESNO'S RESPONSE:

In order to ensure that all entries in the beneficiary's medical record include the date of signature to identify when the document was completed and entered into the medical record, Fresno County has mutually emphasized this in trainings and has revised its chart review standards, including:

1. The *FCMHP Audit Summary Tool,* item 68 (See Attachment I) have all been reviewed and updated as necessary for utilization of all MHP chart reviews.
2. All progress notes and electronic forms in the MHP's Avatar system have been developed to capture the date of the electronic signature when a progress note is finalized. With a "Staff Billing QA Report" that lists by staff member any issues including entries that are left in draft status and have not been finalized by date, date of signature of entries can be monitored and addressed (See Attachment R). The Clinical Supervisor can run this report to monitor and ensure all entries are completed, including date of signature when entry is finalized.
3. For county-operated programs: For county-operated programs, the Division Managers, Medical Director and Chief Child Psychiatrist will require that all supervisors and staff obtaining signatures or otherwise involved with medication consent forms will be informed of the deficiency identified during this audit and the plan of correction with their subordinate employees.
4. In addition, the medication consent is completed online in Avatar and includes the date that it is signed by the client or legal guardian on the printout/viewer.
5. The MHP provides documentation and billing training for new employees and annually and includes this requirement in the training.
6. The Plan of Correction (POC) will be reviewed with all appropriate staff within 30 days of submission to DHCS with ongoing training, chart audits and continuous quality improvement thereafter.

Attachment A
Access Line Monthly Test Calls

Fresno County Department of Behavioral Health
Access Line Test Monthly Test for December 2015 and
Calendar Year End Comparison

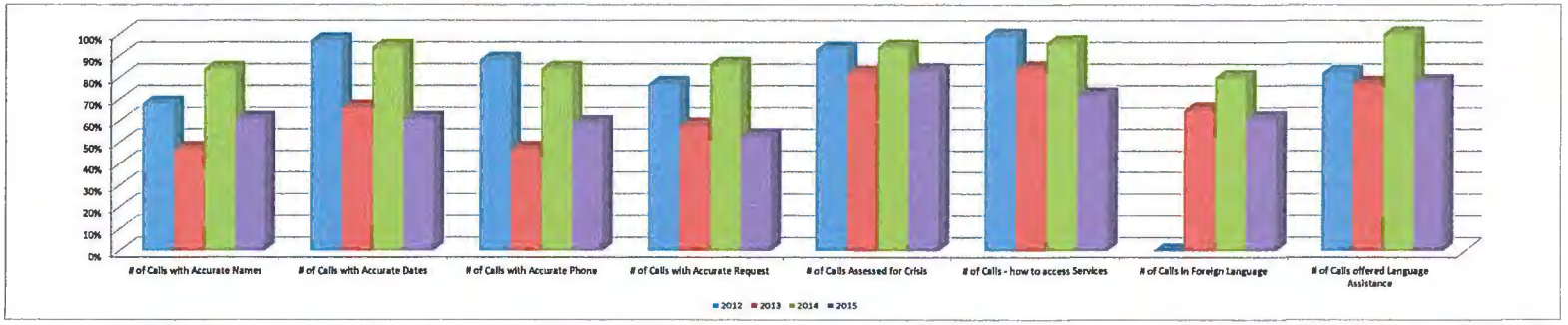
Operator	Call Date	Call Time	Caller Name	Reason for Call	Name Accurate	Date Accurate	Phone # Accurate	Reason/ Request Accurate	Assessed for Crisis	Disposition Appropriate – Info. given on how to access SMHS	Language	LEP Consumers offered assistance to free language assistance services	Comments
Maria	12/15/15	8:53AM	Alicia	#2 -Grief After Loss	CALL NOT LOGGED					X	Spanish	X	Directed to call DBH 600-9150 (was not informed it was DBH Admin)
Michelle	12/26/15	4:20PM	Judy T	#4 - Calling for Self MH	X	X	X	X	X		English		I was asked if I was a DBH Member/Address/last 4 digits of my SS#. Operator stated I would be contacted within 3 days.
Megan	12/30/15	3:46PM	Armando C	#1 - Parent for Child	CALL NOT LOGGED				X	X	English		Opertor didn't let me finish what I was saying, ask my child age and then gave me outpatient services number.

	Total # of Calls	Total # of Calls Logged	Total # of Calls w/ Accurate Names	Total # of Calls w/ Accurate Dates	Total # of Calls w/ Accurate Phone #'s	Total # of Calls w/ Accurate Reasons/Requests	Total # of Calls Assessed for Crisis	Total # of Calls w/ Appropriate Info. given on how to access SMHS	Total # of Calls in a Foreign Language	Total # of Calls offered assistance to free Language Assistance Services
	3 =	1 of 3 =	1 of 3 =	1 of 3 =	1 of 3 =	1 of 3 =	2 of 3 =	2 of 3 =	1 of 3 =	1 of 1 =
	100%	33%	33%	33%	33%	33%	67%	67%	33%	100%

CALENDAR YEAR 2015 SUMMARY OF ACCESS LINE TEST CALLS

	Total # of Calls	Total # of Calls Logged	Total # of Calls w/ Accurate Names	Total # of Call w/ Accurate Dates	Total # of Calls w/ Accurate Phone #'s	Total # of Calls w/ Accurate Reasons/Requests	Total # of Calls Assessed for Crisis	Total # of Calls w/ Appropriate Info. given on how to access SMHS	Total # of Calls in a Foreign Language	Total # of Calls offered assistance to free language assistance services
JAN	6	5 of 6 = 83%	5 of 6 =83%	5 of 6 =83%	5 of 6 =83%	5 of 6 =83%	6 of 6 = 100%	6 of 6 = 100%	5 of 6 = 83%	4 of 5 = 80%
FEB	6	4 of 6 = 67%	4 of 6 = 67%	4 of 6 = 67%	4 of 6 = 67%	4 of 6 = 67%	6 of 6 = 100%	4 of 6 = 67%	5 of 6 = 83%	5 of 5 = 100%
MAR	7	3 of 7 = 43%	3 of 7 = 43%	3 of 7 = 43%	3 of 7 = 43%	3 of 7 = 43%	5 of 7 = 71%	5 of 7 = 71%	5 of 7 = 71%	3 of 5 = 60%
APR	2	1 of 2 = 50%	0 of 2 = 0%	1 of 2 = 50%	1 of 2 = 50%	1 of 2 = 50%	2 of 2 = 100%	2 of 2 = 100%	2 of 2 = 100%	2 of 2 = 100%
MAY						NO TEST CALLS WERE COMPLETED				
JUN	7	6 of 7 = 86%	6 of 7 = 86%	6 of 7 = 86%	5 of 7 = 71%	4 of 7 = 57%	5 of 7 = 71%	5 of 7 = 71%	5 of 7 = 71%	4 of 5 = 80%
JUL	7	7 of 7 = 100%	7 of 7 = 100%	6 of 7 = 86%	6 of 7 = 86%	5 of 7 = 71%	7 of 7 = 100%	7 of 7 = 100%	2 of 7 = 29%	2 of 2 = 100%
AUG	6	4 of 6 = 67%	4 of 6 = 67%	4 of 6 = 67%	4 of 6 = 67%	2 of 6 = 33%	6 of 6 = 100%	3 of 4 = 75%	6 of 6 = 100%	5 of 6 = 83%
SEP	6	3 of 6 = 50%	3 of 6 = 50%	3 of 6 = 50%	3 of 6 = 50%	3 of 6 = 50%	4 of 6 = 67%	4 of 6 = 67%	3 of 6 = 50%	2 of 3 = 67%
OCT	3	1 of 3 = 33%	1 of 3 =33%	1 of 3 =33%	1 of 3 =33%	1 of 3 =33%	3 of 3 = 100%	1 of 3 =33%	2 of 3 = 67%	1 of 2 = 50%
NOV	13	6 of 13 = 46%	6 of 13 = 46%	6 of 13 = 46%	6 of 13 = 46%	6 of 13 = 46%	9 of 13 = 69%	7 of 13 = 54%	4 of 13 = 31%	2 of 4 = 50%
DEC	3	1 of 3 = 33%	1 of 3 =33%	1 of 3 =33%	1 of 3 =33%	1 of 3 =33%	2 of 3 = 67%	2 of 3 = 67%	1 of 3 = 33%	1 of 1 = 100%
YR to DATE	66	41 of 66 = 67%	40 of 66 = 61%	40 of 66 = 61%	39 of 66 = 59%	35 of 66 = 53%	55 of 66 = 83%	46 of 64 = 72%	40 of 66 = 61%	31 of 40 = 78%

Access Line Test Calls Comparison by Calendar Year 2012, 2013, 2014, and 2015



Number of Test Calls vary by Calendar Year with the goal of 84 calls per year, number of calls by year are as follows: 2012 (Unknow number of calls); 2013 (100 calls); 2014 (49 calls); and 2015 (66 Calls) . The Departments goal for test calls Fiscal Year 2015-16: 7 calls per month, with 5 calls tested in a foreign langauage, to test the County's threshold languages: (3 Spanish/2 Hmong/2 English).

Attachment B
Claims Processing, Inpatient Psychiatric Hospital Services Policy and Procedure Guide

Attachment B-1
Training Sign-in Sheet

Section No.: 4 - **Managed Care** **Effective Date: 04/01/1998**

Chapter No.: 3 - **Billing & Claims Processing** **Revised Date: 03/29/2016**

Item No.: 1 - **Claims Processing, Inpatient Psychiatric Hospital Services**

POLICY: The Fresno County Mental Health Plan (FCMHP) ensures that all inpatient psychiatric facilities that provide services to its clients are compensated in a timely manner.

PURPOSE: To establish a process for timely processing of claims for payment from inpatient psychiatric facilities.

REFERENCES: CCR, title 9, chapter 11, sections 1810.242, 1820.220(c), (d), 1820.220 (f), 1820.220 (h), and 1820.215 and CFR, title 42, section 438.210 (d)

DEFINITIONS: Utilization Review Specialist: A State of California licensed Clinical Social Worker, Marriage and Family Therapist, or Registered Nurse with at least one (1) year full-time, paid mental health experience as a Social Worker, Marriage and Family Therapist or Registered Nurse.

PROCEDURE:

I. CLAIMS SUBMISSION THROUGH TREATMENT AUTHORIZATION REQUEST (TAR) 18-3

A. Fee-for-Service providers (i.e., Community Behavioral Health Center and Kaweah Delta Mental Health Hospital) providing services to Medi-Cal beneficiaries must submit their claims to the FCMHP through a Treatment Authorization Request (TAR) 18-3 Form.

B. The original TAR and copy of the consumer's medical records must be submitted to the FCMHP within fourteen (14) calendar days of client's discharge from the facility.

C. The original TAR will be date stamped by FCMHP staff when the TAR and medical record is received from the provider. The FCMHP's Utilization Review Specialist will process the claim for payment within fourteen (14) calendar days of receipt of the TAR and medical records.

D. To process a claim, the following steps will be followed:

1. Review of timeliness of notification of admission and submission of the TAR. Notification beyond ten (10) calendar days of admission may cause a denial of

requested services. In addition, TARS not submitted within fourteen (14) calendar days after discharge may also result in denial of the service request.

2. Review the TAR for completeness. Refer to Attachment A for TAR sample and instructions for completing the TAR.

3. Review medical record for medical necessity of inpatient psychiatric stay.

4. The Utilization Review Specialist will approve, deny, or modify the payment request after reviewing related documentation. The TAR must be filled out following the instructions on Form 18-3. In addition, the Fresno County logo must be stamped on the TAR after all boxes are completed. (See 7. below for additional steps in processing denied/modified TARS.)

5. The completed TAR must be copied in duplicate. The original TAR will be kept in the consumer's file at the Managed Care office. A copy is sent to the Department of Heatlh Care Services (DHCS) Fiscal Intermediary and the other copy is mailed to the provider.

6. Information from completed TARS are entered into Avatar for reporting and statistical analysis.

7. If the Utilization Review Specialist denies, modifies, or reduces a service request, the Utilization Review Specialist will consult with the FCMHP psychiatrist from the Children's Division for consumers under age 18 and the Adult Services Division for consumers 18 years of age and older before making the final decision. The Psychiatrist must sign the TAR by the date indicated at the top of the TAR Denial Worksheet (Attachment B). If the psychiatrist agrees with the Utilization Review Specialist, a NOA-C form is completed within 3 working days of the noticeable act and a copy is mailed to the consumer and the provider and a copy is kept on file at Managed Care.

II. OTHERS

A. Short-Doyle/Medi-Cal providers that are contracted with FCMHP and providing services to FCMHP Medi-Cal and indigent clients will submit their claims to the FCMHP through an original Request for Mental Health Stay in Hospital form (Attachment C). Fee-for-service contract providers providing services to FCMHP indigent clients will also submit their claims to FCMHP through a Request For Mental Health Stay in Hospital Form. Short-Doyle/Medi-Cal providers that do not have a contract with the FCMHP may request payment using their own claim form. (Refer to Attachment D as sample).

B. The Request/claim form and copy of the client's medical record must be submitted to the FCMHP within fourteen (14) calendar days following discharge.

For the indigent, a copy of a completed UMDAP application should be included.

C. The FCMHP's Utilization Review Specialist will process the claim for payment within fourteen (14) calendar days of receipt of the request and medical record.

D. To process a claim, the following steps will be followed:

1. Review of timeliness of ten (10) calendar days notification of admission and submission of the claim. Notification beyond ten (10) calendar days of admission may cause a denial of requested services. In addition, claims not submitted within fourteen (14) calendar days after discharge may also result in denial of the service request.

2. Review the claim form for completeness.

3. Review the medical record for medical necessity of inpatient psychiatric stay.

4. The Utilization Review Specialist will approve, deny, or modify the payment request after reviewing related documentation. The claim form will be filled out with the authorization decision. The Fresno County logo must be stamped on the claim form after all boxes are completed. (See 7. below for additional steps in processing denied/modified TARS.)

5. The completed claim form must be copied in duplicate. The original claim form will be kept in the client's file at the Managed Care office. A copy is sent to Business Office for payment, and the other copy goes to the provider.

6. Information from completed claim forms are entered into Avatar for reporting and statistical analysis.

7. If the Utilization Review Specialist denies, modifies, or reduces a service request, the Utilization Review Specialist will consult with the FCMHP psychiatrist from the Children's Division for consumers under age 18 and the Adult Services Division for consumers 18 years of age and older before making the final decision. The Psychiatrist must sign the TAR by the date indicated at the top of the TAR Denial Worksheet. If the psychiatrist agrees with the Utilization Review Specialist, a NOA-C form is completed within 3 working days and a copy is mailed to the consumer and the provider and a copy is kept on file at Managed Care

Division Manager Approval: Betty Brown Signature	Date 4-8-16
Director Approval: Dawna Utecht Signature	Date 4-11-16
Compliance Officer: Elizabeth Jones Signature	Date 4/11/16

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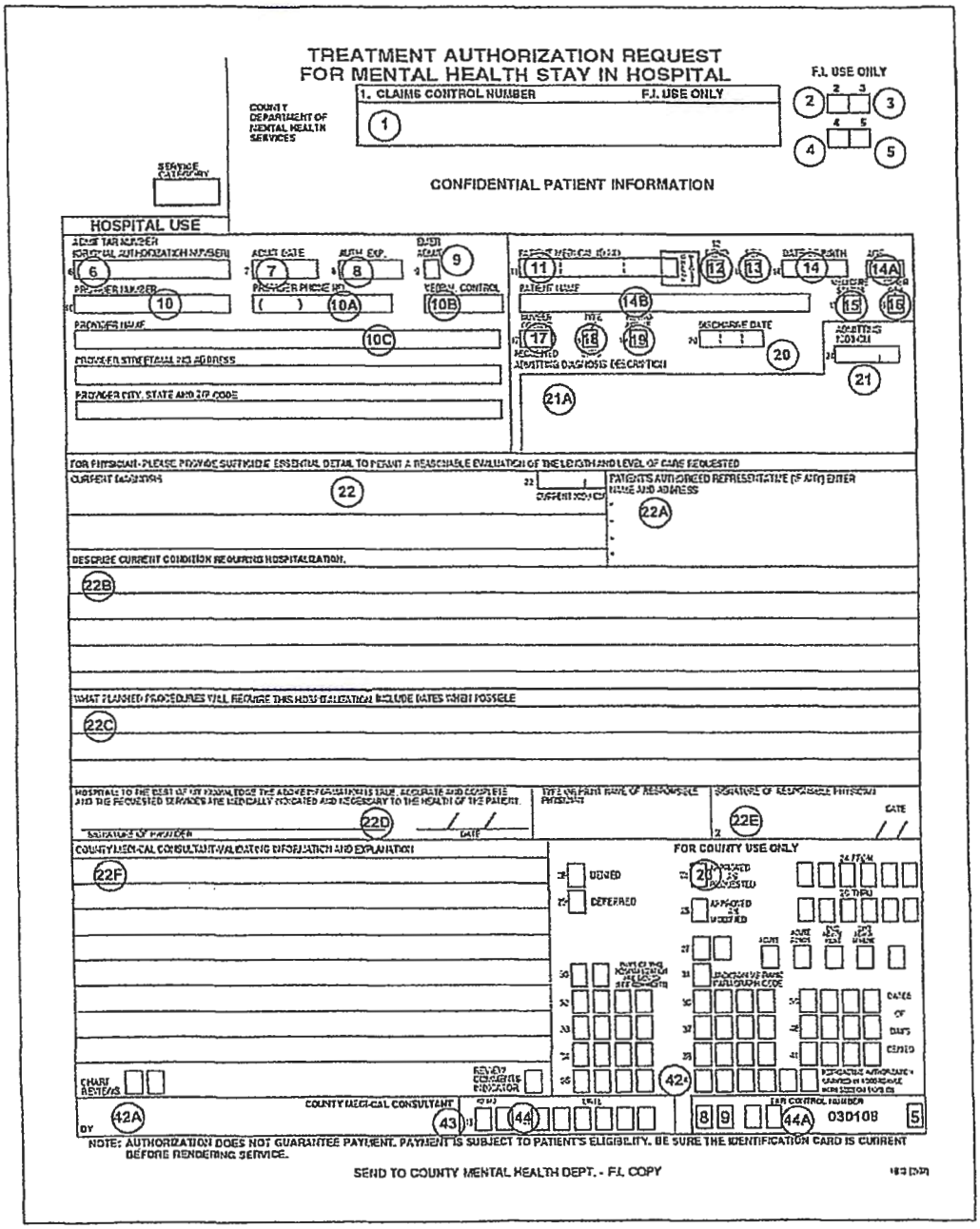

TREATMENT AUTHORIZATION REQUEST
FOR MENTAL HEALTH STAY IN HOSPITAL

F.I. USE ONLY

1. CLAIM CONTROL NUMBER F.I. USE ONLY

COUNTY DEPARTMENT OF MENTAL HEALTH SERVICES

SERVICE CATEGORY

CONFIDENTIAL PATIENT INFORMATION

HOSPITAL USE

ADMIT/AR NUMBER
HOSPITAL AUTHORIZATION NUMBER
ADMIT DATE
AUTH. EXP.
DATE ADMIT
PROVIDER NUMBER
PROVIDER PHONE NO.
MEDICAL CONTROL
PROVIDER NAME
PROVIDER STREET MAIL ADDRESS
PROVIDER CITY, STATE AND ZIP CODE
PATIENT MEDICAL RECORD
PATIENT NAME
DATE OF BIRTH
AGE
SEX
MARITAL STATUS
RACE
ETHNICITY
DISCHARGE DATE
ADMITTING DIAGNOSIS (DESCRIPTION)
ADMITTING DIAGNOSIS

FOR PHYSICIAN - PLEASE PROVIDE SUFFICIENT DETAIL TO PERMIT A REASONABLE EVALUATION OF THE LENGTH AND LEVEL OF CARE REQUESTED

CURRENT LOCATION
PATIENT'S AUTHORIZED REPRESENTATIVE (IF ANY) ENTER NAME AND ADDRESS
DESCRIBE CURRENT CONDITION REQUIRING HOSPITALIZATION.
WHAT PLANNED PROCEDURES WILL REQUIRE THIS HOSPITALIZATION INCLUDE DATES WHEN POSSIBLE

I CERTIFY TO THE BEST OF MY KNOWLEDGE THE ABOVE REPRESENTATIONS ARE TRUE, ACCURATE AND COMPLETE AND THE REQUESTED SERVICES ARE MEDICALLY INDICATED AND NECESSARY TO THE HEALTH OF THE PATIENT.
SIGNATURE OF PHYSICIAN
DATE
TYPE OR PRINT NAME OF RESPONSIBLE PHYSICIAN
SIGNATURE OF RESPONSIBLE PHYSICIAN
DATE

COUNTY MEDICAL CONSULTANT VALIDATING INFORMATION AND EXPLANATION

FOR COUNTY USE ONLY
DENIED
DEFERRED
APPROVED AS PROPOSED
APPROVED AS MODIFIED
ACUTE
CHART REVIEW
REVIEW CONCURRENT INDICATOR
COUNTY MEDICAL CONSULTANT
BY
DATE
LOR CONTROL NUMBER
030108

NOTE: AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PAYMENT IS SUBJECT TO PATIENT'S ELIGIBILITY. BE SURE THE IDENTIFICATION CARD IS CURRENT BEFORE RENDERING SERVICE.

SEND TO COUNTY MENTAL HEALTH DEPT. - F.I. COPY

Figure 1. Sample *Request for Mental Health Stay in Hospital* (Form 18-3).

ATTACHMENT "A"
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Explanation of Form Items: Form 18-3

The following item numbers correspond to a circled number on the *Request for Mental Health Stay in Hospital* (18-3) (Figure 1).

Item	Description
1.	**CLAIM CONTROL NUMBER.** Leave blank. For FI use only.
2. – 5.	**F.I. USE ONLY.** Leave blank.
6.	**ADMIT TAR NUMBER (ORIGINAL AUTHORIZATION NUMBER).** Leave blank. For emergency admits, refer to Item 9.
7.	**ADMIT DATE:** Enter the date of admission.
8.	**AUTHORIZATION EXPIRES.** Enter the date the current TAR expires.

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Item	Description
9.	**EMER. ADMIT.** Enter an "X" if the patient was admitted to the hospital. Providers requesting an approval of admission, transfer or extension of hospital stay on the 18-3 form must complete the following fields accurately: • The *Patient Medi-Cal ID No.* (Box 11) should be copied from the recipient's Benefits Identification Card (BIC) or the paper Medi-Cal ID card. This is a 14-character number. Enter the county code and aid code above Box 11. • The *Provider Number* (Box 10) should be the NPI. • The *Number of Days Requested* (Box 17) is the total number of days requested on this extension. • *Admitting ICD-9-CM* (Box 21) and *Current ICD-9-CM* (Box 22) should be completed using the *International Classification of Diseases, 10th Revision, Clinical Modification.* **Note:** The field names will not be updated on the TAR Form 18-3.

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Item	Description
10.	**PROVIDER NUMBER.** Enter the NPI.
10A.	**PROVIDER PHONE NO.** Enter the provider's telephone number; include area code.
10B.	**VERBAL CONTROL.** If a verbal request for a TAR was made, enter the number provided by the MHP consultant. **Note:** A written TAR indicating this number must be submitted to the MHP point of authorization. The Verbal Control Number is not the authorized TAR Control Number and cannot be used for billing.
10C.	**PROVIDER NAME AND ADDRESS.** Enter the name of the hospital, street address, city, state and nine-digit ZIP code.
11.	**PATIENT MEDI-CAL ID NO. and CHECK DIGIT.** When entering the recipient identification number from the Benefits Identification Card (BIC), begin in the farthest left position of the field. The county code and aid code must be entered just above the recipient *Medi-Cal ID No.* box. Please do not enter any characters (dashes, hyphens, special characters, etc.) in the remaining blank positions of the *Medi-Cal ID* field or in the *Check Digit* box.
12.	**PEND.** Enter a "P" if the patient's Medi-Cal eligibility is not yet established and the Medi-Cal number is not known. Otherwise, leave blank.

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Item	Description
13.	**SEX.** Enter the patient's sex: • "F" for female • "M" for male
14.	**DATE OF BIRTH.** Enter the patient's date of birth (month, day, year).
14A.	**AGE.** Enter the age of the patient.
14B.	**PATIENT NAME.** Enter the patient's last name, first name, and middle initial.
15.	**MEDICARE STATUS.** If Medicare is not billed, enter the appropriate Medicare status code number. See the *UB-04 Completion: Inpatient Services* section in this manual for a listing of Medicare Status Codes. **Note:** If the Medi-Cal eligibility verification system indicates the recipient has Medicare coverage, and Medicare is not billed, the Medicare status code must be other than "under age 65, does not have Medicare coverage." MHPs do not process TARs for recipients who have Medicare Part A coverage unless their benefits have been exhausted.

Item	Description

16. **OTHER COVERAGE.** Enter an "X" if the recipient has other insurance or Other Health Coverage (OHC).

OHC includes insurance carriers as well as Health Maintenance Organizations (HMOs) which provide all or most of the recipient's health care needs.

Note, however, that providers should refer recipients with HMO coverage to their HMOs for treatment, except for emergencies. Refer to the *Other Health Coverage (OHC) Guidelines for Billing* section of the Part 1 manual.

In all cases, when recipients have OHC, providers must bill the insurance carrier or HMO prior to billing Medi-Cal. This also applies to recipients with Medicare coverage.

Claims for recipients with OHC will be denied unless proof of "Other Coverage denial" in the form of a denial letter from the carrier or HMO is submitted with the Medi-Cal claim. Denial letters must include:

HMO name and address, statement of denial because of non-covered service(s)

* Recipient's name
    * Code number for recipient's health plan
    * Date(s) the service is/was not covered
    * Procedure (service rendered)
    * Signature of authorized HMO representative

Refer to the *Eligibility: Recipient Identification* section in the Part 1 manual, for eligibility verification procedures. For OHC coding information, refer to the *Eligibility: Services Restrictions* section in the Part 1 manual.

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Item	Description
17.	**NUMBER OF DAYS.** Enter the number of days requested on this TAR, for example, 3.
18.	**TYPE OF DAYS.** Enter the code indicating type of days requested: 0 Acute 2 Administrative
19.	**RETROACTIVE.** Enter a capital "X" if this request is retroactive.
20.	**DISCHARGE DATE.** Enter the date the patient was discharged from the facility.
21.	**ADMITTING ICD-9-CM.** Enter the numeric code for the admitting diagnosis using the ICD-10-CM code book. Note: The field names will not be updated on the TAR Form 18-3.
21A.	**ADMITTING DIAGNOSIS DESCRIPTION AND ICD-9-CM DIAGNOSIS CODE.** Always enter the English description of the diagnosis from the ICD-10-CM code book. Note: The field names will not be updated on the TAR Form 18-3.
22.	**CURRENT DIAGNOSIS.** Current diagnosis and medical justification – provide sufficient medical justification for the MHP consultant to determine whether the service is medically justified. If necessary, attach additional information. Enter the current ICD-10-CM code in Box 22.
22A.	**PATIENT'S AUTHORIZED REPRESENTATIVE.** Enter the name and address (if known) of the patient's authorized representative, representative payee, conservator over the person, legal representative, or other representative handling the recipient's medical and personal affairs.
22B.	**DESCRIBE CURRENT CONDITION REQUIRING HOSPITALIZATION.** Enter sufficient information for the MHP consultant to determine if the services are medically necessary.

ATTACHMENT "A"
pg. 8 of 8

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Item	Description
22C.	**WHAT PLANNED PROCEDURES WILL REQUIRE THIS HOSPITALIZATION, INCLUDE DATES WHEN POSSIBLE.** Enter the recipient's plan of care and dates when services will be performed.
22D.	**HOSPITAL.** Must be signed and dated by a representative of the hospital.
22E.	**SIGNATURE OF RESPONSIBLE PHYSICIAN.** Must be signed and dated by the admitting physician or other licensed personnel with admitting privileges. The provider assumes full legal responsibility to Department of Mental Health for the information provided by the representative. Original signatures are required.
22F.	**COUNTY MEDI-CAL CONSULTANT – VALIDATING INFORMATION AND EXPLANATION.** Leave blank; for MHP use.
23. – 42.	**FOR COUNTY USE ONLY.** Leave blank; for MHP use. (This section will contain the decision of the MHP consultant.)
42A.	**COUNTY MEDI-CAL CONSULTANT.** Leave blank. Signature block for MHP use.
43. – 44.	**ID. NO./DATE.** MHP consultant completes.
44A.	**TAR CONTROL NUMBER.** This number is imprinted on the form and will have the prefix "89" or "92." The two-digit county code is added after the prefix "89" or "92" by the MHP consultant.

In order to meet Title 9 regulations, please complete, sign and return this form to Managed Care no later than: _____

TAR Denial Worksheet

ATTACHMENT "B"
pg. 1 of 1

Client Name: _____ SSN: _____ Age: _____

Admit Date: _____ DC Date: _____ LOS: _____ *day(s)*

Reviewer's Recommendations:

Medical Necessity Documented: _____ *Day(s)* Dates: _____

No Documented Medical Necessity: _____ *Day(s)* Dates: _____

Comment:

Reviewer: _____ Date Reviewed: _____

Reviewer's Signature: _____

MD's Name: _____ Date of Review: _____

Begin Time: _____ End Time: _____

Review Findings by MD:

☐ Agree with recommendation as listed above

☐ Disagree. Deny the following dates Dates: _____

☐ Disagree. Grant the following dates Dates: _____

MD Findings for Denied Days: _____

MD's Signature: _____

REQUEST FOR MENTAL HEALTH STAY IN HOSPITAL

ATTACHMENT "C"
pg. 1 of 1

CONFIDENTIAL PATIENT INFORMATION

FACILITY USE

Patient's Name (Last, First, MI)	Date of Birth	Age	SSN	Sex

Facility Name/Address	Admit Date	Discharge Date	Days Requested

Type of Days: ACUTE

FOR PHYSICIAN

Admitting diagnosis (DSM-IV) (Code/Description)	Discharge diagnosis (DSM-IV) (Code/Description)

Condition Requiring Hospitalization:

Name of Responsible Physician	Signature of Responsible Physician	Date

FRESNO COUNTY AUTHORIZATION UNIT USE

Approved	Date From	Date To	Total Days Approved	Type of Days
				ACUTE

Denied	Date From	Date To	Total Days Denied	Type of Days
				ACUTE

Fresno County Authorization Unit's Validating Information and Explanation:

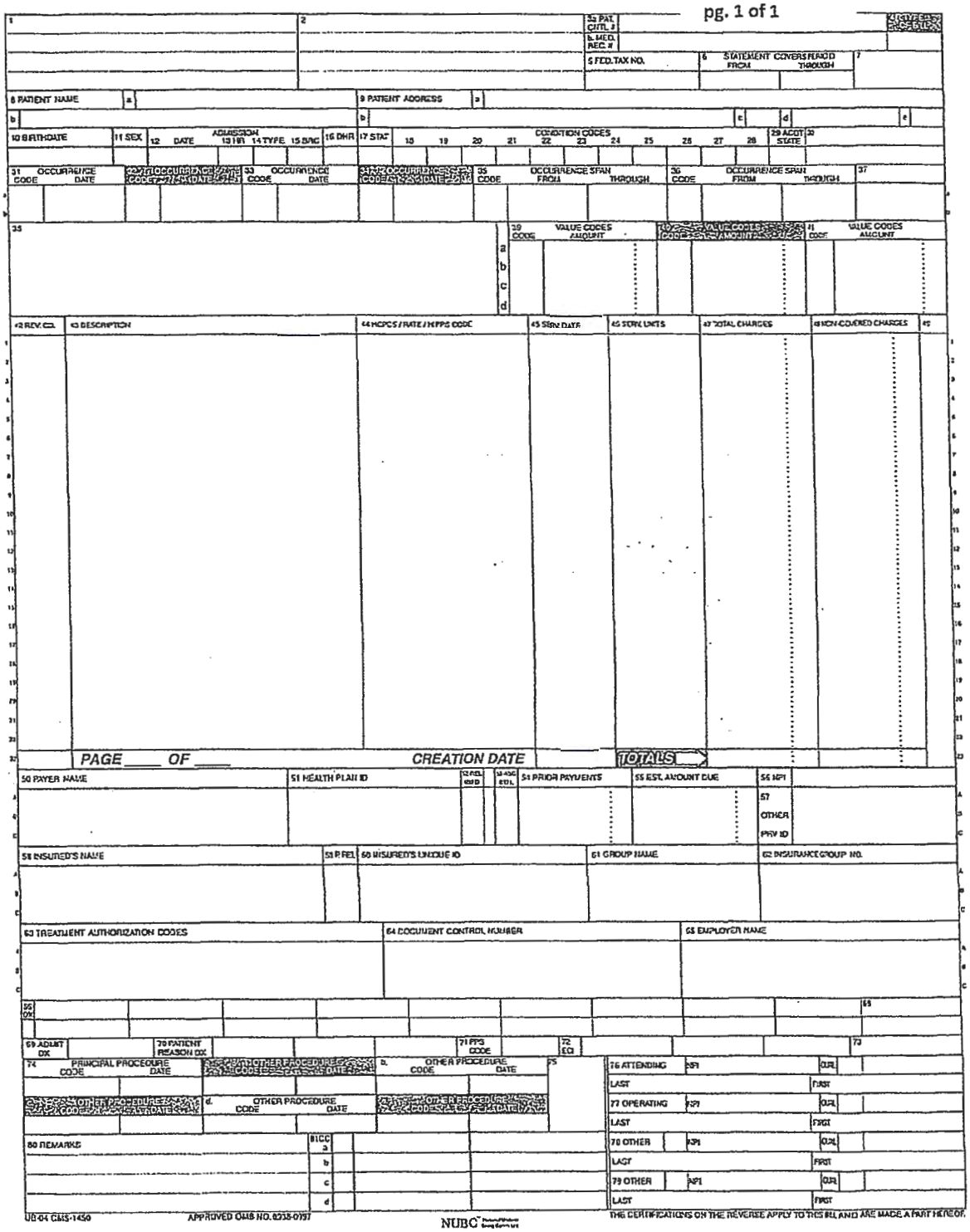
Signature of Fresno County Authorization Unit Representative	Date

Payor Code:

FRESNO COUNTY SEAL

INPATIENT 2/24/11

ATTACHMENT "D"
pg. 1 of 1



Managed Care
Training/Overview PPG
4.3.1 Claims Processing, Inpatient Psychiatric Hospital Services
3/29/16

Attendees:

Print Name	Signature
Linda Sereda	
Sandra Nelson	
Jonathan Scott Halverstadt	
Chris Schreiber	
Karen Nuñez	
Heather Redmond	
Karen Berry	

Attachment C
Authorization of Day Treatment Intensive, Day Rehabilitation, and Designated Specialty Mental Health Services for Out of County Providers Policy and Procedure Guide

Attachment C-1
Training Sign-in Sheet

Section No.:	**4 - Managed Care**	**Effective Date:**	**4/1/1998**
Chapter No.:	**2 - Authorization**	**Revised Date:**	**3/29/16**
Item No.:	**4 - Authorization of Day Treatment Intensive, Day Rehabilitation, and Designated Specialty Mental Health Services for Out of County Providers**		

POLICY: Designated initial authorizations and reauthorizations for mental health service requests from Day Treatment Intensive, Day Rehabilitation, and Out of County providers are reviewed and authorized by a Managed Care Utilization Review Specialist (LCSW, LMFT, RN).

PURPOSE: To ensure that mental health services, from designated providers are reviewed and authorized by a Managed Care Utilization Review Specialist, for compliance with the State Department of Health Care Services' medical necessity criteria for specialty mental health services by a Day Treatment Intensive provider, Day Rehabilitation provider, or an Out of County provider per DMH Information Notice No. 02-06 (Exhibit A) and DMH Information Notice No. 08-24 (Exhibit C).

DEFINITIONS: Utilization Review Specialist: A State of California licensed Clinical Social Worker, Marriage and Family Therapist, or Registered Nurse with at least two (2) year full-time, paid mental health experience as a Social Worker, Marriage and Family Therapist or Registered Nurse.

REFERENCE: DMH Information Notice No. 02-06 (Exhibit A); DMH Information Notice No. 08-24 (Exhibit C).

PROCEDURE:

I. AUTHORIZATION REQUESTS

A. Requests received from Day Treatment Intensive, Day Rehabilitation, or Out of County providers requesting authorization of services will be assigned to a Managed Care Utilization Review Specialist (MC URS).

B. For Out of County providers, the request will include the Service Authorization Request Form (SAR), along with any other required documents related to the type of authorization, and submitted to Fresno County Mental Health Plan (FCMHP) through mail or fax, before authorization of specialty mental health services is granted.

C. For Day Treatment Intensive or Day Rehabilitation providers, the request is to be submitted

on the Request for Authorization of Day Treatment Form. In addition, the provider will indicate the types of services requested (i.e. individual therapy, group therapy, case consultation, etc.), including the proposed duration and frequency of treatment, and if the request is urgent requiring an expedited decision.

1. Reauthorizations – Request for Authorization of Day Treatment Form must be submitted at least every three (3) months for continuation of Day Treatment Intensive, and at least every six (6) months for continuation of Day Rehabilitation.

D. Upon receipt of the written request, the Managed Care Clerical staff stamps the receipt date on the forms, and the Admitting Interviewer verifies the beneficiary's Medi-Cal eligibility through the Medical Eligibility Data System (MEDS).

E. Requests for services for a non Medi-Cal eligible beneficiary will be returned to the requesting provider. An exception to the rule is a request for service for a minor beneficiary who is ordered by the court to receive mental health services. A copy of the court/minute order must be received prior to service authorization.

F. If a beneficiary is Medi-Cal eligible, the request is forwarded to a MC URS for authorization review.

G. The MC URS will verify the beneficiary's previous contact(s) with Fresno County mental health service sites to avoid possible duplication of currently received or requested services.

II. AUTHORIZATION DECISIONS

A. To maintain consistency, the MC URS uses the State Department of Health Care Services' medical necessity criteria for specialty mental health services.

B. Timeframe for Decisions:

1. Day Treatment Intensive and Day Rehabilitation
    a. Standard Decision – The MC URS, will process the request within fourteen (14) calendar days of receiving the initial request for services.
        1. An extension of up to fourteen (14) calendar days may be allowed if the beneficiary or provider requests an extension, or if FCMHP justifies, to the State Department of Health Care Services, a need for additional information and how the extension will be in the beneficiary's best interest. A written notice will be provided to the beneficiary in an easily understood format and in the preferred language of the

beneficiary, on the date the decision to extend is made. The provider will be notified of the extension.

b. Expedited Decision – the MC URS will process the urgent request within three (3) working days of receiving the initial request for services.
   1. An extension of up to fourteen (14) calendar days may be allowed if the beneficiary requests an extension, or if FCMHP justifies, to the State Department of Health Care Services, a need for additional information and how the extension will be in the beneficiary's best interest. A written notice will be provided to the beneficiary in an easily understood format and in the preferred language of the beneficiary, on the date the decision to extend is made. The provider will be notified of the extension.

c. When the request for day treatment intensive and day rehabilitation services is for more than five (5) days per week, the request must be in advance of service delivery.

d. Counseling, psychotherapy or other mental health services defined in Title 9, CCR, Section 1810.227, but not including services to treat emergency and urgent conditions and therapeutic behavioral services, that are to be provided on the same day that Day Treatment Intensive or Day Rehabilitation services are provided to the beneficiary, must be authorized by the MC URS.

2. Foster Care Related Decision
   a. If the beneficiary is of the Foster Care Program, Adoption Assistance Program, or other type of foster care arrangement such as Kinship Guardianship Assistance Program, the MC URS will make an authorization decision and notify the host county and the requesting Out of County provider within three (3) working days of the date of receipt of the request for service by the MHP of origin (see Exhibit B – Flow Charts).
      1. If the MC URS documents a need for additional information to evaluate the beneficiary's need for the service, an extension may be granted up to three (3) working days from the date the additional information is received, or fourteen (14) calendar days from the receipt of the original Treatment Authorization Request, whichever is less.

C. Approved Request

1. If an authorization request is granted, the provider will receive notification within

fourteen (14) calendar days of the approval.

2. Within thirty (30) calendar days of the date of authorization of services, the FCMHP shall arrange for reimbursement for the approved services provided to a foster child placed Out of County, to reimburse the host county or the Out of County provider.

D. Denied, Modified, Reduced Service Request

The MC URS will first attempt to discuss with the provider any disagreements regarding the request for services. If the MC URS denies, modifies, reduces, or terminates the service authorization request, the MC URS will notify the provider within fourteen (14) calendar days of the decision. The provider will also be informed of his or her right to file an appeal regarding the decision.

A Notice of Action-B (NOA-B) and consumer's right to appeal will be provided to the beneficiary when there is a denial, modification, reduction, or termination of services, within the timeframe described in Policy and Procedure Guide 1.2.12. Notice of Action/Fair Hearing/Aid Paid Pending for Medi-Cal Beneficiaries section B.

III. CONSISTENCY MONITORING

A. The MC URS's will meet, at a minimum, once a year to monitor for consistency of authorization decisions.

Section:4 Chapter:2

Effective Date: 4/1/1998
Revised Date: 3/29/16

Item:4 Authorization of Day Treatment Intensive, Day Rehabilitation, and Designated Specialty Mental Health Services for Out of County Providers

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Division Manager Approval: Betty Brown Signature	Date 4-8-16
Director Approval: Dawan Utecht Signature	Date 4-11-16
Compliance Officer Approval: Elizabeth Dray Signature	Date 4/11/16

Item:4 Authorization of Day Treatment Intensive, Day Rehabilitation, and Designated Specialty Mental Health Services for Out of County Providers

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EXHIBIT A PAGE 1 of 8

CALIFORNIA DEPARTMENT OF
Mental Health

1600 9th Street, Sacramento, CA 95814
(916) 654-2309

October 1, 2002

DMH INFORMATION NOTICE NO.: 02-06

TO: LOCAL MENTAL HEALTH DIRECTORS
LOCAL MENTAL HEALTH PROGRAM CHIEFS
LOCAL MENTAL HEALTH ADMINISTRATORS
COUNTY ADMINISTRATIVE OFFICERS
CHAIRPERSONS, LOCAL MENTAL HEALTH BOARDS

SUBJECT: CHANGES IN MEDI-CAL REQUIREMENTS FOR DAY TREATMENT INTENSIVE AND DAY REHABILITATION

The Department of Mental Health (DMH) is issuing this notice to inform mental health plans (MHPs) and interested stakeholders of DMH's intent to change the criteria for Medi-Cal reimbursement of day rehabilitation and day treatment intensive for Medi-Cal eligible children, youth, adults and older adults. DMH intends the new requirements to apply to day treatment intensive and day rehabilitation services delivered on or after January 1, 2003. The changes will be implemented via an amendment to the DMH/MHP contracts. DMH, in consultation with the Department of Health Services, will continue to review the issues and may include some of the requirements in regulations at Title 9, California Code of Regulations (CCR), Division 1, Chapter 11, at a later date.

The changes are intended to clarify policy where there is ambiguity in the current regulations and DMH/MHP contracts. DMH has also included some changes intended to ensure there is appropriate clinical/rehabilitation focus in the services being reimbursed through Medi-Cal. These changes are intended to ensure more consistent implementation of these services statewide. Overall, the goal is to improve quality and accountability for these Medi-Cal specialty mental health services.

Basic criteria for Medi-Cal reimbursement of day treatment intensive and day rehabilitation remain the same. DMH is not changing the definitions of day treatment intensive or day rehabilitation (Title 9, CCR, Sections 1810.212 and 1810.213), the requirement that MHPs provide or arrange and pay for the MHP covered services that are adequate to meet the needs of the beneficiary (Title 9, CCR, Section 1810.345), the Medi-Cal medical necessity criteria (Title 9, CCR, Sections 1830.205 and 1830.210), the

state maximum allowance for day treatment intensive and day rehabilitation (Title 22, CCR, Section 51516.2), general criteria for claiming for service functions (Title 9, CCR, Section 1840.314), or the lockouts for day treatment intensive and day rehabilitation (Title 9, CCR, Section 1840.360). MHP will retain their authority to establish service necessity criteria based on the impairment and intervention criteria in the medical necessity regulations to determine the level of intensity and the duration necessary to meet the beneficiaries' needs. MHPs will retain their authority to establish standards for day treatment intensive and day rehabilitation above the minimum standards described in this notice. MHPs must continue to assure that medical necessity and service necessity determinations are made on the basis of an assessment of each beneficiary's individual needs, not on the basis of the beneficiary's level of placement. MHPs must continue to assure that providers, with the participation of the client, develop client plans that include specific observable or quantifiable goals to be achieved by treatment and interventions that are consistent with the client's diagnoses and client plan goals.

DMH will be requiring MHPs to meet additional contractual obligations in the areas of MHP payment authorization (Title 9, CCR, Section 1830.215), criteria for payment of services based on half days and full days (Title 9, CCR, Section 1840.318), day treatment intensive and day rehabilitation contact requirements (Title 9, CCR, Sections 1840.326 and 8140.330), day treatment intensive and day rehabilitation staffing requirements (Title 9, CCR, Sections 1840.350 and 1840.352), and the frequency of progress notes (DMH/MHP contract, Exhibit A, Attachment 1, Appendix C). DMH will also be establishing minimum acceptable service components for day treatment intensive and day rehabilitation programs and adding program review requirements to the current standards for on-site reviews of organizational providers.

Authorization Requirements
Currently, MHPs are not required to have a formal authorization system for any non-hospital services. Title 9, CCR, Section 1830.215, establishes the criteria for an MHP payment authorization system, but does not require the MHP to establish the system for any particular services. Many MHPs use MHP payment authorization functions for specialty mental health services provided by their individual and group providers, but allow organizational providers to make treatment decisions without formal authorization from the MHP. Effective January 1, 2003, the DMH/MHP contract will require MHPs to establish, or use their existing, MHP payment authorization systems for day treatment intensive and day rehabilitation. MHPs must require providers, including MHP staff, to request an initial MHP payment authorization for day treatment intensive and for day rehabilitation. MHPs must require providers, including MHP staff, to request prior authorization when day treatment intensive or day rehabilitation will be provided for more than five days per week. MHPs must also require providers to request MHP payment authorization for continuation of day treatment intensive at least every three months and

Item:4 Authorization of Day Treatment Intensive, Day Rehabilitation, and Designated Specialty Mental Health Services for Out of County Providers

day rehabilitation at least every six months. MHPs will not be permitted to delegate the authorization function to providers. In the event the MHP is the day treatment provider, the MHP will be required to assure that the authorization process does not include staff involved in providing day treatment intensive or day rehabilitation.

In addition, effective January 1, 2003, MHPs must require providers to request initial MHP payment authorization for counseling, psychotherapy or other similar therapeutic interventions (mental health services as defined in Title 9, CCR, Section 1810.227), excluding services to treat emergency and urgent conditions (see Title 9, CCR, Sections 1810.216 and 1810.253) and therapeutic behavioral services, that will be provided on the same day that day treatment intensive or day rehabilitation is being provided to the beneficiary. The MHP must also require the providers of these services to request MHP payment authorization for continuation of these services on the same cycle required for continuation of day treatment intensive or day rehabilitation for the beneficiary. MHPs are not permitted to delegate the authorization function to the provider of day treatment intensive or day rehabilitation or the provider of the additional services.

Hours of Operation, Contact and Staffing Requirements
DMH intends to set hours of operation, contact and staffing requirements in addition to the requirements in Title 9, CCR, Sections 1840.318, 1840.328, 1840.330, 1840.350, and 1840.352. The hours of operation that establish day treatment intensive and day rehabilitation as a half-day or full-day program must be provided in a therapeutic milieu (see Attachment A for a description of therapeutic milieu) and must be continuous. Program staff may be required to spend time on day treatment intensive and day rehabilitation activities outside the hours of operation and therapeutic milieu, e.g., time for travel, documentation, and caregiver contacts.

Beneficiaries are expected to be present for all scheduled hours of operation for each day. When a beneficiary is unavoidably absent for some part of the hours of operation, day treatment intensive and day rehabilitation for an individual beneficiary will only be eligible for Medi-Cal reimbursement if the beneficiary is present for at least 50 percent of the scheduled hours of operation for that day. For example, if the beneficiary is present for less than one and a half hours of a three-hour half-day program because of illness, the service for that beneficiary for that day will not be Medi-Cal reimbursable.

Although the staffing ratios for day treatment intensive and day rehabilitation are unchanged, the staffing requirements will be expanded to require at least one staff person to be present and available to the group in the therapeutic milieu for all scheduled hours of operation. For day treatment intensive, staffing must include at least one staff person whose scope of practice includes psychotherapy.

There is no change in audit related staffing requirements. If day treatment intensive or day rehabilitation staff are also staff with other responsibilities (e.g., as staff of a group home, a school, or another mental health treatment program), a clear audit trail continues to be required. There must be documentation of the scope of responsibilities for these staff and the specific times in which day treatment intensive or day rehabilitation activities are being performed exclusive of other activities.

Required Service Components
DMH intends to establish minimum standards for the content of day treatment intensive and day rehabilitation. MHPs will retain the authority to set additional higher or more specific standards. The minimum standards for content include the specific service components described in detail in Attachment A. The service components include a required daily community meeting, a required number of hours for specified core service activities, standards for involvement with caregivers, the capability for on-site crisis response, a weekly schedule and the staffing requirements described above.

Documentation Requirements
Currently, progress notes for day treatment intensive and day rehabilitation must be documented weekly. There is no specific requirement for review by licensed mental health professionals. Documentation requirements for day rehabilitation will not change. Effective January 1, 2003, however, documentation for day treatment intensive will be required to include daily progress notes on activities and a weekly clinical summary reviewed and signed by a physician, a licensed/waivered/registered psychologist, clinical social worker, or marriage and family therapist; or a registered nurse who is either staff to the day treatment intensive program or the person directing the service.

Certification Requirements
DMH intends to set additional standards for certification of individual, group and organizational providers of day treatment intensive and day rehabilitation. MHPs will be required, at a minimum, to conduct a review of the provider's program description to ensure that the day treatment intensive and day rehabilitation requirements in this notice are incorporated. For individual and group providers, this review will not be required to be conducted on the provider's site. For organizational providers, the review must be included in the required on-site review. DMH will also be applying these new standards to its own on-site reviews of MHP owned and operated provider sites. The changes in review requirements will apply to reviews of new providers and to the reviews required as a part of biannual recertifications conducted on or after July 1, 2003. MHPs and providers, however, must comply with the new standards effective January 1, 2003.

Item:4 Authorization of Day Treatment Intensive, Day Rehabilitation, and Designated Specialty Mental Health Services for Out of County Providers

DMH expects to issue DMH/MHP contract amendments to the MHPs no later than November 1, 2002, with the amendments effective January 1, 2003. MHPs are encouraged to consult with DMH as needed to resolve any questions or concerns regarding implementation of the changes. Please contact your contract managers in the Technical Assistance and Training Section below for assistance.

DMH Technical Assistance and Training Contract Managers

Bay Area Region	Ruth Walz	(707) 252-3168
Central Region	Anthony Sotelo	(916) 651-6848
Northern Region	Jake Donovan	(916) 651-9867
Southern Region	Eddie Gabriel	(916) 654-3263

Sincerely,

(Original signed by)

Wm. DAVID DAWSON
Chief Deputy Director

Enclosure

cc: California Mental Health Planning Council
Chief, Technical Assistance and Training

EXHIBIT A PAGE 6 of 8

ATTACHMENT A

DAY TREATMENT INTENSIVE AND DAY REHABILITATION SERVICE COMPONENTS

THERAPEUTIC MILIEU--DEFINITION

The therapeutic milieu:

- Provides the foundation for the provision of day treatment intensive and day rehabilitation and differentiates these services from other specialty mental health services.
- Includes a therapeutic program that is structured by well-defined service components with specific activities being performed by identified staff.
- Takes place for the continuous scheduled hours of operation for the program (more than four hours for a full-day program and a minimum of three hours for a half-day program).
- Creates a supportive and nurturing interpersonal environment that teaches, models, and reinforces constructive interaction.
- Supports peer/staff feedback to clients on strategies for symptom reduction, increasing adaptive behaviors, and reducing subjective distress.
- Empowers clients through involvement in the overall program (such as the opportunity to lead community meetings and to provide feedback to peers) and the opportunity for risk taking in a supportive environment.
- Supports behavior management interventions that focus on teaching self-management skills that children, youth, adults and older adults may use to control their own lives, to deal effectively with present and future problems, and to function well with minimal or no additional therapeutic intervention.

COMMUNITY/MILIEU MEETING

Both day treatment intensive and day rehabilitation must provide for community meetings that occur at a minimum once a day, but may occur more frequently as necessary, to address issues pertinent to the continuity and effectiveness of the treatment milieu. The meeting must actively involve staff and clients. For day treatment intensive the meeting must include a staff person whose scope of practice includes psychotherapy. For day rehabilitation, the meeting must include a staff person who is a physician; a licensed/waivered/registered psychologist, clinical social worker, or marriage and family therapist; a registered nurse, a psychiatric technician, a licensed vocational nurse, or a mental health rehabilitation specialist. The content of the meeting should include a variety of items including, but not limited to: what the schedule for the

1

day will be; any current events; individual issues clients or staff wish to discuss to elicit support of the group milieu process; conflict resolution within the milieu; planning for the day, the week, or for special events; old business from previous meetings or from previous day treatment experiences; and debriefing or wrap-up.

THERAPEUTIC MILIEU SERVICE COMPONENTS

The following menu of services must be made available during the course of the therapeutic milieu for at least an average of three hours per day for full-day programs and an average of two hours per day for half-day programs. For example, a full-day program that operates five days per week would need to provide a minimum of 15 hours per week; a program that operates seven days per week would need to provide a minimum of 21 hours. (Please note that day treatment intensive and day rehabilitation also include components that occur outside the therapeutic milieu, e.g., family therapy, travel, documentation, and contacts with significant support persons.)

DAY REHABILITATION

- Process Groups: Staff facilitate these groups to help clients develop the skills necessary to deal with their individual problems/issues by using the group process to provide peer interaction and feedback in developing problem-solving strategies and to assist one another in resolving behavioral and emotional problems. Process groups are based on the premise that much of human behavior and feeling involves the individual's adaptation and response to other people and that the group can assist individuals in making necessary changes by means of support, feedback and guidance. It is a process carried out by informally organized groups that seek change. Day rehabilitation may include psychotherapy instead of process groups or in addition to process groups.

- Skill Building Groups: Staff help clients to identify barriers/obstacles related to their psychiatric/psychological experiences and, through the course of group interaction, become better able to identify skills that address symptoms and behaviors and to increase adaptive behaviors.

- Adjunctive Therapies: Staff and clients participate in non-traditional therapy that utilizes self-expression (art, recreation, dance, music, etc.) as the therapeutic intervention. Participants do not need to have any level of skill in the area of self-expression, but rather be able to utilize the modality to develop or enhance skills directed towards client plan goals.

DAY TREATMENT INTENSIVE

Day treatment intensive programs must include the skill building groups and adjunctive therapies required of day rehabilitation and must also include psychotherapy as described below. Day treatment intensive may include process groups in addition to psychotherapy.

2

- Psychotherapy: Psychotherapy means the use of psychosocial methods within a professional relationship to assist the person or persons to achieve a better psychosocial adaptation, to acquire greater human realization of psychosocial potential and adaptation, to modify internal and external conditions that affect individuals, groups, or communities in respect to behavior, emotions, and thinking, in respect to their intrapersonal and interpersonal processes. Psychotherapy is provided by licensed, registered, or waivered staff practicing within their scope of practice. Psychotherapy does not include physiological interventions, including medication intervention.

CONTACT WITH SIGNIFICANT SUPPORT PERSONS

Both day rehabilitation and day treatment intensive must allow for at least one contact (face-to-face or by an alternative method (e.g., e-mail, telephone, etc.)) per month with a family member, caregiver or other significant support person identified by an adult client, or one contact per month with the legally responsible adult for a client who is a minor. Adult clients may choose whether or not this service component is done for them. The contacts and involvement should focus on the role of the significant support person in supporting the client's community reintegration.

CRISIS RESPONSE

Both day rehabilitation and day treatment intensive must have an established protocol for responding to clients experiencing a mental health crisis. The protocol must assure the availability of appropriately trained and qualified staff and include agreed upon procedures for addressing crisis situations. The protocol may include referrals for crisis intervention, crisis stabilization, or other specialty mental health services necessary to address the client's urgent or emergency psychiatric condition (crisis services). If clients will be referred to crisis services outside the day treatment intensive or day rehabilitation program, the day treatment intensive or day rehabilitation staff must have the capacity to handle the crisis until the client is linked to the outside crisis services.

SCHEDULE

Day treatment intensive and day rehabilitation must have and make available to clients and, as appropriate, to their families, caregivers or significant support persons a detailed written weekly schedule that identifies when and where the service components of program will be provided and by whom. The written weekly schedule will specify the program staff, their qualifications, and the scope of their responsibilities.

STAFFING RATIOS

Staffing ratios must be consistent with the requirements in Title 9, CCR, Sections 1840.350 and 1840.352; and, for day treatment intensive, must include at least one staff person whose scope of practice includes psychotherapy.

Item:4 Authorization of Day Treatment Intensive, Day Rehabilitation, and Designated Specialty Mental Health Services for Out of County Providers

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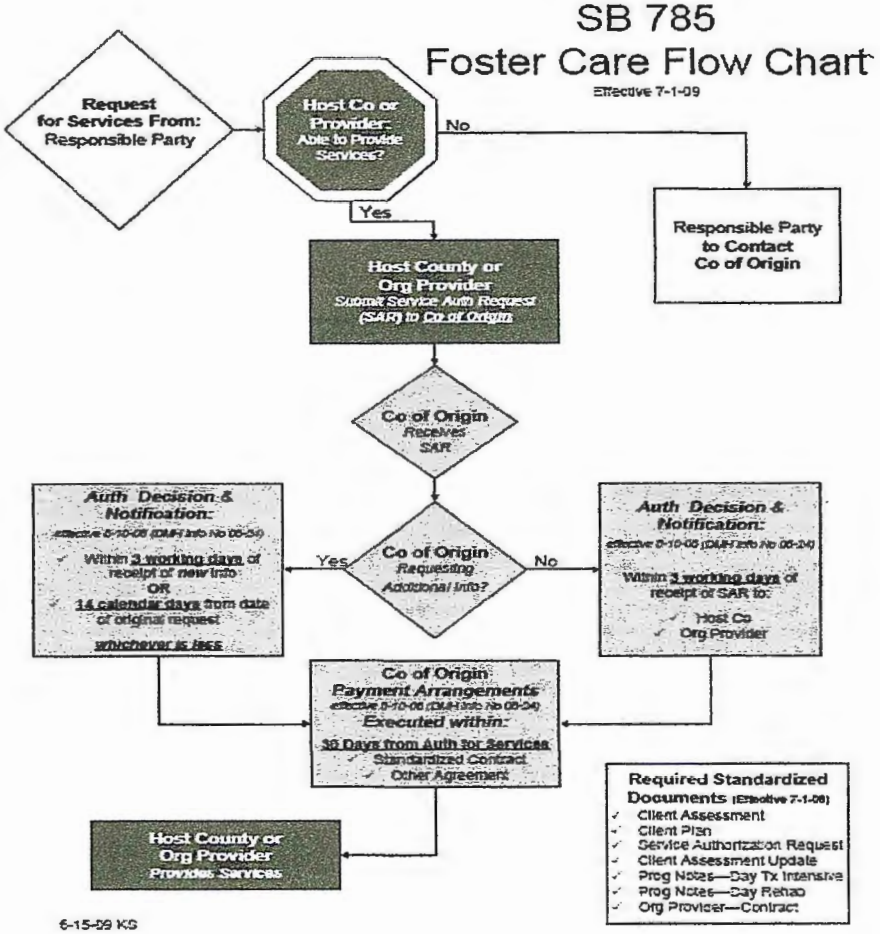
EXHIBIT B – FLOW CHARTS



1 of 3

Item:4 Authorization of Day Treatment Intensive, Day Rehabilitation, and Designated Specialty Mental Health Services for Out of County Providers

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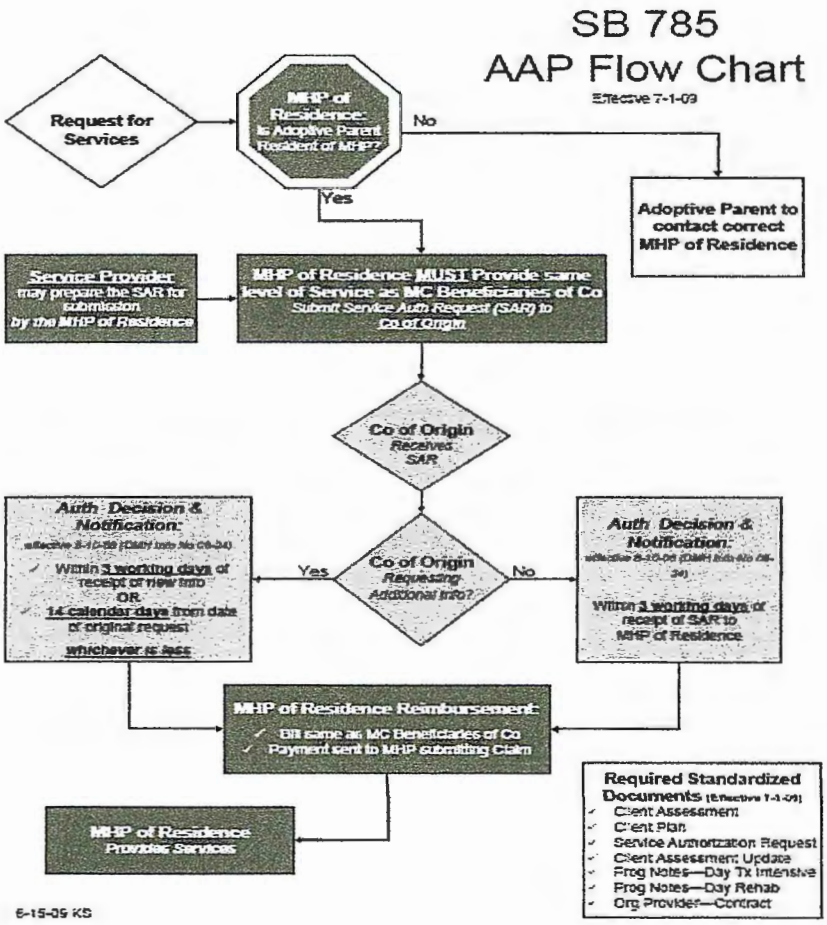
EXHIBIT B – FLOW CHARTS



2 of 3

Item:4 Authorization of Day Treatment Intensive, Day Rehabilitation, and Designated Specialty Mental Health Services for Out of County Providers

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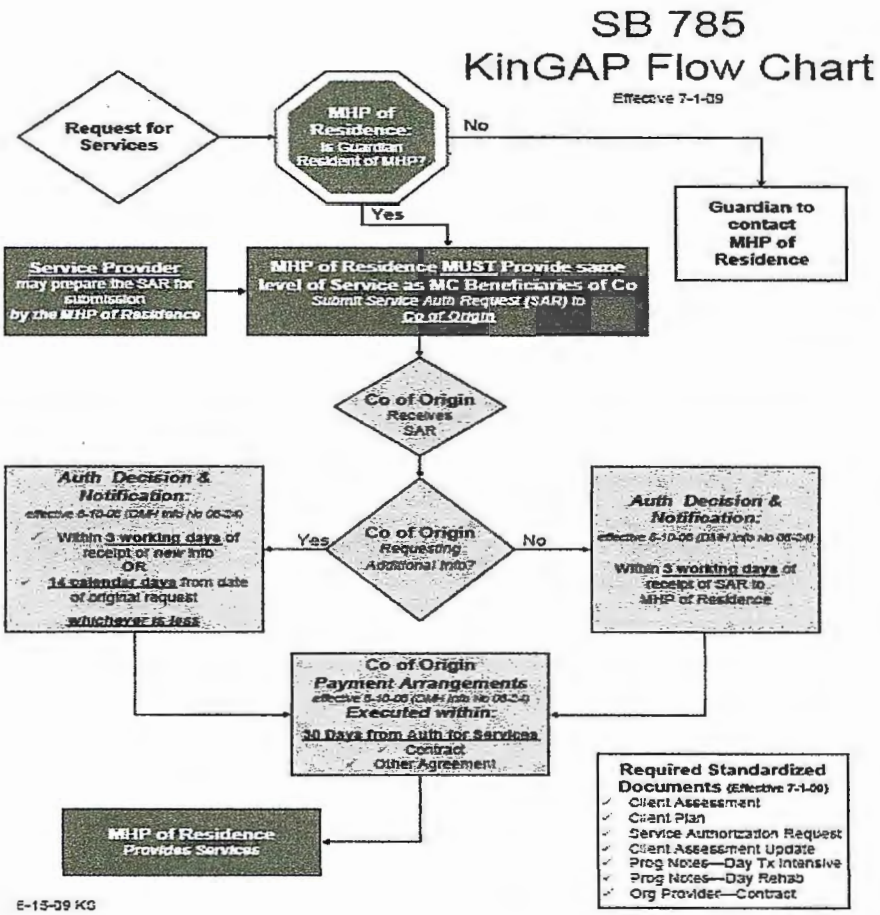
EXHIBIT B – FLOW CHARTS



3 of 3

EXHIBIT C

CALIFORNIA DEPARTMENT OF
Mental Health

1600 9th Street,, Sacramento, CA 95814
(916) 654-2309

August 13, 2008

DMH INFORMATION NOTICE NO.: 08-24

TO: LOCAL MENTAL HEALTH DIRECTORS
LOCAL MENTAL HEALTH PROGRAM CHIEFS
LOCAL MENTAL HEALTH ADMINISTRATORS
COUNTY ADMINISTRATIVE OFFICERS
CHAIRPERSONS, LOCAL MENTAL HEALTH BOARDS

SUBJECT: AUTHORIZATION OF OUT-OF-PLAN SERVICES

The proposed rulemaking package for the Authorization for Out-of-Plan Services was adopted by the California Office of Administrative Law and filed with the Secretary of State on July 11, 2008. The regulations become effective on **August 10, 2008**. This rulemaking package adopts Sections 1610.207.5; 1810.220.5 and amends Section 1830.220(b)(4)(A) of Title 9, California Code of Regulations (CCR).

The regulatory changes are consistent with Senate Bill (SB) 745, (Chapter 811, Statutes of 2000), which added Section 5777.6 to Welfare and Institutions Code (W&IC) requiring local mental health plans (MHPs) to establish a procedure to ensure access to outpatient specialty mental health services for foster children placed outside of their county of origin (adjudication).

Current statute requires each MHP to ensure access to outpatient specialty mental health services for foster children placed out of their county of origin; however, there are no specific time frames that govern the authorization and reimbursement process.

The following changes were made to the regulations:

- Title 9, CCR Section 1810.207.5 was adopted to define which county has legal authority for a specified group of beneficiaries.
- Title 9, CCR Section 1810.220.5 was adopted to define "host county" as it relates to the Foster Care, Adoption Assistance and Kin-GAP programs for mental health services.

EXHIBIT C

DMH INFORMATION NOTICE NO.: 08-24
August 13, 2008
Page 2

Title 9, CCR Section 1830.220(b)(4)(A) was amended to incorporate the following:

- Subsection (1) to require the county of origin to authorize services for a child or youth placed outside his/her county within **three (3) working days** following the date of request for service and notify the host county and the requesting provider of the authorization decision. Specifically, this citation states the following:

  > If the MHP of the county of origin documents a need for additional information to evaluate the beneficiary's need for the service, an extension may be granted up to **three (3) working days** from the date the additional information is received, or **14 calendar days** from the receipt of the original Treatment Authorization Request, whichever is less.

- Subsection (2) to require the MHP of the county of origin within **30 calendar days** of the date of authorization of service to arrange for reimbursement for the services provided to the child or youth through the host county or requesting provider.

- Subsection (3) to require the MHP of the county of origin and the MHP of the host county to resolve any disagreements through the arbitration process provided in Section 1850.405.

The changes to the regulations constitute a change in the authorization and reimbursement processes MHPs are required to follow to provide out-of-plan services. Therefore, as required by Exhibit A, Attachment 1, Section Y of the MHP contract, MHPs shall submit a revised report for providing out-of-plan services to: Medi-Cal and Health Care Benefits Branch, Department of Mental Health, 1600 9th Street, Room 100, Sacramento, CA 95814, within **30 days** from the issuance of this information notice. Although the reports may be provided at a later date, MHPs are required to be in compliance with the regulations as of August 10, 2008.

If you have questions regarding this notice, please contact your County Contract Manager listed on the following internet site: http://www.dmh.ca.gov/docs/CoOpRoster.pdf .

Sincerely,

Original signed by

STEPHEN W. MAYBERG, Ph.D.
Director

Managed Care
Training/Overview PPG
4.2.4 Authorization of Day Treatment Intensive, Day Rehabilitation, and Designated Specialty Mental Health Services for Out of County Providers
3/29/16

Attendees:

Print Name	Signature
Linda Serada	
SANDRA NELSON	
Jonathan Scott Halverstadt	
Chris Schreiber	
Karen Nuñez	
Heather Redmond	

Attachment D
Notice of Action / Fair Hearing / Aid Paid Pending for Medi-Cal Beneficiaries Policy and Procedure Guide

Attachment D-1
Training Sign-in Sheet

Department of Behavioral Health
Policy and Procedure Guide

Section No.:	**1 -**	**Administration**	**Effective Date: 4/1/98**
Chapter No.:	**2 -**	**Quality Assurance**	**Revised Date: 3/29/16**
Item No.:	**12 -**	**Notice of Action / Fair Hearing / Aid Paid Pending for Medi-Cal Beneficiaries**	

POLICY: A Notice of Action (NOA) is provided to a Medi-Cal beneficiary when the Fresno County Mental Health Plan (MHP) or its providers determine during the initial intake assessment that the beneficiary does not meet medical necessity and is not entitled to any specialty mental health services; the MHP denies, modifies, or defers a payment authorization request from a provider for specialty mental health services; the MHP denies payment authorization of a service that has already been delivered to the beneficiary as a result of a retrospective payment determination; the MHP fails to act within the timeframes for disposition of standard grievances, the resolution of standard appeals, or the resolution of expedited appeals; or the MHP fails to provide a service within the standard timeline established by the MHP.

The back of the NOA form includes information regarding State Fair Hearing. A beneficiary who is currently receiving services must request a State Fair Hearing within ten (10) calendar days of receipt of the NOA to be eligible for Aid Paid Pending. The MHP will provide Aid Paid Pending to a beneficiary who wants continued services and has filed a timely request (10 days from the date an NOA was mailed or personally given to the beneficiary, or before the effective date of the change, whichever is later) for an appeal or State Fair Hearing. When criteria are met, benefits will continue while an appeal or State Fair Hearing is pending.

A beneficiary must exhaust the MHP problem resolution process before filing for a State Fair Hearing.

PURPOSE: To have clear, established criteria when issuing Notices of Action to affected beneficiaries.

PROCEDURE:

I. **WHEN THE FRESNO COUNTY MENTAL HEALTH PLAN (MHP) OR ITS PROVIDERS DETERMINE DURING THE INITIAL INTAKE ASSESSMENT THAT THE BENEFICIARY DOES NOT MEET MEDICAL NECESSITY AND IS NOT ENTITLED TO ANY SPECIALTY MENTAL HEALTH SERVICES**
   A. FCMHP individual and group contract provider will:
      1. Verbally inform the consumer of his or her right to a second opinion and consumer assistance.
      2. Fax or mail copy of the assessment to Managed Care within 24 hours of the assessment.

B. FCMHP organizational contracted provider or in-house staff clinician will:
   1. Verbally inform the consumer of his or her right to a second opinion, and how to access the problem solution process.
   2. Complete a NOA-A, and give it to the consumer within three (3) working days of the noticeable act.
   3. Fax or mail a copy of the NOA-A to Managed Care.

II. WHEN THE MHP DENIES, MODIFIED, OR DEFERS A PAYMENT AUTHORIZTION REQUEST FROM A PROVIDER FOR SPECIALTY MENTAL HEALTH SERVICES

The Managed Care Authorization Unit Clinician who defers, denies, or modifies the mental health service will complete a NOA-B and mail a copy to the consumer within three (3) working days of the noticeable act. A copy of the completed NOA is also mailed to the requesting provider.

III. 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

The Managed Care Authorization Unit Clinician who denies a payment authorization for a service that has already been delivered to the beneficiary as a result of retrospective payment authorization will complete a NOA-C and mail a copy to the consumer within three (3) working days of the noticeable act, and mail a copy to the provider who provided the service.

IV. WHEN THE MHP FAILS TO ACT WITHIN THE TIMEFRAMES FOR DISPOSITION OF STANDARD GRIEVANCES, THE RESOLUTION OF STANDARD APPEALS, OR THE RESOLUTION OF EXPEDITED APPEALS

The Managed Care Quality Improvement Clinician processes grievances and appeals within the timelines stated in the regulations, and issues a NOA-D when the established timelines are not met. Refer to Policy and Procedure Guide Nos. 1.2.11 and 1.2.18 for details. The original copy of the NOA is sent to the consumer and a copy kept in the Managed Care consumer file.

V. WHEN THE MHP FAILS TO PROVIDE A SERVICE WITHIN THE STANDARD TIMELILNE ESTABLISHED BY THE MHP

Refer to Policy and Procedure Guide No. 1.2.13 for description of NOA-E.

VI. STATE FAIR HEARING

The beneficiary may request a State Fair Hearing after he/she has exhausted the FCMHP problem resolution process. Refer to Policy and Procedure Guide No. 1.2.16 regarding State Fair Hearing.

VII. AID PAID PENDING

Item 12: Notice of Action/Fair Hearing/Aid Paid Pending for Medi-Cal Beneficiaries

A beneficiary who is currently receiving services must request a State Fair Hearing within ten (10) calendar days of receipt of the NOA to be eligible for Aid Paid Pending. The FCMHP will continue to provide services until the State Fair Hearing decision is rendered.

Division Manager Approval: Betty Brown Signature	Date 4-8-16
Director Approval: Dawan Utecht Signature	Date 4-11-16
Compliance Officer Approval: Signature	Date 4/11/16

Managed Care
Training/Overview PPG
1.2.12 NOA/Fair Hearing/Aid Paid Pending for Medi-Cal Beneficiaries
3/29/16

Attendees:

Print Name	Signature
Linda Sereda	
SANDRA NELSON	
Jonathan Scott Halverstadt	
Chris Schreiber	
Karen Nuñez	
Heather Redmond	

Attachment E
Consumer Grievance Resolution Process
Policy and Procedure Guide

Attachment E-1
Training Sign-in Sheet

Section No.: 1 - **Administration** **Effective Date:** 3/17/12

Chapter No.: 2 - **Quality Assurance** **Revised Date:** 3/29/16

Item No.: 11 - **Consumer Grievance Resolution Process**

POLICY: The Fresno County Mental Health Plan (FCMHP) will maintain written materials at each service site explaining the consumers' rights and responsibilities and describing the process of registering a grievance.

A grievance is an expression of dissatisfaction about any matter other than a denial, modification, reduction or termination of services, or a failure to provide services in a timely manner.

All grievances will be responded to in a timely manner as defined within the scope of the procedure. The grievance process will provide for resolution of the consumer's grievance as quickly and simply as possible. Consumer grievances are protected by confidentiality.
Consumers and family members will be encouraged to share concerns regarding their care without fear of retribution.

The consumer grievance process, investigation and interviews are protected from discovery and subpoena by California Evidence codes 1156, 1157 and 1157.7.

PURPOSE: To support the FCMHP's philosophy of recognizing and acknowledging consumer satisfaction and commitment to excellent staff performance.

To establish a mechanism to receive, investigate, evaluate, and respond to grievances regarding a consumer's mental health services.

REFERENCE: Title 9, CCR, Section 1850.205, Title 42, CFR Part 438, Subpart F.

PROCEDURE:

I. INFORMATION DISTRIBUTION

A. The FCMHP will provide written materials outlining the grievance resolution process in easily understood terms and translated in the threshold languages.

B. Written information regarding the grievance process will be given to each consumer upon admission. This information will also be available at all provider sites and upon request.

C. The consumer handbooks, brochures, and self-addressed stamped envelopes will be available at each service site. Each program and provider is responsible to make copies of the handbooks for their waiting room(s). Managed Care is to be notified if self-addressed stamped envelopes are needed.

II. GRIEVANCE PROCESS

A. The FCMHP will log each grievance within one working day of receipt.

B. The consumer will receive written acknowledgement of the grievance request.

C. The consumer will be encouraged to speak with the clinician/provider about his or her grievance or problem.

D. If the problem is not resolved by the provider or the consumer is uncomfortable discussing this with program staff, the consumer may describe his or her grievance in person, call the consumer access line or fill out a grievance form and mail it to the Fresno County Mental Health Plan.

E. The decision making process shall involve a health care professional with the appropriate clinical expertise in treating the beneficiary's condition.

F. The decision-maker shall not be involved in a previous level of review or decision-making.

G. The FCMHP will respond to the consumer or their representative in writing within 60 calendar days regarding the grievance decision. The timeframe may be extended by up to 14 calendar days if the consumer requests an extension, or if the FCMHP determines that there is a need for additional information and that the delay is in the consumer's interest. If written notification is not possible, documentation of the efforts to notify the consumer or his or her representative must be made.

H. If the FCMHP extends the timeframe, the FCMHP shall, for any extension not requested by the consumer, notify the consumer of the extension and the reasons for the extension in writing.

I. If the consumer is a minor subject to a guardianship or is a ward of the court, the minor's grievance must be submitted through his or her guardian or legal representative.

J. If the consumer is an adult subject to a conservatorship, the person's grievance must be submitted through his or her conservator, guardian ad litem or legal

representative.

K. In a residential setting, the grievance process will be user friendly and time-sensitive to the life threatening nature of psychotic and/or depressive episodes or similar situations. Services will continue until the grievance is resolved, unless the consumer poses a danger to self or others in his or her placement.

III. CONSUMER ASSISTANCE

A. When filing a grievance the consumer may authorize another person or a legal representative to act on his or her behalf.

B. When requested, the FCMHP staff will be available to assist the consumer with all problem resolution procedures, as well as providing the consumer with information regarding the status of the problem resolution process.

C. The Patient's Rights Advocate may assist the consumer in filing his or her grievance. The FCMHP's problem resolution procedures do not replace nor conflict with the duties of the Patient's Rights Advocate.

D. Interpreter services are available to assist the consumer in filing a grievance at no cost to the consumer.

IV. RECORD KEEPING/REPORTING

A. All grievance requests will be recorded in the Beneficiary Protection log within one working day of receipt. The log will include, but is not limited to, the name of the consumer, date of receipt of the grievance, date of written acknowledgment to the consumer or her or his representative of each grievance, nature of the problem, the final disposition, and date of grievance disposition letter to consumer or her or his representative.

B. Managed Care will present a quarterly report of consumer grievances to the Quality Improvement Council.

C. The FCMHP's Beneficiary Protection log and grievance files will be open to the California Department of Health Care Services for review.

Division Manager Approval: Betty Brown Signature	Date 4-8-16
Director Approval: Dawn Utecht Signature	Date 4-11-16
Compliance Officer Approval: Signature	Date 4/11/16

Managed Care
Training Overview PPG
1.2.11 Consumer Grievance Resolution Process
3/29/16

Attendees:

Print Name	Signature
Linda Sereda	
SANDRA NELSON	
Jonathan Scott Halverstadt	
Chris Schreiber	
Karen Nunn	
Heather Redmond	

Attachment F
Consumer Appeal and Expedited Appeal Process Policy and Procedure Guide

Attachment F-1
Training Sign-in Sheet

Section No.: 1 - **Administration** **Effective Date: 07/01/2004**

Chapter No.: 2 - **Quality Assurance** **Revised Date: 03/29/2016**

Item No.: 18 - **Consumer Appeal and Expedited Appeal Process**

POLICY:

The Fresno County Mental Health Plan (FCMHP) will maintain a beneficiary appeal and expedited appeal resolution process that enables the FCMHP and beneficiaries to resolve appeals within the guidelines set forth by federal and state regulations. A beneficiary shall not be discriminated or penalized for filing an appeal and no beneficiary shall be prevented from accessing the appeal process solely on the grounds that the appeal was incorrectly filed with either the FCMHP or the provider.

The FCMHP shall allow an Expedited Review Process for Appeals when the FCMHP determines or the beneficiary and/or the provider certifies that taking the time for a standard resolution could seriously jeopardize the beneficiary's life, health or ability to attain, maintain, or regain maximum function.

PURPOSE:

To establish a mechanism to receive, investigate, evaluate and respond to appeals within the established guidelines and timelines.

REFERENCE:

Title 9, CCR, Section 1850.205

DEFINITIONS:

Appeal: A request for review of an action as defined below or for review of a provider's determination to deny, in whole or in part, a beneficiary's request for a covered specialty mental health service or for review of a determination by the FCMHP or its providers that the medical necessity criteria in Title 9, CCR, Section 1830.205(b)(1), (b)(2), and (b)(3)(C) have not been met and the beneficiary is not entitled to any specialty mental health services from the FCMHP .

Action: An action occurs when the FCMHP does at least one of the following:

1) Denies or modified the FCMHP payment authorization of a requested service, including the type or level of service;

2) Reduces, suspends, or terminates a previously authorized service;

3) Denies, in whole or in part, payment for a services prior to the delivery of the service or denies, in whole or in part, payment for a service post-service

delivery but pre-payment based on a determination that the services was not medically necessary or otherwise not a service covered by the FCMHP;

4) Fails to provide services in a timely manner, as determined by the FCMHP or;

5) Fails to act within the timeframes for disposition of standard grievances, the resolution of standard appeals, or the resolution of expedited appeals.

PROCEDURE:

I. Beneficiary Notification

A. The FCMHP's Consumer Informing Materials provides information about the appeal process.

B. Notices explaining the appeal process are available at all FCMHP provider sites. These notices are available in threshold languages. These notices are available in alternative formats and in Braille by contacting Managed Care.

C. Appeal forms and self-addressed envelopes are available for beneficiaries to pick up at all FCMHP provider sites without having to make a verbal or written request to anyone.

D. The consumer may call the FCMHP toll-free access line to request for information on how to file an appeal. The toll-free line has interpreter services available to beneficiaries at all times.

II. Beneficiary Representation/Confidentiality of Information

A. The FCMHP shall allow a beneficiary to authorize another person to act on his/her behalf or allow a beneficiary's legal representative to use the appeal process. The beneficiary may select a provider as his or her representative.

B. The FCMHP shall identify a staff person or other individual as having responsibility for assisting a beneficiary with the problem resolution processes at the beneficiary's request.

C. The FCMHP shall provide a staff person or other individual with responsibility to provide information on request by the beneficiary or an appropriate representative regarding the status of the beneficiary's appeal.

D. The FCMHP shall ensure that no provision of the FCMHP's beneficiary problem resolution processes shall be construed to replace or conflict with the duties of county

patients' rights advocates as described in Welfare and Institution Code, Section 5520.

E. The FCMHP shall have procedures for the processes that maintain the confidentiality of beneficiaries. Refer to PPG 1-3-8c for complete policy on confidentiality.

III. Beneficiary Protection Log

A. The FCMHP shall maintain a Beneficiary Protection log and record appeals in the log within one working day of the date of receipt of the appeal. The log entry shall include but not be limited to the name of the beneficiary, the date of receipt of the appeal, and the nature of the problem.

B. The FCMHP shall record the final dispositions of appeals, including the date the written disposition is sent to the beneficiary.

IV. Notification and Processing Timelines

A. The FCMHP shall acknowledge the receipt of each appeal to the beneficiary in writing within one working day of receipt.

B. Standard Appeals:

1. The FCMHP shall provide for a decision on the appeal and notify the affected parties within 45 calendar days of receipt of the appeal. This timeframe may be extended by up to 14 calendar days if the beneficiary requests an extension, or the FCMHP determines that there is a need for additional information and that the delay is in the beneficiary's interest.

2. If the FCMHP fails to notify the affected parties of the appeal decision within the established timeframes, the FCMHP shall provide a Notice of Action (NOA) to the beneficiary advising the beneficiary of the right to request a State Fair Hearing. The FCMHP shall provide the NOA on the date that the timeframe expires.

C. Expedited Appeals:

1. The FCMHP shall resolve an appeal and notify the affected parties in writing, no later than three working days after the FCMHP receives the appeal. This timeframe may be extended by up to 14 calendar days if the beneficiary requests an extension, or the FCMHP determines that there is need for additional information and that the delay is in the beneficiary's interest. If the FCMHP extends the timeframes for any extension not requested by the

beneficiary, the FCMHP shall give the beneficiary written notice of the reason for the delay.

2. If the FCMHP fails to notify the affected parties of the appeal decision within the specified timeframes, the FCMHP shall provide a Notice of Action (NOA) to the beneficiary advising the beneficiary of the right to request a State Fair Hearing.

D. The FCMHP shall notify those providers cited by the beneficiary or otherwise involved in the appeal of the final disposition of the beneficiary's appeal. The notice shall contain:

1. The results of the appeal resolution process,

2. The date that the appeal decision was made,

3. If the appeal is not resolved wholly in favor of the beneficiary, the notice shall contain information regarding the beneficiary's right to a State Fair Hearing and procedure for filing for a State Fair Hearing.

V. Appeal Process

A. The FCMHP shall allow a beneficiary to file an appeal orally, or in writing. Standard oral appeals shall be followed-up with written, signed appeals. The Contactor shall treat the oral appeal as an appeal to establish the earliest possible filing date.

B. The FCMHP shall ensure that the individual making the decision on the appeal was not involved in any previous level of review or decision-making; and, if the appeal is regarding a deniable services based on lack of medical necessity, or is about clinical issues, ensure that the decision-maker has the appropriate clinical experience as determined by the FCMHP and scope of practice considerations, in treating the beneficiary's condition.

C. The FCMHP shall inform the beneficiary of his or her right to request a State Fair Hearing at any time after the appeal process has been completed.

D. The FCMHP shall allow the beneficiary to have a reasonable opportunity to present evidence and allegations of factor or law, in person or in writing.

E. The FCMHP shall allow the beneficiary and/or his or her representative to examine the beneficiary's case file, including medical records, and any other documents or records considered during the appeal process before and during the appeal

process.

F. The FCMHP shall allow the beneficiary and/or his or her representative, or the legal representative of a deceased beneficiary's estate to be included as parties to the appeal.

G. The FCMHP shall promptly provide or arrange and pay for the disputed services if the decagon of the appeal resolution process reverses a decision to deny services.

VI. Expedited Appeal Process

A. The FCMHP shall allow the beneficiary to file the request orally without written follow up and ensure that no punitive action is taken against a beneficiary or a provider who requests an expedited resolution or supports a beneficiary's appeal.

B. The FCMHP shall provide the beneficiary with written notice of the expedited appeal disposition and also make reasonable efforts to provide oral notice to the beneficiary and/or his/her representative.

C. If the FCMHP denies a request for expedited resolution or an appeal, the FCMHP shall:

1. Transfer the appeal to the timeframe for standard appeal resolution; and

2. Make reasonable efforts to give the beneficiary and his/her representative prompt oral notice of the denial of the expedited appeal process, and follow up within two calendar days with a written notice.

VII. Reporting to Quality Improvement Council/Oversight Agencies

A. The FCMHP shall have procedures by which issues identified as a result of the appeal processes are transmitted to the FCMHP's Quality Improvement Committee, administration or another appropriate body within the FCMHP 's organization for review and, if applicable, implementation of needed system changes.

B. The FCMHP's Beneficiary Protection logs any appeal files will be open for review by the State Department of Health Care Services, and any appropriate oversight agency.

Division Manager Approval: Signature Betty Brown	Date 4-8-16
Director Approval: Signature Dawan Utecht	Date 4-11-16
Compliance Officer Approval: Signature	Date 4/11/16

Managed Care
Training/Overview PPG
1.2.18 Consumer Appeal and Expedited Appeal Process
3/29/16

Attendees:

Print Name	Signature
Linda Sereda	
SANDRA NELSON	
Jonathan Scott Halverstadt	
Chris Schreiber	
Karen Nutter	
Heather Redmond	

Attachment G
Consumer Grievance Resolution Process
Policy and Procedure Guide

Attachment G-1
Training Sign-in Sheet

Section No.: 1 - Administration **Effective Date:** 3/17/12

Chapter No.: 2 - Quality Assurance **Revised Date:** 3/29/16

Item No.: 11 - Consumer Grievance Resolution Process

POLICY: The Fresno County Mental Health Plan (FCMHP) will maintain written materials at each service site explaining the consumers' rights and responsibilities and describing the process of registering a grievance.

A grievance is an expression of dissatisfaction about any matter other than a denial, modification, reduction or termination of services, or a failure to provide services in a timely manner.

All grievances will be responded to in a timely manner as defined within the scope of the procedure. The grievance process will provide for resolution of the consumer's grievance as quickly and simply as possible. Consumer grievances are protected by confidentiality.
Consumers and family members will be encouraged to share concerns regarding their care without fear of retribution.

The consumer grievance process, investigation and interviews are protected from discovery and subpoena by California Evidence codes 1156, 1157 and 1157.7.

PURPOSE: To support the FCMHP's philosophy of recognizing and acknowledging consumer satisfaction and commitment to excellent staff performance.

To establish a mechanism to receive, investigate, evaluate, and respond to grievances regarding a consumer's mental health services.

REFERENCE: Title 9, CCR, Section 1850.205, Title 42, CFR Part 438, Subpart F.

PROCEDURE:

I. INFORMATION DISTRIBUTION

A. The FCMHP will provide written materials outlining the grievance resolution process in easily understood terms and translated in the threshold languages.

B. Written information regarding the grievance process will be given to each consumer upon admission. This information will also be available at all provider sites and upon request.

C. The consumer handbooks, brochures, and self-addressed stamped envelopes will be available at each service site. Each program and provider is responsible to make copies of the handbooks for their waiting room(s). Managed Care is to be notified if self-addressed stamped envelopes are needed.

II. GRIEVANCE PROCESS

A. The FCMHP will log each grievance within one working day of receipt.

B. The consumer will receive written acknowledgement of the grievance request.

C. The consumer will be encouraged to speak with the clinician/provider about his or her grievance or problem.

D. If the problem is not resolved by the provider or the consumer is uncomfortable discussing this with program staff, the consumer may describe his or her grievance in person, call the consumer access line or fill out a grievance form and mail it to the Fresno County Mental Health Plan.

E. The decision making process shall involve a health care professional with the appropriate clinical expertise in treating the beneficiary's condition.

F. The decision-maker shall not be involved in a previous level of review or decision-making.

G. The FCMHP will respond to the consumer or their representative in writing within 60 calendar days regarding the grievance decision. The timeframe may be extended by up to 14 calendar days if the consumer requests an extension, or if the FCMHP determines that there is a need for additional information and that the delay is in the consumer's interest. If written notification is not possible, documentation of the efforts to notify the consumer or his or her representative must be made.

H. If the FCMHP extends the timeframe, the FCMHP shall, for any extension not requested by the consumer, notify the consumer of the extension and the reasons for the extension in writing.

I. If the consumer is a minor subject to a guardianship or is a ward of the court, the minor's grievance must be submitted through his or her guardian or legal representative.

J. If the consumer is an adult subject to a conservatorship, the person's grievance must be submitted through his or her conservator, guardian ad litem or legal

representative.

K. In a residential setting, the grievance process will be user friendly and time-sensitive to the life threatening nature of psychotic and/or depressive episodes or similar situations. Services will continue until the grievance is resolved, unless the consumer poses a danger to self or others in his or her placement.

III. CONSUMER ASSISTANCE

A. When filing a grievance the consumer may authorize another person or a legal representative to act on his or her behalf.

B. When requested, the FCMHP staff will be available to assist the consumer with all problem resolution procedures, as well as providing the consumer with information regarding the status of the problem resolution process.

C. The Patient's Rights Advocate may assist the consumer in filing his or her grievance. The FCMHP's problem resolution procedures do not replace nor conflict with the duties of the Patient's Rights Advocate.

D. Interpreter services are available to assist the consumer in filing a grievance at no cost to the consumer.

IV. RECORD KEEPING/REPORTING

A. All grievance requests will be recorded in the Beneficiary Protection log within one working day of receipt. The log will include, but is not limited to, the name of the consumer, date of receipt of the grievance, date of written acknowledgment to the consumer or her or his representative of each grievance, nature of the problem, the final disposition, and date of grievance disposition letter to consumer or her or his representative.

B. Managed Care will present a quarterly report of consumer grievances to the Quality Improvement Council.

C. The FCMHP's Beneficiary Protection log and grievance files will be open to the California Department of Health Care Services for review.

Division Manager Approval: Betty Brown Signature	Date 4-8-16
Director Approval: Dawn Utecht Signature	Date 4-11-16
Compliance Officer Approval: Signature	Date 4/11/16

Managed Care
Training Overview PPG
1.2.11 Consumer Grievance Resolution Process
3/29/16

Attendees:

Print Name	Signature
Linda Sereda	
SANDRA NELSON	
Jonathan Scott Halverstadt	
Chris Schroeder	
Karen Nunez	
Heather Redmond	

Attachment H
Fresno Provider Report

Fresno County Medi-Cal Providers Report
Last Updated 01/22/16

Provider County	Provider Number	NPI	Provider Name	Contract Type	Provider Street Address	Provider City	SD/MC Mode of Service	SD/MC Start Date	Last MC Cert Date	Overdue providers	County Status/Comments
10	**1040**	1740318484	Adolescent Day Treatment	1	3133 N Millbrook Avenue	Fresno	18	7/1/1982	9/24/2014		
10	**1044**	1073666723	Fresno County Adult Outpatient	1	4441 East Kings Canyon Road	Fresno	18	1/1/1982	8/25/2015		
10	**1045**	1932238482	Fresno County Youth System Of Care	1	3133 N Millbrook Avenue	Fresno	18	8/26/1993	1/27/2016		
10	**1077**	1336273283	Fee-For-Service Psychiatrist	3	4409 E. Inyo Street	Fresno	18	4/1/1998		FFS	
10	**1078**	1932233806	Fee-For-Service Psychologist	3	4409 E. Inyo Street	Fresno	18	4/1/1998		FFS	
10	**1079**	1376677278	Fee-For-Service LCSW	3	4409 E. Inyo Street	Fresno	18	4/1/1998		FFS	
10	**1080**	1730213539	Fee-For-Service MFCC	3	4409 E. Inyo Street	Fresno	18	4/1/1998		FFS	
10	**1081**	1588798383	Fee-For-Service RN	3	4409 E. Inyo Street	Fresno	18	4/1/1998		FFS	
10	**1082**	1528192333	Fee-For-Service Mixed Specialty Group	3	4409 E. Inyo Street	Fresno	18	4/1/1998		FFS	
10	**1083**	1861527517	Older Adult Team	1	2025 E Dakota	Fresno	18	4/1/1998	8/24/2015		
10	**1084**	1215076419	Asian Pacific Islander	1	4445 E Inyo Street	Fresno	18	5/18/1999	10/24/2013		
10	**1090**	1023270907	Metro Services	1	4447 E. Kings Canyon Rd	Fresno	18	6/1/2008	8/25/2015		
10	**1091**	1518095488	Violet Heintz Education Academy	1	4939 E Yale Avenue	Fresno	18	4/27/2001	8/29/2013		
10	**1097**	1417076720	Families First Inc., WRAP	3	1630 E Shaw Ave #150	Fresno	18	9/14/1999	2/27/2014		
10	**1098**	1902946635	Fresno County Team Conservatorship	1	2085 East Dakota	Fresno	18	3/19/2001	8/29/2013		
10	**10A1**	1114095080	Rebekah Children's Services	3	290 Ioof Avnue	Gilroy	18	7/9/2015			
10	**10A3**	1962586297	Vicotr Treatment Center Redding	3	855 Canyon Road	Redding	18	7/1/2005	5/31/2013		
10	**10A7**	1881753663	Victor Treatment Centers Santa Rosa	3	3164 Condo Court	Santa Rosa	18	7/1/2005	4/18/2013		
10	**10AA**	1437328044	Comprehensive Youth Services-Functional Family Therap	3	3795 E Shields	Fresno	18	9/4/2007	2/12/2016		
10	**10AD**	1821179276	California Psychological Institute Inc	3	1470 W Herndon Avenue, #300	Fresno	18	2/28/2001	4/24/2015		
10	**10AM**	1194125393	Fresno Family Connections	3	3122 N Millbrook Ave Suite F	Fresno	18	7/1/2002	9/5/2014		
10	**10BX**	1922185578	Milhous Children's Services	3	24077 State Highway 49	Nevada City	18	7/21/2015			
10	**10C2**	1467695858	Kings View Projects for Assistance Transition From Homelessness (PATH	3	4910 E Ashlan Avenue Ste 118	Fresno	18	6/1/2010	11/25/2015		
10	**10C4**	1699909812	Urgent Care/Wellness Center	1	4411 E. Kings Canyon Road	Fresno	18	6/29/2009	5/17/2015		
10	**10C9**	1881825172	MHSA TAY-Turning Point	3	83 E. Shaw Avenue, Suite 102 and 204	Fresno	18	8/31/2009	2/14/2014		
10	**10CC**	1902950751	Summitview Child and Family Services	3	5036 Sunrey Road	Placerville	18	4/28/2011	6/12/2014		
#	**10CH**	1730213323	Comprehensive Youth Services Inc.	3	4545 N West Ave	Fresno	18	9/18/2007	2/12/2016		
10	**10CI**	1023163201	Families First Inc-MHSA SMART MOC	3	1630 E Shaw Avenue Suite 150	Fresno	18	9/18/2007	2/27/2014		
10	**10CT**	1659532612	JDT Consultants, Inc	3	4205 West Figarden Drive	Fresno	18	7/1/2007	9/11/2014		
10	**10CU**	1629266507	Exceptional Parents Unlimited Inc. MHSA SMART MOC	3	4440 N. First Street	Fresno	18	10/9/2008	4/23/2015		
10	**10CV**	1174772933	Turning Point Reedley Rural Mental Health Clinic	3	1131 I Street	Reedley	18	10/1/2008	7/30/2014		
10	**10CW**	1518116375	Turning Point Pinedale Rural Mental Health Clinic	3	34 & 40 Minarets Avenue	Pinedale	18	11/4/2008	3/7/2014		
10	**10CX**	1447409289	Turning Point Sanger Rural Mental Health Clinic	3	225 and 231 Academy Avenue	Sanger	18	11/13/2008	7/30/2014		
10	**10CY**	1174710651	Living Well Program	3	4879 E. Kings Canyon Road	Fresno	18	7/1/2010	9/1/2014		
10	**10CZ**	1861551715	Victor-Lodi	3	12755 N Hwy 88	Lodi	18	7/1/2008	6/8/2014		

Fresno County Medi-Cal Providers Report
Last Updated 01/22/16

Provider County	Provider Number	NPI	Provider Name	Contract Type	Provider Street Address	Provider City	SD/MC Mode of Service	SD/MC Start Date	Last MC Cert Date	Overdue providers	County Status/Comments
10	10D2	1497174031	Fresno Impact	3	2550 W Clinton Ave Building A, Ste B	Fresno	18	6/18/2014			
10	10D5	1689933913	Turning Point - AB109	3	3636 N 1st Street 160, 135	Fresno	18	3/10/2014	9/3/2015		
10	10D7	1518367705	Central Star Community Services	3	2140 Merced Street Suite 101	Fresno	18	9/3/2014			
10	10DB	1083936785	Perinatal Program	1	142 E. California Avenue	Fresno	18	4/7/2010	3/25/2016		
10	10DF	1336458934	Families First Inc. - MHSA Act	3	1630 E. Shaw Ave Ste #150	Fresno	18	9/18/2007	2/27/2014		
10	10DJ	1740560465	Exodus Recovery, Inc	3	4411 E. Kings Canyon Road	Fresno	18	5/23/2012	6/3/2015		
10	10DN	1720181795	Star View Adolescent Center Inc	3	4025 W 226th Street	Torrance	18	6/1/2012	6/18/2015		
10	10DQ	1760829410	Turning Point Selma Rural Mental Health Clinic	3	3800 McCall Avenue	Selma	18	7/8/2013			
10	10DR	1669819314	Turning Point Coalinga Rural Mental Health Clinic	3	311 Coalinga Plz	Coalinga	18	7/16/2013			
10	10DS	1033556774	Turning Point Kerman Rural Mental Health Clinic	3	275 S Madera Avenue Ste 404 & 403	Kerman	18	7/8/2013			
	10DT	1801927363	Hathaway Symcamore Children and Family Services	3	2933 El Nido Drive	Altadena	18	8/26/2015			
10	10DY	1912319906	Child Welfare Mental Health Team	1	2011 Fresno Street	Fresno	12	10/1/2014			
10	10ED	1013265859	First Street Center Outpatient AB 109	3	3636 N 1st Street Suite 135, 154	Fresno	18	4/29/2015			
10	10EE	1427461136	Central Star Psychiatric Health Facility	3	4411 East Kings Canyon Road Bldg 319	Fresno	5	4/17/2015			
10	10EF	1205212139	Transitional Age Youth Program	1	4411 E Kings Canyon Road	Fresno		5/11/2015			Certification sent to DHCS on 02/08/2016; awaiting approval
10	10EH	1417334392	PEI First Onset Metro	1	4411 E Kings Canyon Road	Fresno		5/11/2015			Certification sent to DHCS on 02/08/2016; awaiting approval
10	10EK	1265819734	Vista	3	258 N Blackstone Avenue	Fresno	18	7/1/2015			
10	10EM	1508249368	Kings View Corporation	3	4910 E Ashlan Ave, Suite 118	Fresno	18	11/25/2015			
10	10EO	1891170668	Central Star Behavioral Health, Inc	3	2934 Fresno St	Fresno	18	8/18/2015			
10	10EP	1326423971	Recovery with Inspiration and Empowerment	1	4411 E Kings Canyon Road	Fresno		5/13/2014			Certification sent to DHCS on 02/18/2016; awaiting approval
	10EQ	1982075610	Families First Inc. - CWMH	3	1630 E Shaw Avenue #150	Fresno	18	12/1/2015			
10	10ER	1942665484	Exodus PHF Fresno	3	4411 E Kings Canyon Road	Fresno	5	1/1/2016			
10	10ZZ	1699809400	Fresno County Foster Care ASO	1	1221 Fulton Mall	Fresno	18	11/1/1999		FOSTER	

Contract Type: 1= countyowned/operated; 2= IA agreement: 3=contracted

FFS and zz(foster care) Providers do not require recertification

Overdue Provider

Termination Completed

Pending Action

Department of Behavioral Health

Dawan Utecht, Mental Health Director/Public Guardian

Providing Quality Mental Health and Substance Abuse Services for the People of Fresno County

AGENDA

Utilization Review Specialists - Meeting

Tuesday, October 6, 2015.
1:30 p.m. – 3:00 p.m.

Department of Behavioral Health
Managed Care Division

CALL TO ORDER

INTRODUCTIONS

1. **CONSIDER AND ADOPT** Future meeting minutes (to begin 10/20/15).

2. **OLD BUSINESS:**
   A) Chart Review
      1) Chart Review Tool revision 09/22/15 – See Karen's current revision containing additions, percentage of compliance, and identification of possible duplicate issues.

   B) Appeals Process
      1) Karen taken over task from Chris. Heather was scheduled to be trained as a back-up.
      2) Reminder: More supportive detail (rational/roadmap for doctors) when denying days requested.

   C) Reminders – I need your **holiday time-off requests** by 10/20/15 and your **list of 2015 trainings** by the end of this week.

3. **NEW BUSINESS:**
   A) Diagnostic issues (ICD-10 conversion) in Avatar (Linda)

   B) DBH Monthly Contractors' meeting
      1) Next meeting October 14
      2) Linda's recommendation – bring copies of ICD-10 list for contract providers that could not access electronic copy
      3) Any other suggestions/needs you would like communicated to providers?

   C) Medi-Cal Site Certification Tracking
      1) Monitoring of needs for certification and re-certification for both County-operated and contract provider programs to be a regular part of URS meeting and minutes
      2) Kathy is currently working on a list of Overdue Certifications in conjunction with Contracts, ASOC, and YSOC. List contains total of 26 past due certifications. Anticipate we will be able to clear list by the end of this month once DBH fire clearances are received. Will then assign tracking to a URS for monthly report.

   D) Provider Chart Reviews
      1) Current scheduling
      2) Any recent significant issues

   E) Mark your calendars – **Recovery training with Dr. Mark Ragins on Monday, November 2**
      1) Requested all URS staff (and staff analyst) attend
      2) Consists of 3 workshops – *Making recovery Practical; Recovery Based Medication Services, Working Together to Create a Recovery Based System of Care*
      3) Unknown if CEUs will be provided

   F) 5150 Certification Trainings
      1) Kings View SB 82 (New Program) – Kathy offered to train the week of 10/18
      2) CRMC Ambulatory Care staff – need trainer and date

   G) Provider Question – Double Staffing from EMQ

   H) Other business

4. **NEXT MEETING OF URS Staff:** Tuesday, October 20, 2015.

5. **ADJOURNMENT**

Department of Behavioral Health

Dawan Utecht, Mental Health Director/Public Guardian

Providing Quality Mental Health and Substance Abuse Services for the People of Fresno County

AGENDA

Utilization Review Specialists - Meeting

Wednesday, December 2, 2015
1:30 p.m. – 3:00 p.m.

Department of Behavioral Health
Managed Care Division

1. **CONSIDER AND ADOPT** minutes from November 17, 2015.

2. **OLD BUSINESS:**

A) **Medi-Cal Site Certification Tracking**

1) Monitoring of needs for certification and re-certification for both County-operated and contract provider programs

1. Kings View PATH and Rural Triage – fire clearance still pending.
2. CYS FFT and SMART – extended office construction still in progress
3. Exodus Recovery PHF – Fire inspection scheduled for 12/04
4. New in-house programs – email today stating no certification for IDT

2) Status of Overdue Certifications (Medi-Cal Oversight Review) – see attached spreadsheet

B) **5150 Certifications** – training and QA review

1) Next trainings scheduled: 12/03 (Kathy) general training; 12/10 (Kathy) general training; 01/07/16 – UCSF psychiatric residents – all trainings at Managed Care, 2:00PM

2) 5150 Training Materials for 2016 – schedule meeting of facilitators for review and revision of PowerPoint, handouts, and posttest for 2016.

B) **Provider Chart Reviews**

1) Coming up: Castani Family Services (Thursday, 12/05); Turning Point RMH Coalinga (Friday, 12/11); EMQ FF WRAP (Tuesday, 12/15); MHS IMPACT (Thursday, 12/17)

2) Chart Reviews- "Comments" on review tools – sometimes incomplete or difficult to summarize. Please make sure you are doing the following to assist the URS that is writing up the final paperwork:

1. Identify the document (when not otherwise clearly stated on tool) (Clinician PN, Assessment, POC, Physician PN, Nurse Note, etc)
2. Identify *the date* of the document you are commenting on
3. State the problem/findings in full
4. Type of deficiency (quality of care vs recoupment)

3) Standardized email notifications for sending out requests and acceptances of plans of correction (see attached)

4) Final audit paperwork – email to Clinical Supervisor should include final letter of acceptance, provider's response to POC, and password-protected Compliance Spreadsheet along with your recommendation for follow-up. Please make sure all audit related material is then placed in appropriate folder on P drive (MC Share > Chart Reviews)

5) Any significant issues that need to be discussed regarding recent reviews

C) **Chart Review Tool** – revisions – continue review

3. **NEW BUSINESS:**

D) SARs and requests for care coordination from Out-of-County SWs – follow up on status of number of requests and concerns, if any.

E) Other issues or concerns

4. **NEXT MEETING OF URS Staff:** Moved to Wednesday, December 16, 2015, due to EMQ audit.

5. **ADJOURNMENT**

Department of Behavioral Health

Dawan Utecht, Mental Health Director/Public Guardian

Providing Quality Mental Health and Substance Abuse Services for the People of Fresno County

AGENDA

Utilization Review Specialists - Meeting

Tuesday, January 5, 2016
1:30 p.m. – 3:00 p.m.

Department of Behavioral Health
Managed Care Division

1. **CONSIDER AND ADOPT** minutes from December 16, 2015. **(Unable today)**

2. **OLD BUSINESS:**

A) **Medi-Cal Site Certification Tracking**

1) Monitoring of needs for certification and re-certification for both County-operated and contract provider programs

1. New in-house programs – All material in for TAY, FOT, DBT. Laura will be sending in requests for DHCS certification visit.

2) Status of Overdue Certifications (Medi-Cal Oversight Review) – Submission of Out-of-County program certifications is being coordinated with Laura to be completed this week.

3) Current re-certifications due this month - none

B) **5150 Certifications** – training and QA review

1) Next trainings scheduled: 01/07/16 – UCSF psychiatric residents (Sandra N); 01/13/15 – Exodus PHF Staff (AM and PM sessions) (Heather)

2) 5150 Training Materials for 2016 – A meeting of facilitators for review and revision of PowerPoint, handouts, and posttest has been scheduled for Wednesday, 01/06 at 2:00PM.

3) Still need to schedule at least 2 more trainings for start of Feb to capture 21 newly hired UMHCs from DBH.

4) NEW ITEM: Request for 5150 Certification and 5150 Application PPG from Compliance (Need volunteer)

C) **Provider Chart Reviews**

1) No regular audits scheduled this month

2) Scheduling follow-ups for recent audits: clear communication with PRSs needed (who needs a follow up; when should it be scheduled; how many charts; etc.)

D) **Chart Review Tool** – revisions – continue review **Thursday, 01/14 at 2:00PM.**

3. **NEW BUSINESS:**

A) Recoupments of recent audits

B) Medi-Cal Oversight Review (response to draft; no final POC yet)
   a. Sections B & C – Diana will be asking us to review
   b. Compiling Section K tasks - update

C) Requests from other Departments/DBH staff for URS participation

D) Other issues or concerns

4. **NEXT MEETING OF URS Staff:** Tuesday, January 19, 2016

5. **ADJOURNMENT**

Attachment I
FCMHP Audit Summary Tool

FRESNO COUNTY MENTAL HEALTH PLAN
AUDIT SUMMARY

	CRITERIA Class: H = HIPAA, Q = Quality, R = Recoupment, S = Safety	COMPLIANCE Y	N	NA	%	Class	
CONSENT OF TREATMENT							
1	Consent for treatment is present and appropriately executed (i.e., by client 18 and older, legal guardian, court order, Deputy Conservator) and in the record for each voluntary episode of inpatient hospitalization, voluntary crisis stabilization services and prior to starting outpatient services.					Q	
ASSESSMENT							
2	Client was offered a choice of provider.					Q	
3	Client was offered Advance Directive information (Adults only).					Q	
4	The assessment was completed in accordance with FCMHP's established standards for timeliness and frequency.					Q	MHP Report 2a; MHP Report 2b
5	**The assessment includes ALL of the following:**					Q	MHP Report 2a; MHP Report 2c
a	**Presenting problem**; chief complaint, history of presenting problem(s), including current level of functioning, relevant family history and current family information.						
b	**Client strengths** in achieving goals related to their MH needs and functional impairments as a result of the MH diagnosis.						
c	**Relevant conditions and psychosocial factors** affecting the client's physical health and mental health; including, as applicable, living situation, daily activities, social support, cultural and linguistic factors and history of trauma or exposure to trauma.						
d	**Substance exposure/substance Use**; past and present use of tobacco, alcohol, caffeine, CAM (complementary and alternative medications) and over-the-counter, and illicit drugs.						
e	**Mental Health History**; previous treatment, including providers, therapeutic modality (e.g., medications, psychosocial treatments) and response, and impatient admissions. Other sources of clinical data, such as previous mental health records, and relevant psychological testing or consultation reports.						
f	**Medical History**; relevant physical health conditions reported by the client or significant support person. Include name and address of current source of medical treatment. For children and adolescents, the history must include prenatal events and relevant/significant developmental history.						
g	**Medications**; information about medications the client has received, or is receiving, to treat MH and medical conditions, including duration of treatment. Should include the absence or presence of allergies or adverse reactions.						
h	**Risks**; situations that present a risk to the client and/or others, including past or current trauma (e.g. suicidal/homicidal risks and grave disability are noted and updated).						

FRESNO COUNTY MENTAL HEALTH PLAN
AUDIT SUMMARY

	CRITERIA Class: H = HIPAA, Q = Quality, R = Recoupment, S = Safety	COMPLIANCE Y	N	NA	%	Class	
i	**A mental status examination**						
j	**A complete diagnosis;** a diagnosis from the current ICD-code must be documented, consistent with the presenting problems, history, MSE and/or other clinical data; including any current medical diagnosis.						
6	The assessment includes the date of service, signature of person providing the service (or electronic equivalent), employee ID number, type of professional degree, licensure or job title, and the date the documentation was entered into the medical record.					R	
7	Cultural issues (including language, gender identity, and sexual orientation) are noted in the assessment.					Q	
8	Duration times (service duration, doc/travel, total), date, language, location match what was billed in Avatar. (When assessment activity is within audit timeframe.)					R	
9	Staff completed the appropriate outcomes measurement (Does not apply to individual/group providers).					Q	
CLIENT PLAN (a.k.a Treatment Plan; Plan of Care)							
10	The client plan is completed within 60 days of the assessment unless there is documentation supporting the need for more time.					R5	MHP Report 3a
11	The client plan is completed on an annual basis or as specified in the MHP's documentation guidelines and is reviewed and/or updated as appropriate in response to a crisis event resulting in emergency services or whenever there is a significant change in the client's condition.					R6	MHP Report 3a, 3b
12	Plan includes specific, observable, and/or specific quantifiable goals/treatment objectives related to the client's mental health needs and functional impairments as a result of the MH diagnosis.					Q	MHP Report 3c-1
13	Plan identifies the proposed type type(s) of intervention/modality including a detailed description of the intervention to be provided.					Q	MHP Report 3c-2
14	Plan includes the proposed frequency and duration of the intervention(s).					Q	MHP Report 3c-3
15	Includes interventions that focus and address the identified functional impairments as a result of the MH disorder.					Q	
16	Interventions are consistent with client plan goal(s)/treatment objective(s).					Q	
17	Plan is consistent with the qualifying diagnosis.					R3	

FRESNO COUNTY MENTAL HEALTH PLAN
AUDIT SUMMARY

	CRITERIA Class: H = HIPAA, Q = Quality, R = Recoupment, S = Safety	COMPLIANCE Y	N	NA	%	Class	
18	Plan of care is signed by one of the following: The person providing the service or; The person representing a team providing the service or; The person representing a team or program providing the service **OR**					R	
	By one of the following, as a co-signer, if the client plan is used to establish that services are provided under the direction of an approved category of staff, and if the signing staff is NOT of the approved categories, one (1) of the following must sign: A Physician; A Licensed/Registered/Waivered Psychologist, SW, or MFT; NP or RN.						
19	Plan of care includes the client's signature or the signature of the client's legal representative when: the client is expected to be in long-term treatment, as determined by the MHP, and, the client provides that the client will be receiving more than one type of SMHS; **OR**					R7	
20	In absence of a client signature, documentation of the client's participation in an agreement with the plan (e.g. Court ordered treatment; reference of participation and agreement in the body of plan; or a description of the client's participation and agreement in the medical record) and there is a written explanation if it is absent and documents ongoing attempts to obtain the appropriate signature(s).					R7	
21	Documentation that the contractor/provider offered a copy of the treatment plan to the client. Documentation includes acceptance/decline.					Q	MHP Report 3g
22	Cultural issues (e.g. language, culture/ethnicity) are noted in the client plan.					Q	
23	For a non-English speaker, the client plan documents how the client plan was developed.					Q	
24	The duration, date, location on client plan match what has been billed in Avatar					R	
25	For a non-English speaker, the client was offered a copy of the client plan in their preferred language					Q	
MEDICAL NECESSITY							
26	As established by a clinical assessment, the client meets **all three** (26a, b, and c) of the following medical necessity criteria below.					R	
26a	A current ICD diagnosis which is included for non-hospital SMHS in accordance with the MHP contract?						
26b	The client, as a result of a mental health disorder or emotional disturbance (listed in 26a), must have at least ONE of the following criteria (1-4 below):						
	1. Significant impairment in an important area of life functioning; OR						MHP Report 1c.1

FRESNO COUNTY MENTAL HEALTH PLAN
AUDIT SUMMARY

	CRITERIA Class: H = HIPAA, Q = Quality, R = Recoupment, S = Safety	COMPLIANCE Y	N	NA	%	Class	
	2. Probability of significant deterioration in an important area of life functioning; OR						
	3. Probability that the child will not progress developmentally as individually appropriate; OR						
	4. For full scope Medi-cal beneficiaries under the age of 21 yrs., a condition as a result of the mental health disorder or emotional disturbance that SMHS can correct or ameliorate. (EPSDT standard)						
26c	The proposed and actual intervention(s) meet the intervention criteria listed below:						
	1. The focus of the proposed and actual intervention(s) is to address the condition identified in 26b, or for full scope Medi-cal beneficiaries under the age of 21 years, a condition as a result of the mental disorder or emotional disturbance that SMHS can correct or ameliorate per 26b4.						
	2. The expectation is that the proposed and actual intervention(s) will do at least one (1) of the following (a-d) below:						
	a) Significantly diminish the impairment.						
	b) Prevent significant deterioration in an important area of life functioning.						
	c) Allow the child to progress developmentally as individually appropriate.						
	d) For full scope Medi-cal beneficiaries under the age of 21 years, correct or ameliorate the condition.						
27	If the client did not meet medical necessity, a Notice of Action A was provided to the client/family and a copy is in the chart.					Q	
PROGRESS NOTES							
28	Progress notes document the following:					R	MHP Report 4a-d
	a) Interventions applied and the client's response to the interventions.						
	b) The date the services were provided.						
	c) The location where services were provided.						
	d) The amount of time taken to provide services is documented on the progress note and matches claim for service.						
	e) The signature of the person providing the service, employee ID number, type of professional degree, and licensure or job title.						MHP Report 4b-8

FRESNO COUNTY MENTAL HEALTH PLAN
AUDIT SUMMARY

	CRITERIA Class: H = HIPAA, Q = Quality, R = Recoupment, S = Safety	COMPLIANCE Y	N	NA	%	Class	
	f) The progress note is completed in accordance with the timeliness and frequency requirements specific to the Fresno County MHP documentation standards.						
29	Services billed to the FCMHP are consistent with the documentation in the client's record and include the following:					R	MHP Report 4a-d
	a) The date of service						
	b) The correct purpose of visit/service code						
	c) The name of the provider on the claim matches the name of the provider that facilitated the service.						
30	There is a progress note for every service claimed by the provider.					R9	MHP Report 4a, 4b
31	Progress note indicates service is provided in an eligible setting (not an IMD, jail, during day treatment program hours, or other lockout setting).					R11	
32	Progress or lack of progress toward treatment goals are documented and refer to the most recent treatment plan goals.					Q	
33	Notes indicate service(s) **do not include** time spent for transportation, clerical, payee related, or for a missed appointment.					R16-18	
34	Service not solely for substance use disorder.					R1; R19c	
35	Service provided was solely for one of the following:					R13	
	a) academic educational services						
	b) vocational services that has work or work training as its actual purpose						
	c) recreation						
	d) socialization that consists of generalized group activities that do not provide systematic individualized feedback to the specific targeted behaviors.						
36	Medical necessity for continued treatment is documented for each claimed service. Medical necessity is demonstrated by continued symptoms and impairment which impacts daily social and community functioning.					R2	MHP Report 1c.1
37	Documentation of interventions clearly describes what was done to reduce symptoms/impairments and match the POC for each claimed service.					R4	MHP Report 1c.2
38	Evidence-based practice used and appropriately documented in text of progress note (i.e. Dialectical Behavioral Therapy, Eye Movement Desensitization and Reprocessing, Cognitive Behavioral Therapy, Structural Family Therapy, Motivational Interviewing etc.)					Q	
39	Staff interventions and client response to life-threatening conditions, i.e.; suicidal/homicidal ideation and grave disability are documented.					S	

	CRITERIA Class: H = HIPAA, Q = Quality, R = Recoupment, S = Safety	COMPLIANCE Y	N	NA	%	Class	
40	Progress or lack of progress toward treatment goals are documented and refer to the most recent treatment plan goals.					Q	
41	Evidence of collaboration and referrals to community resources or other agencies when appropriate.					Q	
42	Discharge summary or plan for follow-up care, when appropriate, must include the reason for discharge and referral. If no referrals are provided, the reason for no referrals is documented.					Q	
43	If the client has ceased services, there is documentation to explain follow up referrals, attempts to contact or reasons for termination.					Q	
44	If the diagnosis has changed for any reason, and a clinical assessment was not completed, appropriate documentation with clinical justification is noted in a progress note. The clinical documentation must provide the current DSM and/or ICD-based reasoning for the diagnostic change.					R	
45	If multiple providers are concurrently treating the client, documented evidence of communication between the providers is noted in the chart.					Q	
46	If a client had a recent 5150 episode or inpatient psychiatric hospitalization, appropriate follow up was documented and provided (e.g. Treatment plan was reviewed and updated when appropriate).					Q	
47	The "Primary Diagnosis" selected at the time of the service is an included Medi-cal diagnosis (for billable services only).					R1	
48	Effort to contact the client after missed appointments is documented.					Q	
	TYPE OF SERVICE CONTACT (Purpose of Visit)						MHP Report 4b (See items 49-61 this
49	**103** (Assessment) notes focus on information gathering activities and determination of medical necessity.					R19a	
50	**126** (Individual psychotherapy), **156** (family psychotherapy), and **83** (individual or family psychotherapy) notes show a service that focuses primarily on symptom reduction for the client even if it is a family session.					R19a	
51	**82 and 85 Notes** (Group therapy and Rehabilitation) demonstrate a service that focuses on symptom reduction and is provided to multiple clients in one session. The progress note includes:					R19a; R14	MHP Report 4b-3, 4b-7
	a) The group note must be individualized to speak to the specific progress of the individual client.						
	b) Demonstrates medical necessity justifying more than one facilitator, and specific contributions of each.						

FRESNO COUNTY MENTAL HEALTH PLAN
AUDIT SUMMARY

	CRITERIA Class: H = HIPAA, Q = Quality, R = Recoupment, S = Safety	COMPLIANCE Y	N	NA	%	Class	
	c) Time is properly apportioned to all clients present and, if applicable, to multiple providers. Group formula components included on progress note.						
	d) The number of clients, number of staff, and units of time is documented						
52	When services are being provided to, or on behalf of, a client by two or more persons at one point in time, the progress notes include:					R	
	a) Medical necessity for having more than one provider.						
	b) Documentation of each person's involvement in the context of the mental health needs of the client.						
	c) The exact number of minutes used by persons providing the service.						
	d) Signature(s) of all person(s) providing the services.						
53	**150 Notes** (Collateral) show contact with the client's significant support person(s) including consultation and training to assist in better utilization of services and understanding of the client's mental illness per POC.					R19a	
54	**153 Notes** (group collateral) show a service that focuses on symptom reduction and is provided to multiple significant support persons in one session. The notes must be individualized to speak to the specific progress of each client represented. Group formula is applied to number of clients represented. group service meets criteria of Item # (a-c) above. **Only provided as permitted per FCMHP contract.**					R19; R14	
55	**158 Notes** (Individual rehab) or 85 (Group rehab) show client was offered assistance, training, counseling, support, or encouragement with mental health stated symptoms, and impairments per POC.					R19	
56	**159 Notes** (Plan Development) show a service activity which consists of development and approval of the client's plan, and/or monitoring of the client's progress.					R19a	
57	**205 Notes** (Case management linkage and consultation) show client was linked, assisted, monitored, or advocated for by staff per POC (i.e., services were not for providing transportation or completing a task for the client)					R19	
58	**205 Notes** (Case management linkage and consultation) show appropriate follow up when a referral has been made.					R19	
59	**206 Notes** (Case management placement) show client was offered assistance in locating and securing an appropriate living environment or funding per POC.					R19	

	CRITERIA Class: H = HIPAA, Q = Quality, R = Recoupment, S = Safety	COMPLIANCE Y	N	NA	%	Class	
60	**31 Notes** (Crisis Intervention - Other) or **181 Notes** (Crisis Intervention - Therapy) show client's condition required (and received) a more timely response than a regularly scheduled visit and provided interventions to attempt to de-escalate the client's urgent mental health condition. **Only provided per FCMHP contract.**					R19	
61	**180 Notes** (Crisis Intervention Assessment) show appropriate risk assessments and safety assessments to correspond with the crisis episode. Risk and safety assessments must include documentation of both risk and protective factors, collateral supports with contact information, homicidal and suicidal risk and contingency plans. **Only provided per FCMHP contract.**					R19	
62	Timeliness/frequency as follows:					R	
	a) Every service contact for: mental health services, medication support services, crisis intervention, and targeted case management.						
	b) Daily for crisis residential, crisis stabilization (one per 23 hour period), day treatment intensive.						
	c) Weekly for day treatment intensive (clinical summary), day rehabilitation, adult residential.						
	MEDICATION REVIEW						
63	**170 or 190 notes** (Meds mgmt. assessment) is used by MD, PA, or NP for in-depth assessment (psychiatric evaluation) of client who is managed primarily with psychotropic meds.					R19	
64	**172 or 192 notes** (Meds mgmt. brief) is used by a Physician, PA or NP, when the client is stable but requires drug regimen oversight. Services may include evaluating the safety and effectiveness of the medication and/or providing a simple dosage adjustment to a long-term medication. Prescription may or may not change.					R19	
65	**173 or 193** (Meds evaluation follow-up) Medication adjustment for stabilization used by the Physician, PA or NP.					R19	
66	**40 notes** (Med refills/injection) used for meds administered by RN/LVN. Also used for nursing interventions related to medication refill needs.					R19	
67	**41 notes** (Meds education/administration) focus on informing client and significant support persons about the psych meds being prescribed. May also be used for general nursing interventions such as MD consultation, MD consent (completion of the JV 220), and other nursing services which do not fall under the category of med refill/injection.					R19	

	CRITERIA Class: H = HIPAA, Q = Quality, R = Recoupment, S = Safety	COMPLIANCE Y	N	NA	%	Class	
68	The provider obtained and retained a current written medication consent form signed by the client 18 and older, legal guardian, court order or conservator for each medication prescribed and inaccordance with timeliness and frequency standards specified in the MHP's documentation standards.						MHP Report 2d
69	Medication consent for psychiatric medications include the following required elements: Reason, alternative treatments available, if any; type of medication; dosage; frequency; method of administration; duration; probable side effects; possible side effects if taken longer than 3 months; consent may be withdrawn at any time.					Q	MHP Report 2e
70	Medication is appropriate for diagnosis or treatment of symptoms.					Q	
71	Lab work ordered as required to monitor for safety concerns.					Q/S	
72	AIMS survey or similar is current or discussed in progress notes.					Q	
73	Adherence and response to target symptoms of medication is documented.					Q	
74	Drug allergy is prominently documented as an alert.					S	
75	Referral to PCP or other community resources or other agencies when appropriate.					Q	
CULTURAL COMPETENCE							
76	Regarding cultural/linguistic services and availability in alternative formats and there is evidence the client is made aware that SMHS are available in their preferred language as documented by one or more of the following:					Q	
	a) Documentation that mental health interpreter services are offered and provided, when applicable.						
	b) When the need for language assistance is identified in the assessment, there is documentation of linking clients to culture-specific and/or linguistic services as described in the MHP's CCPR.						
	c) When applicable, service-related personal correspondence is provided in the client's preferred language.						
	d) When applicable, treatment specific information is provided to the client in an alternative format (e.g., braille, audio, large print, etc.).						
OVERALL QUESTIONS							
77	Non-electronic client records are legible.					R3; R19a	
78	Release(s) of information present in the medical record when appropriate.					H	

FRESNO COUNTY MENTAL HEALTH PLAN
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	CRITERIA Class: H = HIPAA, Q = Quality, R = Recoupment, S = Safety	COMPLIANCE Y	N	NA	%	Class	
79	Mandated reporting to CPS, APS completed if necessary and documented.					S	
80	Mandated Tarasoff notification made to law enforcement and intended victim.					S	
81	Provider is working within scope of practice, documented throughout chart.					R19d	
82	Client signature of authorization for payment and release of information for claiming purposes located in the client record and is dated prior to services claimed (Found on CMS 1500 form lines 12 and 13 or elsewhere in chart)					R	

COMMENTS:

Reviewer signature and date

Reviewer signature and date

Attachment J
Collaborative Provider Responses

Attachment J-1
10C9 MHSA TAY – Turning Point; 10CW Turning Point Pinedale Rural Mental Health Clinics

Attachment J-2
10CI Families First Inc – MHSA SMART MOC

Attachment J-3
10CY Living Well Program

Attachment J-4
10AD California Psychological Institute

Attachment J-5
10DP Bayfront Youth and Family Services

TURNING POINT
OF CENTRAL CALIFORNIA, INC.

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Office: (559) 476-2176
Fax: (559) 221-0307

October 28, 2015

Re: Plan of Correction Response to DHCS Medical Record Audit

To: Katherine Rexroat

We have provided the following plan to outline the corrective steps we have taken to address the areas of deficiency outlined in the medical record audit performed by DHCS:

Item 1C-1 (Medical Necessity, Interventions): Upon hire, all Turning Point employees that complete clinical documentation as part of their job duties are required to attend a compliance and documentation training facilitated by Fresno County Department of Behavioral Health, as well as a documentation training provided by Turning Point's Quality Assurance (QA) department. Both trainings address how to establish medical necessity and appropriate interventions to address medical necessity criteria. Turning Point QA staff will continue to provide ongoing documentation training. Monitoring of clinical documentation and progress notes will be conducted by both QA staff and program supervisors to ensure compliance with documentation standards. As areas of deficiencies are identified during monitoring, staff will be instructed on how to appropriately document to meet medical necessity standards. Program staff received training on 10/5/2015 reviewing criteria for establishing medical necessity.

Item 2b and 2c (Assessments, timeliness and missing elements): Turning Point employees are required to attend documentation training provided by Turning Point QA staff upon hire. All components and elements of the mental health assessments and standards including completion and submission timeframes are instructed by QA staff. Clinical staff receive on-going trainings and monitoring by QA staff and supervisors. Additional training will be provided as necessary. Clinical supervisors and program directors will monitor assessments regularly for timeliness and completeness to ensure assessments are submitted in a timely manner and all components are completed properly. Supervisors and directors will take necessary corrective actions for underperforming staff including requiring further training and/or disciplinary procedures. Program staff received training on 10/5/2015 reviewing assessment standards and guidelines.

Item 2e (Medication consents): It is Turning Point's understanding that Fresno County Department of Behavioral Health will be updating/revising their medication consent form in the near future to meet the required elements specified in the mental health plan. It is our intent to begin utilizing Fresno County's updated medication consent form at the time it is made available and is accessible to Turning Point staff. Until that time, Turning Point will instruct all company and contracted psychiatrists to include dosage ranges and frequencies on all medication consent forms. Medication consents will be monitored for completeness by the program nursing staff, program directors, and QA staff.

Item 3C-1, 2, 3 (Client plans, objectives, and interventions): Turning Point clinical staff are required to attend documentation training provided by Turning Point QA staff upon hire. Staff will be trained on the required elements of

client plans including ensuring goals and treatment objectives are specific, observable, and relate to the documented mental health needs and impairments. Clinical staff will be trained on proposed interventions to ensure each include a detailed description with an expected duration and frequency indicated. Supervisors and program directors will provide regular monitoring of client plans and will provide feedback and training as needed.

Item 3g (Client plans, copy offered): Turning Point clinical staff are required to attend documentation training provided by Turning Point QA staff upon hire. Clinical staff will be trained on all elements of a client treatment plan and how to develop a plan to meet documentation standards. Clinical staff will be instructed to offer a copy of the plan to the client after completion. Clinical staff will be instructed to document in the plan that a copy was offered to the client. Program supervisors and directors will provide regular monitoring and supervision of client plans to ensure copies of client plans are being offered and documented appropriately.

Item 4b-1, 8 (Timely completion of progress notes, relevant aspects of client care, provider credentials): Turning Point employees are required to attend documentation training provided by Turning Point QA staff upon hire. All components of a progress note will be reviewed including how to establish medical necessity, interventions relevant to the mental health needs and impairments as stated in the client plan of care, and expected completion and submission timelines. Provider signatures will be reviewed with staff to include printed name and signature as well as degree, licensure, or job title. Program supervisors and directors will monitor progress notes weekly for timeliness and completeness to ensure adherence to submission and written documentation standards. Progress notes identified that do not meet the minimum documentation standards will be reviewed with staff and staff will be assigned to additional training when areas of deficiency are recognized. Supervisors and directors will take corrective actions for underperforming staff including requiring further training and/or disciplinary procedures. Program staff received training on 10/5/2015 reviewing progress note requirements/components and submission standards.

Please let us know if you have further questions in regards to our plan of corrections outlined here.

Thank you.

Ryan Banks, M.P.A.
Deputy Regional Director, Region 7A
Turning Point of Central California
559-476-2176 Ext. 4015

EMQ Families First
Plan of Correction for MHP Review Report 04 2016

Summary statement of deficiency (As indicated by the Consolidated specialty mental health services fiscal year 2014-1015 Fresno county review May 4-7, 2015 draft report)	EMQFF Plan of Correction
FINDING: 2b. Assessments were not completed in accordance with the MHP's written documentation standards for timeliness and frequency: • ...Line#20: The initial assessment was completed late. In addition, for Line #19, the second provider completed an assessment that was late. PLAN OF CORRECTION: 2b. The MHP shall submit a POC that indicates how the MHP will ensure that assessments are completed in accordance with the MHP's written documentation standards for timeliness and frequency.	2b. EMQFF will utilize their Assessment and Plan of Care training to emphasize to staff the importance of completing their assessment and plan of care within 30 days (signed by staff and client/care provider). In addition to addressing the 30 day limit, training will include: • The date used to indicate when the 30 day timeframe begins. • Methods to engage families that are hesitant to begin the assessment process. • Correct methods of documenting cancellations and no-shows. • Steps to take if assessment is unable to be completed within 30 days.
FINDING: 2c. One or more of the assessments reviewed did not include all of the required elements as specified in the MHP contract with the Department. The following required elements were missing: 1) Medical History: Line #19 (2nd provider's assessment) 2) Substance Exposure/Substance Use: ...Line #19. PLAN OF CORRECTION: 2c. 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.	2c. EMQFF will utilize their Assessment and Plan of Care training to train staff how best to phrase the findings when families indicate that a child or family has no notable medical history or substance exposure/Substance use. Staff will be trained to specifically state that each area of the Fresno County Assessment form was covered in collaboration with the child and the caregiver and to clearly indicate when the child/family shares that they do not have specific information (i.e. substance exposure when child is in foster care and that history is unavailable) or no need is evident in that area at this time (no significant medical needs exist).
FINDING: 3a. Reason for recoupment #5 – The initial client plan was not completed within the time period specified in the MHP's documentation standards, with no evidence supporting the need for more time: • Line #19: The initial client plan was not completed within the time period specified in the MHP's documentation standards, and therefore, there was no client plan in effect during part of the audit review period. *The MHP should review all services and claims during which there was no initial client plan in effect and disallow those claims as required.* PLAN OF CORRECTION:	3a.1) EMQFF will utilize their Assessment and Plan of Care training to emphasize to staff the importance of completing their assessment and plan of care within 30 days (signed by staff and client/care provider). In addition to addressing the 30 day limit, training will include: • The date used to indicate when the 30 day timeframe begins. • Methods to engage families that are hesitant to begin the assessment process. • Correct methods of documenting cancellations and no-shows. • Steps to take if assessment is unable to be completed within 30 days. 3a.3) a. EMQFF's electronic health record allows for an expiration date on goals and does not allow a note to be written without a goal. At intake,

ATTACHMENT J-2

EMQ Families First

Plan of Correction for MHP Review Report 04 2016

3a. The MHP shall submit a POC that indicates how the MHP will: **1) Ensure that initial client plans are completed in accordance with the MHP's written documentation standards.** **2) (Not identified need for EMQFF)** **3) Ensure that services are not claimed:** **a. When an initial client plan has not been completed.** **b. When not indicated on the initial plan.** **4) Provide evidence that those services claimed outside of the audit review period for which there were no client plans in effect are disallowed.**	customer services will set an expiration date for 30 days from intake so that no services can be billed after the 30 day mark until the Plan of Care is signed and services are authorized. 3a.3) b. EMQFF audits every client plan to ensure that all services are included prior to submitting them as completed. This did not appear to be a disallowance for EMQFF in this audit, but EMQFF will continue this practice to ensure all services are indicated on the initial plan. 3a.4) Once all disallowance are identified, our finance/billing department can make changes in Avatar for those services and then provide evidence that changes were made through the associated Service Correction Adjustment Request Forms (SCARFs).
FINDING: **3c-1-3. The following line #s had client plans that did not include all of the items specified in the MHP Contract with the Department:** **1) 3c-1. ...Line #19: One or more of the goals/treatment objectives were not specific, observable, and/or quantifiable and related to the beneficiary's mental health needs and identified functional impairments as a result to the mental health diagnosis.** **2) 3C-3. ...Line #20: One or more of the proposed interventions did not indicate an expected frequency.** **PLAN OF CORRECTION:** **3c-1-3 The MHP shall submit a POC that indicates how the MHP will ensure that:** **1) All client plan goals/treatment objectives are specific, observable and/or quantifiable and relate to the beneficiary's documented mental health needs and functional impairments as a result of the mental health diagnosis.** **2) 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) All mental health interventions proposed on client plans indicate both an expected frequency and duration for each intervention.**	Beginning as of January 1st, 2014 all new and reauthorized plans of care were required by EMQ Families First to include: 1) Goals/treatment objectives that are specific, observable, and/or quantifiable and related to the beneficiary's mental health needs and identified functional impairments as a result to the mental health diagnosis. 2) Goals/treatment objectives that indicate an expected frequency and duration. These components are monitored and audited for compliance and quality assurance by a Clinical Program Manager prior to plan of care approval and submission to chart. This process is outlined in our attached *Central Region Internal Audit Process* document with timelines indicated on the document titled *Audit tools and timelines quick reference.* The auditing tools mentioned in these documents have also been included as attachments for review (*Quality Tool, Assessment and Legal Tool, and Treatment Plan Tool*). **Note:** (highlights have been added to all documents listed above to better identify relevant portions of the documents)
FINDING:	4b-1, 4b-8 1) EMQFF already has methods in place to ensure timely completion

4b-1, 4b-8. Progress notes did not document the following. **1) 4b-1. ...Line #19 and Lind #20: Timely documentation of relevant aspects of beneficiary care as specified by the MHP's documentation standards (i.e., progress notes completed late based on the MHP's written documentation standards in effect during the audit period).** **PLAN OF CORRECTION:** **4b-1, 4b-8. The MHP shall submit a POC that indicates how the MHP will ensure that progress notes document:** **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.** **2) The provider's professional degree, licensure or job title.**	of notes and corrective action identified when staff members fall outside of this expectations. As no specific timelines or disallowances were identified in this audit EMQFF will continue to implement the methods currently in place unless specific disallowances or timeframes are identified and the need to adjust those methods becomes evident. - Attached is the document titled, *EMQ Families First Note Turnaround Accountability Guidelines*, which outlines EMQ Families First Central Region's note turnaround preferences and accountability practices. Additionally, you will find attached a sample report that informs these accountability practices. 4b-1, 4b-8 2) EMQFF holds monthly audits and every note is audited for signature. Degree and licensure or job title is on the printed signature line for every note, but there may be some instances where signature lines were not entered into the system correctly. Signature lines will be reviewed through monthly audits to identify any that are out of compliance and changes will be made. As no specific disallowances were identified in this audit EMQFF will continue to implement the audit practices currently in place unless specific disallowances are identified and the need to adjust those audit practices becomes evident.

Revised 10-8-14

EMQ FamiliesFirst

Place Client ID Label Here (If no label, write below)	
Name:	Program:

Assessment and Legal Tool

Review Date: **Intake Date:**	**Reviewer:**
Review Time Period: ☐ Initial ☐ Year ☐ 2 Yr ☐ Other:_____	**Chart Clinician/Facilitator:**

Initial & Renewal Assessment

Are the following documents present, complete & current?	Initial Yes	Initial No	Initial N/A	Renewal Yes	Renewal No	Renewal N/A	Notes	Corrected
1. Initial Consents have been audited and submitted. ROI's are up to date.								
2. There is a progress note that documents initial intake activity								
3. Identifying information complete and accurate (No blanks)								
4. Presenting problems & relevant conditions affecting mental/physical health								
5. Psychosocial History is complete (include cultural considerations)								
6. Special Status/Risk Situations complete								
7. Mental Health History assessed								
8. Substance Abuse assessed								
9. Current Psychotropic Medications (including dosage, prescribing MD and start date, if available)								
10. Mental Status Exam (MSE) complete including duration								
11. Client Strengths in achieving identified goals								
12. 5-Axis Diagnosis complete (Included eligible Axis 1 Dx) and matches psychiatrist and county diagnosis								
13. Medical History assessed (include allergies, developmental History - pre-natal, perinatal)								
14. Meets AT LEAST ONE of the following requirements for Medical Necessity								
a. Significant impairment in an important area of life functioning								
b. Probability of significant deterioration								
c. Probability that the child will not progress developmentally as individually appropriate (school, home, community)								
15. Signature of assessor within required timeframe (not to exceed 60 days at intake, and annually)								

16. Assessment notes reviewed in TIER. If more than one service date is documented, notes indicate why additional service dates were needed (unique and not duplicative). SERVICE TIMES ON NOTES MUST MATCH TIMES ON ASSESSMENT.	Service Dates	Direct + Documentation	Travel	Total	
	1._____	_____	_____	_____	
	2._____	_____	_____	_____	
	3._____	_____	_____	_____	
	4._____	_____	_____	_____	
	5._____	_____	_____	_____	
		Total: _____	Total: _____	Total: _____	

Reviewer Signature:	**Date:**

I HAVE CORRECTED THE ABOVE PROBLEMS AND REVIEWED THE AREAS OF CONCERN WITH MY STAFF.

Supervisor Name:	**Supervisor Signature:**	**Date:**
HIM/Admin Name:	**Signature:**	**Date:**

Revised 10-10-14

AUDIT TOOLS AND TIMELINES

QUICK REFERENCE

Assessment – Reauthorization – Plan of Care

Audit tools: - Quality Review Tool (or)
- Assessment and Legal Tool **and** Treatment Plan Tool

Timelines: - Clinician submits completed and signed assessment/POC within 30 days of enrollment.
- CPM completes and submits tools and documents within 24 hrs of receipt from clinician (Follow Doc Tracking Procedures).

Monthly Claims and Quality Audit

Audit Tools: - Progress Note Quality Review Tool
- Internal Audit Sign-Off Sheet

Timelines: - Audit occurs monthly and includes review of progress note content and claims for the previous month.
- Corrections must be completed within one week of audit date.
- Both audit tools must be turned into QSM within one week + one day of audit date (Binder clipped together).

Staff Transfer, Termination, and Leave Audit

Audit Tools: -Progress Note Quality Review Tool *(Use on progress notes for any claims since last monthly audit for departing staff member.)*
- Quality Review Tool *(Use on any Authorizations or POC's completed by departing staff member or check for gaps that may affect non-waivered staff.)*

Timelines: - Complete Audit 2 weeks prior to staff departure (when possible)
- CPM gathers audit tools and submits to QSM within 1 week of audit date.

Discharge Audit

Audit Tools: - Quality Review Tool

Timelines: - Once discharge date is determined CPM emails HIS to lock out managed care goals in Tier (so no one goes in and bills managed care after discharge)
- CPM has at most 10 days after discharge date to complete the discharge audit (preferably audit occurs prior to discharge)
- CPM has 5 days post-audit to collect any needed corrections.
- CPM turns in discharge summary (last line of summary indicates medi-cal discharge date and should match date provided in earlier email) and audit tool to HIS by day 15.
- HIS changes status in Tier. (we are still at day 15 here).
- HIM completes chart closeout over the next 15 days.

Internal Audit, Audit Readiness Strategy Compliance Plan, Central Region

1. **Assessment and Treatment Plan Audit**: This audit will be conducted as the Assessment and Treatment Plan are submitted to the CPM of the waivered staff completing the documents. Assessments and Treatment Plans will not go to chart until this audit is completed. There are three quality audit documents, the **Qaulity Review Tool** (which can be used individually to conduct the initial audit) and the **Assessment and Legal Tool** and the **Treatment Plan Tool** (which must be used in conjunction to conduct the initial audit). The same audit process will apply for both initial and renewal assessments and treatment plans. CPMs will submit completed and corrected assessment audit tools in the applicable program binder in the billing room. During this audit, the following steps must occur:

    a. CPM's will audit all initial consents as soon as they are submitted to ensure completeness and accuracy. CPMs will submit these documents to the Health Information Specialist or Designee (per the critical document tracking process).
    b. The clinician will start a plan development note in tier using the "assessment in progress" goal as a place holder until the actual goals go live. At reauthorization an active goal can be utilized instead of "assessment in progress".
    c. Assessing clinician will promptly route progress notes related to the Assessment and Plan Development services to their CPM.
    d. The CPM will review the assessment and plan development progress notes (in Tier or have staff print and submit with assessment/POC), verifying their completion and quality, concurrent to completing the audit of the assessment and POC.
    e. Review of these progress notes will be documented on the Assessment and Legal Tool and Treatment Plan Tool. This process will negate the need for direct service staff to audit Assessment and Plan Development notes during the monthly Quality audit.
    f. CPMs will submit these documents to the Health Information Specialist or Designee (per the critical document tracking process).
    g. Clinician can go back and replace the "assessment in progress goal" with the POC goals after they receive the email stating the goals are in Tier and final save note.

2. **The Monthly Claims and Quality Audit** will be conducted one time monthly within teams, and will review all charts of youth currently served by the team each month. Admin staff will prepare and pull charts for the teams, prepare a claims sheet for each chart, prepare a staff sign-off sheet for the charts, print and prepare audit tools, and file the charts following audit.

    a. **Claims Audit**: Admin staff will print claims data and the Direct Service Staff will review 100% of charts to ensure that all of the prior month's medi-cal notes are in the chart. The Progress Note Quality Review Tool will be utilized.

b. **Progress Note Audit**: Direct Service Staff will complete an audit on 100% of charts 'owned' by the team for the prior month's medi-cal progress note quality, using the Progress Note Quality Review Tool.
c. Following the monthly audit, Progress Note Audit tools will be collected by the direct service team's CPM. The CPM will oversee corrections. Corrections may be made 'live' during the audit, or within **one week** of the monthly audit date. The CPM will gather all corrected Claims and Progress Note Audit Tools, and submit them to the QSM for reporting purposes.

Tracking process for the completion of internal monthly Claims and Progress Note audits:

Admin staff will print an audit sign-off sheet for each team's monthly internal audit. The sign-off sheet will include the following information:

1. Youth's initials (first two initials of first and last name affiliated with chart)
2. Staff sign-in [acknowledging chart(s) selected for individual staff to audit]
3. Staff sign-off
4. Date Corrections Received
5. CPM Sign-off on corrections, and date
6. QSM sign off and date of receipt of sign-off sheet and completed audit tools

After the monthly audit, the CPM will ensure that all youth represented by the CPM's clinical oversight have had a claims and progress note audit via the audit sign-off sheet. The CPM will submit the completed sign-off sheet with all corrected audit forms to the QSM. The CPM will submit all corrections to the appropriate program filing bin in the chart room. QSM will make note of the date the corrected audit forms were received by the QSM. QSM will file this sign-off sheet for tracking, compliance, and reporting purposes.

3. Quarterly Audit:

1. QSM will audit 5% of all program charts on a quarterly basis using the Quality Review Tool, including the Medication Support audit if applicable. Corrected Quality Review Tools will be collected from CPMS, and audit outcomes will be reported per Agency Audit Readiness Strategy.

4. Staff Transfer, Termination, and Leave Audit:

1. This audit will be provided 2 weeks prior to staff departure for all charts affected (i.e, all youth currently assigned). The CPM will oversee this process. Direct Service Staff are responsible for a claims and quality audit of the notes written since the last monthly program audit. Manager will pull a list from Tier of all notes written since the last monthly program audit. Waivered staff associated with the team would complete the Quality Review Audit on assessments /POCs completed by waivered staff that are leaving or to check for any gaps that may affect non-waivered staff that are leaving. The CPM of the departing staff would gather all collected audit tools within one week of the audit, and submit them to the QSM for review.

5. Discharge Audit:

1. This audit will be provided within **10 days** prior to TIER discharge, 100% of the time, by waivered staff using the **Quality Review Tool**. Corrected audit tools will be gathered by the CPM **five business** days following the audit, and submitted to the QSM for reporting.
2. There is also a discharge chart analysis that will be completed by Admin Staff to support completion and closure of discharge charts. This process is in compliance with HIM standards and exists separately from our internal audit processes.
3. Discharge timelines:
    a. Once discharge date is determined CPM emails HIS to lock out managed care goals in Tier (so no one goes in and bills managed care after discharge)
    b. CPM has at most 10 days after discharge date to complete the discharge audit (preferably audit occurs prior to discharge)
    c. CPM has 5 days post-audit to collect any needed corrections.
    d. CPM turns in discharge summary (last line of summary indicates medi-cal discharge date and should match date provided in earlier email) and audit tool to HIS by day 15.
    e. HIS changes status in Tier. (we are still at day 15 here).
    f. HIM completes chart closeout over the next 15 days.

Standards:

1. All management and staff with audit responsibilities will do their part in every audit, every month.
2. A CPM must be present to oversee the audit. If on vacation or sick, CPMs will schedule the audit for a date prior to or within the week of return after the time off. If on leave, the Associate Director or Clinical Director will cover. Program Supervisors or other lead staff will not be put in charge of oversight of the audit.
3. If staff are out, or scheduled to be out, they may do their share of the audit before going on vacation, or within 2 business days of return from sick leave.
4. Audits are an important part of work, much like documentation timeliness and service delivery. As such, compliance with our internal audit process, including audit standards and timeframes, will be supported with similar levels of accountability.

Please note the many different types of user friendly audit tools we now have access to:

Claims Audit Tool
Progress Note Quality Audit Tool
Assessment and Legal Tool
Treatment Plan Audit Tool
Quality Review Tool
File Review Tool (user friendly if done once annually for programs that require this tool)

EMQ Families First Note Turnaround Accountability Guidelines

3 business days has been established as the benchmark for identifying those individuals who are outside of the agency preference for progress note turnaround time. To ensure adherence to this preference the note turnaround time report will be run the 1st and the 3rd Monday of every month. Anyone that has a note turnaround time average of 3 days or longer must then come in every day and complete progress notes until they fall within acceptable timelines. Staff will sign in each day and managers will be responsible for turning in the sign in sheets to the Clinical Director every Friday. Staff must obtain approval in advance from his or her manager to miss note catch up, and approval will only be given in extreme situations. Anyone who fails to report for one or more days will be subject to disciplinary action in adherence with agency policy.

In addition to this process, we have added an extra layer of oversight as these reports and sign-in sheets will be reviewed by the regional management team (a layer of management above the clinical program managers) at the 1st and 3rd site management meetings of the month (held every Monday). Clinical managers will have to demonstrate accountability and action plans for those staff on their teams that fail to come within the expected note turnaround timeframes within a month's time or repeatedly show up as out of compliance.

Place Client ID Label Here (If no label, write below)	
Name:	**Program:**

EMQ FamiliesFirst

QUALITY REVIEW TOOL

REVIEW DATE: INTAKE DATE:	REVIEWER:
REVIEW TIME PERIOD: ☐ INITIAL ☐ YEAR ☐ 2 YR ☐ OTHER:_____	CHART CLINICIAN/FACILITATOR:

SECTION 1: ADMISSIONS & LEGAL SECTION

Are the following documents present, complete & current?	Y	N	N/A	NOTES	CORRECTED
Admission					
1. Authorizations to Release/Exchange PHI: Within 1-year limit and signed by legal guardian, youth 12+ (PN if not signed), and EMQFF staff?					
2. Consent for Treatment: Program specific and signed by legal guardian, youth 12+ (PN if not signed), and EMQFF staff?					
3. Client's Rights: signed by legal guardian, youth 12+ (PN if not signed), and EMQFF staff					
4. Intake PN that includes reviewing consent, confidentiality, mandates, program info,, etc.					
5. Freedom of choice					
6. Limits of Confidentiality Statement					
7. Consent to Participate in Outcomes/Evaluations					
8. Authorization for Electronic Correspondence					
9. Insurance Claim Form (HCFA 1500)					

SECTION 3: TREATMENT PLAN

	CURRENT			PRIOR				
Are the following documents present, complete & current?	Y	N	N/A	Y	N	N/A	NOTES	CORRECTED
10. Problems/Goals: consistent with primary Dx and symptom/functional impairment								
11. Goals: Specific, Measurable, Observable, Time-bound, etc.								
12. Objectives: Tasks the youth will do to meet goal (can also include other family and team member objectives)								
13. Techniques are measurable (frequency), time-bound (duration), aligned with goals. Includes all applicable services (Med Support, TBS if applicable)								
14. Identifying information complete and accurate (No blanks)								
15. Expected duration of treatment is present.								
16. Youth Signature by due date (or missing signature and resolution noted in PN(s)								
17. Family/Support Person Signature (or missing signature and resolution noted in PN(s))								
18. Proof that copy of plan was offered?								
19. Treatment Plans are continuous (no gaps)								
20. ICFP: required domains included (Required for WRAP and BB. Not required for ACT)								
21. Safety Plan (Required for WRAP and BB. Needed for ACT when only when risk factors indicate need)								

22. Plan Development Notes Reviewed in TIER. More than one PD note can exist for renewals or updates to the POC if services are justified .SERVICE TIMES ON NOTES MUST MATCH TIMES ON POC	Service Dates 1._____ 2._____ 3._____	Direct + Documentation _____ _____ _____ Total: _____	Travel _____ _____ _____ Total: _____	Total _____ _____ _____ Total: _____	

SECTION 2: INITIAL & RENEWAL ASSESSMENT

	INITIAL				RENEWAL				
Are the following documents present, complete & current? *TIER Asses. section identifiers in italics.*	**Y**	**N**	**N/A**		**Y**	**N**	**N/A**	**NOTES**	**CORRECTED**
23. Identifying information complete and accurate (No blanks) *(first section, name–lang. spoken)*									
24. Presenting Problem & impairments are identified *(bullets addressed, problem area check boxes complete, including applicable risk/safety content info in Challenges and Needs, and Summary sections)*									
25. Psychosocial History is Complete (include Cultural Considerations) *(including Family History and Cultural Factors section)*									
26. Mental Health History assessed *(bullets addressed)*									
27. Substance Abuse assessed *(all check boxes complete and Sub Abuse Goals/Comments included*									
28. Current Psychotropic Medications (including dosage, prescribing MD and start date, if available) *(Current Meds; Additional Med Hx; Med Compli.; and Other Med Probs. sections)*									
29. Mental Status Exam (MSE) complete									
30. Youth/Family Strengths identified/described									
31. 5-Axis Diagnosis complete (Included Eligible Axis 1 Dx) and current									
31. Initial/Annual Assessment Diagnosis Matches Psychiatrist's Diagnosis (Doctor PN)									
32. Medical History assessed (including allergies and Developmental History) *(Prenatal/Dev. Hx (bullets addressed), Additional Med Hx)*									
Tentative Discharge Plan and Coordination of Care addressed									
Annual Assessment Only: Tx Plan Update addressed									
Contacts (Coordination of Care) section completed									
33. Meets AT LEAST ONE of the following requirements for Medical Necessity									
a. Significant impairment in an important area of life functioning *(Med Nec 2nd question)*									
b. Probability of significant deterioration without mental health intervention *(Med Nec drop down question)*									
c. Probability that the child will not progress developmentally as individually appropriate (school, home, community) without specialty mental health services *(last Med. Nec. Question)*									
34. Signature of Assessor by due date									
35. Assessment Completed within 60 days of Admission Date									

36. Assessment notes reviewed in TIER. If more than one service date is documented, notes indicate why additional service dates were needed (unique and not duplicative). **SERVICE TIMES ON NOTES MUST MATCH TIMES ON ASSESSMENT.**	Service Dates 1._____ 2._____ 3._____ 4._____ 5._____	Direct + Documentation _____ _____ _____ _____ _____ Total: _____	Travel _____ _____ _____ _____ _____ Total: _____	Total _____ _____ _____ _____ _____ Total: _____

SECTION 4: MEDICATION SUPPORT (INTERNAL DOCTORS) (☐ NOT APPLICABLE)

Are the following documents current?	Y	N	NOTES	CORRECTED
37. Initial Psychiatric Evaluation is complete? (typically one of first PNs)				
38. Consent for Psychotropic Medication (one for EACH prescribed medication) (Wards: JV220; non-wards: EMQFF Consent)				
39. For UNCHANGED medications, the consent is updated annually (EMQFF consent every 2 years)				
40. For Wards of the Court, Psychotropic Medication Authorization Form Complete (No Blanks) (JV-220: renewed every 6 months)				
41. Vital Signs are present/current?				
42. Lab results are present/current?				
43. If Medication is Prescribed, Progress Note documents				
a. Name				
b. Dosage				
c. Quantity (number of pills per prescription)				
d. Frequency				
e. Route of Administration				
f. Evaluation of Side Effects				
g. Client Response(s) to Medication				
h. Client Compliance with Medication Regimen				
44. If Medication is Changed, Progress Note Documents Reason				
45. Child has been seen face-to-face by a psychiatrist AT LEAST every 3 months? (***residential: every 6 weeks if on psychotropic meds; every 3 months if not on psychotropic meds)				
46. Documentation provided if child was not seen by a psychiatrist at least every 3 months?				

SECTION 5: MISCELLANEOUS

Are the following documents current?	Y	N	N/A	NOTES	CORRECTED
Diagnosis					
47. Diagnosis Match between County (listed on UniCare billing sheet), TIER Tx Plan, TIER Assess, (and Dr. Prog Note if applicable)					
48. Documentation of Change of Diagnosis Present (as needed - Data Change Form and Progress Note)					
Contact Information					
50. Client's Current Address/contact info Current (listed on assessment; data change if updated since assessment) Note: for youth in residential placement, caregiver address after placement is listed					

SIGNATURES/APPROVALS

REVIEWER PRINTED NAME:	DATE:
REVIEWER SIGNATURE:	

I HAVE REVIEWED AND CONFIRMED THAT ALL QUALITY REQUIREMENTS HAVE BEEN MET/RESOLVED:

SUPERVISOR PRINTED NAME:	DATE:
SUPERVISOR SIGNATURE:	

HIM/ADMIN NAME:	SIGNATURE:	DATE:

Place Client ID Label Here (If no label, write below)	
Name:	**Program:**

EMQ FamiliesFirst

TREATMENT PLAN TOOL

REVIEW DATE: **INTAKE DATE:**	**REVIEWER:**
REVIEW TIME PERIOD: ☐ INITIAL ☐ YEAR ☐ 2 YR ☐ OTHER:_____	**CHART CLINICIAN/FACILITATOR:**

Are the following documents present, complete & current?	CURRENT YES	CURRENT NO	CURRENT N/A	PRIOR YES	PRIOR NO	PRIOR N/A	NOTES	CORRECTED
1. Goals are consistent with Diagnosis and Presenting Problem(s)								
2. Goals are Specific, Measurable, Observable, Time-bound, etc.								
3. Techniques are measurable (frequency), time–bound (duration), aligned with goals. Includes all applicable services (Med Support, TBS if applicable)								
4. Identifying information complete and accurate (No blanks) *(first section, name, lang. spoken, etc.)*								
5. Client Signature (and PN documenting signature or attempt)								
6. Caregiver Signature or Progress Note (and PN documenting signature or attempt)								
7. Expected duration of treatment is present.								
8. Proof that copy of plan was offered?								
9. Treatment Plans are continuous (no gaps)								

10. Plan Development Notes Reviewed in TIER. (Plan Development can only be billed on the day the POC is signed with initial enrollments). More than one Plan Development note can exist for renewals or updates to the POC if services are justified (unique and not duplicative). SERVICE TIMES ON NOTES MUST MATCH TIMES ON POC	Service Dates 1._____ 2._____ 3._____ 4._____ 5._____	Direct + Documentation _____ _____ _____ _____ _____ Total: _____	Travel _____ _____ _____ _____ _____ Total: _____	Total _____ _____ _____ _____ _____ Total: _____	

SIGNATURES/APPROVALS

REVIEWER SIGNATURE:	**DATE:**

I HAVE CORRECTED THE ABOVE PROBLEMS AND REVIEWED THE AREAS OF CONCERN WITH MY STAFF.

SUPERVISOR NAME:	**SUPERVISOR SIGNATURE:**	**DATE:**
HIM/ADMIN NAME:	**SIGNATURE:**	**DATE:**

Progress Notes Status Summary Report By Program
For All Finalized Services
Service Dates 02/01/2016 - 02/29/2016
Signed Dates 1/1/2000 12:00:00AM - 3/3/2016 11:59:00PM

Selected Programs: Bright Beginnings
Selected Clinicians: More than 5
Selected Svc Func: More than 5

Staff Name	Average Days b/n service and note creation date		Average Days b/n service and note finalization date		Shortest TAT (Days)		Longest TAT (Days)		# Notes Finalized 3 Days or longer		Total # of Progress Notes
	Business dys only	Actual Elapsed	Business dys only	Actual Elapsed	Business dys only	Actual Elapsed	Business dys only	Actual Elapsed	Business dys only	Actual Elapsed	
Bright Beginnings											
Ana Dolores	1.22	1.59	2.85	4.15	0.00	0.00	5.00	10.00	61	66	98
Anna Cozzi	0.34	0.49	0.41	0.60	0.00	0.00	8.00	12.00	1	5	128
Felicia Madrid	1.05	1.62	2.33	3.33	0.00	0.00	5.00	7.00	26	37	60
Genevieve Quintana	1.91	2.91	1.98	3.04	0.00	0.00	5.00	8.00	16	25	46
Guadalupe Solis	1.81	2.56	2.19	3.20	0.00	0.00	8.00	10.00	31	42	80
Kimberly Legh-Page	1.65	2.67	1.79	2.98	0.00	0.00	11.00	18.00	9	13	43
Lawrence Braslow	9.46	14.46	11.15	16.62	5.00	7.00	19.00	28.00	13	13	13
Linda Edhere-Ekezie	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0	0	7
Lynette Quinto	2.10	3.44	2.20	3.64	0.00	0.00	5.00	7.00	38	61	87
Maria Trujillo Velazquez	1.75	2.63	2.56	3.56	0.00	0.00	5.00	7.00	16	22	32
Michelle (Sanchez) Wells	2.56	3.43	3.16	4.66	1.00	1.00	20.00	29.00	83	89	96
Pahoua Her	1.81	2.73	2.35	3.42	0.00	0.00	5.00	7.00	67	75	106
Rebekah Rodriguez	1.63	2.83	3.01	4.49	0.00	0.00	6.00	11.00	55	65	81
Tomas Nino	0.00	0.00	1.00	1.00	1.00	1.00	1.00	1.00	0	0	2
Tyna Huerta	2.05	3.16	3.74	5.16	2.00	2.00	7.00	10.00	15	16	19
Veronica Sandoval	1.85	1.90	2.66	3.54	0.00	0.00	17.00	24.00	56	67	102

Report Print Date: 3/4/2016 4:49:11PM

Staff Name	Average Days b/n service and note creation date		Average Days b/n service and note finalization date		Shortest TAT (Days)		Longest TAT (Days)		# Notes Finalized 3 Days or longer		Total # of Progress Notes
	Business dys only	Actual Elapsed	Business dys only	Actual Elapsed	Business dys only	Actual Elapsed	Business dys only	Actual Elapsed	Business dys only	Actual Elapsed	
Victoria Valdes	1.27	1.76	1.99	2.89	0.00	0.00	9.00	13.00	26	48	94
Bright Beginnings Summary:	**1.65**	**2.38**	**2.34**	**3.44**	**0.00**	**0.00**	**20.00**	**29.00**	**513**	**644**	**1,094**

		Program Summary
Bright Beginnings	Avg Business Days to Finalize Note	2.34
	Avg Actual Days to Finalize Note	3.44
	Range of Business Days to Finalize Note	20.00
	Range of Actual Days to Finalize Note	29.00
	Median Business Days to Finalize Note	2.00
	Median Actual Days to Finalize Note	3.00
	Total Number of PNs	1094
All Selected Programs	**Avg Business Days to Finalize Note**	**2.34**
	Avg Actual Days to Finalize Note	**3.44**
	Range of Business Days to Finalize Note	**20.00**
	Range of Actual Days to Finalize Note	**29.00**
	Median Business Days to Finalize Note	**2.00**
	Median Actual Days to Finalize Note	**3.00**
	Total Number of PNs	**1094**

State audit plan of correction training summary

Assessment/Plan of Care Training

Training consisted of a line by line review of Fresno County's assessment and Plan of Care documents. The required content of each section was discussed and methods of obtaining the desired information were addressed. Areas of focus included:

- Client strengths
- Inclusion of child and family in the assessment process regardless of child's age
- Substantiating the diagnosis
- Assuring diagnoses that account for all presenting symptoms
- 30 day timeline for completion of assessment and signed POC
- Assessing for criteria in each section of the form and how to document that assessment occurred, but family has indicated that they do not have that information (i.e. substance exposure when child is in foster care and that history is unavailable) or no need is evident in that area at this time (no significant medical needs exist).
- The requirement that all POC's include duration and frequency of interventions
- The requirement that all POC's include specific, observable, and /or quantifiable goals.

Assessment and Plan of Care Training 2-18-16
Attendance List

Rachel Zaremba

PRINT	SIGN
1. Elika Beckwith	(Trainer)
2. Joshua Stoick	(Trainer)
3. Pakou Vue	
4. Dave Calandra	
5. Tyna Pittuerta	
6. Victoria Valdez	
7. Jordan Zickafoose	
8. Roxanne Garza	
9. Katrina McGraw	
10. Michelle Pinon	
11. [illegible]	
12. Jackie Hood	Jackie Hood
13. Holly Rooks	
14. Ann Middleton	
15. Genevieve Talamantes	
16. Guadalupe Soh	
17. Rankeisha Woods	
18. Gwen Hackett	
19. ~~[illegible]~~ Michelle Wells	
20. Veronica Sandoval	

Anna Cozzi
Daniel Kimble
Lucia Aguilar
Pahoua Her

Rexroat, Katherine

From: Leng Mouanoutoua <vmouanoutoua@fresnocenter.com>
Sent: Tuesday, October 20, 2015 4:28 PM
To: Rexroat, Katherine
Subject: RE: Fresno County 2015 Systems Review - Coordinated Response from Fresno Center for New Americans Requested

October 20, 2015

Dear Ms. Rexroat,

The following are proposed Plan of Correction to address identified items that are related to FCNA case(s), and appropriate due dates for certain items. The following Plan of Correction reflects our existing program operation and information technology capability, which may be somewhat different from the County:

1. Page 2, item 1c-2 (Medical necessity of intervention)

   A. Clinical Supervisor offers a training for all program staff by 10/30/2015, about appropriate clinical intervention to address the specific symptoms in order to achieve the goals as stated in the clients' Plan of Care.

   B. The identified LWP staff who wrote inappropriate intervention will submit his/her Plan of Care for review with the Clinical Supervisor for appropriate intervention to meet the requirements as stated in the CCR, title 9, chapter 11, section 1830, 205 (b)(3)(B)(1-4) for a duration of at least 3 months to ensure that staff understands and is able to comply with appropriate intervention criteria.

   C. The identified LWP staff will submit samples of his or her progress note weekly for 3 months for review with the Clinical Supervisor to ensure that staff has gained adequate knowledge of clinical symptoms and has learned to apply appropriate clinical intervention to address the clients' mental health needs.

2. Page 4, item 2b and 2c (Assessment timeliness and required elements)

   A. Clinical Supervisor will work with IT staff (or with each staff) to generate a monthly case load list of clients that indicates the due date of important documents (i.e. Re-assessment, Plan of Care, Locus, outcome measure, or client satisfaction survey) for each program staff. Clinical Supervisor shall ensure that each staff receives his or her caseload list by the first of each month and that all staff completes his or her to be due documents timely.

   B. Clinical Supervisor will offer a training by 10/30/2015, on the importance of completing all the required elements of an initial assessment or re-assessment, appropriate ways to obtain all the required elements of an assessment from clients, appropriate follow up to obtain all the required information in the assessment/re-assessment, and how to document when required elements are not available at the time of the assessment.

C. Clinical Supervisor shall review all the assessment and re-assessment completed by the identified staff who omitted the required elements of an assessment/re-assessment for a period of 3 months to ensure that staff consistently completes all the required elements of their assessment or re-assessment.

3. Page 5, item 2e (Medication consents)

   LWP does not have MD staff to prescribe medication and therefore does not seek Medication Consent from clients.

4. Page 8, items 3a and 3b (Client plan of care lapses)

   A. Clinical Supervisor will ensure that all LWP staff receives a monthly case load list of his or her respective clients, which indicates the due date of all the important documentation from his or her case load for the month. Clinical Supervisor further ensures that all staff completes all documentation including the clients' Plan of Care that is due for that month.

   B. Clinical Supervisor ensures that program staff reports any potential lapse of Plan of Care (POC) case to the Clinical Supervisor so every efforts will be made to assist program staff to update the clients' Plan of Care to avoid a lapse of time between the two POCs. In the event that a lapse of time has occurred between two Plan of Care, staff will have a note to chart to indicate the reason as to why an updated Plan of Care is not completed within the time frame, and all clinical services that occur between the lapse of two Plan of Care shall not be billed.

   C. Clinical Supervisor monitors the identified staff who allowed lapse of time between two Plan of Care (POC) for a period of 3 months to ensure that staff consistently updates the Plan of Care for his or her clients in a timely manner.

I hope that the above proposed Plan of Correction is appropriate. I may need further information regarding the specific items to be more detailed and to the point.

Thanks.

Dr. Leng Mouanoutoua
Program/Clinical Director of LWP
Fresno Center for New Americans
Phone: (559) 255-8395
Fax: (559) 8062

From: Rexroat, Katherine [mailto:krexroat@co.fresno.ca.us]
Sent: Friday, October 09, 2015 12:56 PM
To: 'vmouanoutoua@fresnocenter.com'
Cc: Halverstadt, Jonathan; Nunez, Karen
Subject: Fresno County 2015 Systems Review - Coordinated Response from Fresno Center for New Americans Requested

Good afternoon Dr. Mouanoutoua,

The FCMHP Managed Care office has received a preliminary systems review report from DHCS in connection with the system-wide audit that occurred in May. One of the charts in which deficiencies were identified was from the Fresno Center for New Americans.

As we prepare the general MHP response to the items on the DHCS Plan of Correction, we need your assistance and collaboration. I have attached the portion of the Fresno County Review Report that contains highlighted items pertaining to the charts from FCNA. As part of our overall plan, the Managed Care staff is revising the County audit tool to reflect monitoring of the areas noted and will be reviewing the chart as further disallowances were noted by the DHCS staff; however, we also need a specific response from FCNA as the contracted provider as to corrective steps specific to your program. Specifically, from the Fresno County Review Report 2015 – FCNA, please respond to:

- Page 2, item 1c-2 (medical necessity of interventions)
- Page 4, item 2b and 2c (assessment timeliness and required elements)
- Page 5, item 2e (medication consents)
- Page 8,items 3a and 3b (client plan)

If possible, we would like to have an initial plan of correction by **October 26**. As with regular County Plans of Corrections, the corrective steps do not have to be completed by October 26, but later follow up will be requested. Again, we will be taking your plan of correction of the items above and incorporating it into the MHP Plan of Correction report. If you would like further information regarding these specific items or the overall Fresno County Review Report, please let me know.

Thank you for your attention to this matter.

Regards,

Katherine Martinez Rexroat, LMFT
Clinical Supervisor, Managed Care Division
Fresno County Dept. of Behavioral Health
4409 E Inyo Street, Fresno CA 93702
Phone: (559)600-4645
FAX: (559)455-4633
krexroat@co.fresno.ca.us

Summary statement of deficiency (As indicated by the Consolidated specialty mental health services fiscal year 2014-1015 Fresno county review May 4-7, 2015 draft report)	CPI Plan of Correction
FINDING: 2e. Written medication consents did not contain all of the required elements specified in the MHP Contract with the Department: • Line #8: One or more of the following required elements were not documented on the medication consent forms found in the beneficiary's medical record: o Reason for taking each medication; reasonable alternative treatment available, if any; range of frequency and amount; method of administration (oral or injection); duration of taking each medication; additional side effects which may occur when taking the medication beyond three (3) months. PLAN OF CORRECTION: 2e. The MHP shall submit a POC that indicates how the MHP will ensure that every medication consent includes documentation of all of the required elements specified in the MHP Contract with the Department.	The Medication Consent has been revised to include all the necessary information. The reason, range, frequency and amount have been added. We have reviewed the new form with the physicians and all support staff. The new form will be used agency wide effective November 1, 2015. A copy of the form has been included.
FINDING: 3a. Reason for recoupment #5 – The initial client plan was not completed within the time period specified in the MHP's documentation standards, with no evidence supporting the need for more time: • Line #8: The initial client plan was not completed within the time period specified in the MHP's documentation standards, and therefore, there was no client plan in effect during part of the audit review period. *The MHP should review all services and claims during which there was no initial client plan in effect and disallow those claims as required.* PLAN OF CORRECTION: 3a. The MHP shall submit a POC that indicates how the MHP will: 1) Ensure that initial client plans are completed in accordance with the MHP's written documentation standards. 2) Ensure that services are not claimed: a. When an initial client plan has not been completed b. When not indicated on the initia plan. 3) Provide evidence that those services claimed outside of the audit review period for which there were no client plans in effect are	11/19/2015 - Recoupment reversed by DHCS. (KR)

ATTACHMENT J-4

disallowed.	

Medications Consent for Patients

This is to acknowledge that I have had a discussion with my/the conservatee's/my child's physician, concerning his/her prescription of the following checked medication(s) some of which may not have U.S. FDA approval for the use(s) discussed.

I understand that I/the conservatee/my child should avoid alcohol while taking medications. Drug-drug interaction can occur with over the counter medications. I understand that this is only a partial listing of information, and I should discuss all medications that I take with my physician(s).

☐ **Antipsychotic Medication:**
Name: _____
Dosage/Method/Qty./Range: _____
Symptoms Treated: _____
Some possible side effects may occur if medication is and/or is not taken beyond 3 months: nausea, vomiting, dizziness, weight gain, increased blood sugar/lipids, diabetes, sedation, restlessness, tremor, stiff muscles, Tardive Dyskinesia(involuntary movements of face, mouth or head, neck, arms, hands and feet; are potentially irreversible and may appear even after these medications have been discontinued), seizures, sexual problems, Neuroleptic malignant syndrome(rare medical emergency marked by high fever, rigidity, delirium, circulatory and respiratory collapse), increased risks of stroke or cardiovascular accidents. Additionally for Clozapine: seizures; lowered white blood cell count leading to infections; and, rarely, damage to heart. Black-Box warning for Dementia-related Psychosis and suicidality.

☐ **Antianxiety/Hypnotic Medication:**
Name: _____
Dosage/Method/Qty/Range: _____
Symptoms Treated: _____
Some possible side effects may occur if medication is and/or is not taken beyond 3 months: drowsiness, trouble concentrating, confusion, clumsiness, dizziness, weakness, and decreased reflexes

☐ **Antidepressant Medication:**
Name: _____
Dosage/Method/Qty/Range: _____
Symptoms Treated: _____
Some possible side effects may occur if medication is and/or is not taken beyond 3 months: nausea, vomiting, appetite/with changes/ headaches, dizziness, sedation, sleep disturbances, dry mouth, sexual/erectile problems, seizures, abnormal internal bleeding, Persistent Pulmonary Hypertension of the Newborn, Mania. **Especially in youth: Suicidal thoughts and behavior, mood changes, sleep disturbances, irritability, outburst, hostility, and violence.**

☐ **Lithium Medication:**
Name: _____
Dosage/Method/Qty/Range: _____
Symptoms Treated: _____
Some possible side effects may occur if medication is and/or is not taken beyond 3 months: nausea, vomiting, diarrhea, tiredness, mental dulling, confusion, weight gain, thirst, increased urination, tremors, acne, thyroid disorder and birth defects.

☐ **Anti-Extrapyramidal Medications (EPS):**
Name: _____
Dosage/Method/Qty/Range: _____
Symptoms Treated: _____
Some possible side effects may occur if medication is and/or is not taken beyond 3 months: for Cogentin, Artane and Benadryl etc.: Blurred vision, tiredness, mental dulling, dizziness, trouble urinating, dry mouth, constipation etc.

☐ **Mood Stabilizer Medication:**
Name: _____
Dosage/Method/Qty/Range: _____
Symptoms Treated: _____
Some possible side effects may occur if medication is and/or is not taken beyond 3 months: nausea, vomiting, skin rash, weight gain, dizziness, confusion, tiredness, and birth defects. Additionally for Depakote: liver/pancreas problems, ovarian problems, Teratogenitcity; for Carbamazepine: HLA-B* 1502 allele testing in Asians, lowered blood count leading to infections; for Trileptal: possible skin rash, potential life-threatening. For Lamictal: serious skin rash, Steven-Johnson Syndrome, potential life-threatening. Some of these are antipsychotic medications or antiepileptic drugs.

☐ **ADHD Medication: Name:** _____
Dosage/Method/Qty/Range: _____
Symptoms Treated: _____
Some possible side effects may occur if medication is and/or is not taken beyond 3 months: loss of appetite, decreased growth, trouble sleeping, restlessness, nausea, changes in blood pressure/heartbeat. Additionally for Strattera: rare liver injury with possible jaundice (yellow skin and eyes) abdominal pain, itchy skin, flu, dark urine. Additionally for Adderall/Amphetamine salts: risk of sudden unexplained death, primarily with (undetected) underlying cardiac structural abnormalities. Additionally for Concerta/ methylphenidate: psychotic behavior including visual hallucinations, suicidal ideation, aggression or violent behavior. (undetected) underlying cardiac structural abnormalities.

☐ **Other:** _____

By initialing each statement below I agree that my physician and I discussed:

1. _____ **Reasonable alternative treatments** available for my condition, if any.
2. _____ **The type of medication** that I will be receiving, the **frequency** and **range of dosages**, the **method** by which I will take the medication(oral), and **duration** of such treatment.
3. _____ Alternatives, risks, benefits, and side effects, some of which are listed below, for different medications. Not all known or potential side effects are listed. This consent is effective until revoked by the patient/parent/legal guardian/conservator.
4. _____ Possible additional side effects which may occur to beneficiaries taking such medication beyond three (3) months.

I understand that I have the right to refuse this/these medication(s) and that it/they cannot be administered to me/the conservatee/my child until I have spoken with my/the conseratee's/my child physician and have given my consent to treatment with this/these medications.
I may seek further information at any time that I wish, and I may withdraw my consent to treatment with the above medications at any time by stating my intention to my/the conservatee's/my child physician. ☐ ***I withdraw this consent***

I certify with my signature that I have legal authority to sign this medication consent and that the relationship listed is valid and legal.

_____ Client Signature:
_____ Client's Parent/Guardian/Conservator:
_____ Legal Relationship:

Client's Name:

Date:

Bayfront Youth and Family Services

Finding	Provider's Plan of Correction (POC)
Note	Attachment list and attachments (internal chart review tools, policies and procedures (P&P) addressing issue, memos, evidence of staff training, etc.) included at end of POC.
2b	Education on timeliness and frequency requirements was provided to all staff members who complete assessments, including interviewing strategies, time management tips, and review of documentation standards and deadlines (see attachment 1 and 2). All assessments are reviewed by a supervisor for accuracy, thoroughness, and timeliness before being forwarded to the Quality Assurance (QA) Department for a second review.
2c	As with finding 2b, staff have received training on all required elements. Assessments require both supervisor and QA approval before it becomes part of the client's chart. Supervisors and QA return assessments that are missing required elements to the responsible staff member so that they can be corrected and resubmitted.
2d	1) Psychiatrists have been instructed to obtain and retain a written medication consent form for each medication prescribed and administered (see attachment 3). In addition, QA ensures that there is a medication consent form in all applicable charts during internal reviews and audits. 2) Psychiatrists are required to complete a written medication consent form the same day any medication is prescribed or administered (see attachment 3). This issue is also addressed during quarterly doctor meetings. The Director monitors psychiatrist documentation to ensure that they are completed in accordance with the specified timeliness and frequency standards.
2e	Psychiatrists have been instructed to complete and document all required elements on medication consent forms. The QA Coordinator conducts inspections to ensure that these elements are met. Medication consent forms have also been updated to include reason for taking each medication, reasonable alternative treatment available, if any, the method of administration, duration, and additional side effects beyond three months (see attachment 4).
3a, 3b	1) Client charts are reviewed monthly by the Utilization Review Committee (URC). The QA Coordinator maintains a separate spreadsheet with due dates for all important documents, including client plans (see attachment 5). This spreadsheet is sent to supervisors each month to ensure that client plans are completed at least on an annual basis. 2) Staff have been trained to provide only interventions and service modalities that are recorded as proposed interventions on a current client plan. Supervisors and QA review claims to ensure that these match. 3) Staff have received education on writing interventions that are clear, specific, detailed, and address the beneficiary's identified functional impairments as a result of the mental disorder. Client plans are reviewed by a supervisor first and then by QA. If there are any deficiencies, such as with interventions, the plan is returned to the appropriate staff for corrections. 4) Staff have been instructed not to claim non-emergency services before a client plan has been completed or if the services are not included in the current client plan. This is monitored by supervisors and QA, who disallow any claims they see not following this procedure. 5) Please refer to the client plan (attachment 6). The client plan's effective timeframe was from 5/20/14-/20/14. Client disenrolled on 7/14/14. Therefore, all services claimed are within the time covered by the client plan.
3a, 3b	Staff consult with their supervisors on a weekly basis (see attachment 7), providing updates and/or significant changes in the beneficiary's condition. Beneficiary changes are also reviewed during weekly team meetings to ensure that any significant change in the beneficiary's condition will be reflected by an updated client plan.

Finding	Provider's Plan of Correction (POC)
3c-1-3	1) Staff have received education on writing goals/treatment objectives that are specific, observable, quantifiable, and relate to the beneficiary's documented mental health needs and functional impairments as a result of the mental health diagnosis. Trainings have included sample goals that were acceptable and unacceptable with detailed reasons as to why (see attachment 8). Client plans are reviewed by a supervisor first and then by QA. If there are any deficiencies, such as goals/objectives not meeting documentation standards, the plan is returned to the appropriate staff for corrections. 2) Staff have been directed to include detailed descriptions of the interventions to be provided. Client plans receive a two-pronged review, during which time those containing interventions that simply identify a type of modality of service are returned for revision. Bayfront utilizes the Los Angeles County Department of Mental Health Chart Review Tool to ensure the quality of interventions (see attachment 9). 3) Staff have received thorough training on submitting mental health interventions that include an expected frequency and duration for each intervention. All client plans receive a two-pronged review, during which time those plans requiring corrections are returned to the appropriate staff to fix (see attachment 9).
3g	1) Following a preliminary review by the supervisor and a final review by QA, any client plan that does not indicate whether the beneficiary was offered a copy is returned so that corrections can be made. 2) Please refer to chart review tool (attachment 9) and internal memo (attachment 10).
4a, 4b	1) Monthly internal chart audits are conducted by the URC (see attachment 11). These thorough record reviews note all deficiencies in the chart, including whether claims are documented in the medical record, were provided to the beneficiary, were appropriate and relate to the qualifying diagnosis, claimed for the correct service modality and billing code, and claimed to the provider who provided the services. A chart will either pass the review or be found deficient. The information is reported on during monthly Continuous Quality Improvement (CQI) meetings, where root causes for deficiencies are discussed and addressed. 2) Progress notes receive scrutiny on both the supervisory level and the QA level. They are reviewed for accuracy and for meeting documentation requirements. Those that do not meet those requirements are promptly returned for correction. In addition, all progress notes are entered electronically – the electronic health record system will not allow a writer to create a note without the date of service, type of service, and the amount of time taken to provide the service. This ensures that all progress notes written will include those required elements (see attachment 12).
4b-1, 4b-8	1) Staff have received education surrounding the timely completion of completing progress notes and relevant aspects of client care. All progress notes are electronically completed and signed, and reviewed by both supervisors and QA. Staff with deficient progress notes receive counseling to ensure that progress notes meet requirements in accordance with documentation standards (see attachment 12). 2) All progress notes are completed and signed electronically. When staff first receive access to the electronic health record system and capture their signature through Topaz, they include their professional degree, licensure, or job title. This is replicated every time a staff completes and signs a new note.
5a	1) Please see attached Policies and Procedures (attachment 13). 2) Please see attached Policies and Procedures (attachment 13). 3) Please see attached Policies and Procedures (attachment 13). 4) N/A; Bayfront did not provide DR services. 5) Although Bayfront is currently unable to retrieve evidence for community meetings during the time of the client's stay, community meeting attendance logs from other periods are attached to demonstrate compliance towards meeting service components (attachment 14).

Finding	Provider's Plan of Correction (POC)
5f-1	1) The Written Program Description has been updated to reflect specific activities of each service component required in the MHP Contract. 2) Please see attached Written Program Description (attachment 16) and Group names and Descriptions Example (attachment 17).
5f-3	1) Schedules are made by the rehabilitation department and approved by the Clinical Director. Per Therapeutic Milieu policy, a schedule is posted each week for clients to review (see attachment 18). 2) The written weekly schedule clearly identifies time and place of service components provided and by whom via sections "time," "location," and "staff assignment" (please refer back to attachment 19). 3) The identity, qualifications, and scope of services for all program staff can be found at the bottom of the weekly schedule (attachment 19). This is updated whenever there is a change in staff and reviewed by the Clinical Director. 4) Bayfront terminated its Residential RCL 14 Program and associated Agreements effective October 31, 2015. Thus, there are no current Written Weekly Schedules for DTI programs. Before the closure, any change in program staff and/or schedule goes through the Clinical Director for review and approval to ensure that DTI programs are updated.

Attachments

1. P&P Assessment and Client Treatment Plan Submission
2. Interviewing Process
3. P&P Medication Support Services Documentation
4. Medication Consent Form
5. Sample Documentation Tracking Tool
6. Client Plan
7. Supervision Note
8. Treatment Goal Examples with Correction Notes
9. Chart Review Tool
10. Memo
11. P&P Utilization Review Committee (URC)
12. P&P Progress Note Guidelines for DTI
13. P&P Community Meetings
14. Sample Attendance Logs
15. P&P Staffing Requirements
16. Written Program Description
17. Group Names and Descriptions
18. P&P Therapeutic Milieu
19. Weekly Schedule

POLICY NO: Q1.15
APPLICATION: Quality Assurance
DATE OF POLICY: 4/5/2013
DATE OF REVISION: 7/1/2014

POLICY TITLE:

Assessment and Client Treatment Plan Submission

POLICY STATEMENT:

It is the policy of Bayfront Youth and Family Services to ensure that Assessments and Client Care Plans are completed accurately and submitted on a timely basis.

PROCEDURE:

1. Assessment:
   a. Full Assessments are completed by Therapist within 7 days of the initiation of services related to assessment or treatment, unless there is documentation supporting the need for more time. Extensions are granted on a case by case basis.
   b. The assigned Therapist or Intake Coordinator is responsible for ensuring that there is a current complete and accurate Assessment in the Clinical Record.
   c. Formal "completion" is accomplished when the Therapist signs the Assessment and Diagnosis Information Form. Co-signatures are required for unlicensed staff.
   d. Client conditions must be assessed at least annually, and at more frequent intervals as needed.
   e. If additional information is gathered that warrants a change in the Assessment (e.g. update to diagnosis), an Assessment Addendum form is used.

2. Client Treatment Plan:
   a. Client treatment plans should focus on individualized, strengths-based services, address linguistic and interpretive needs, support family involvement, have quantifiable goals, and include specific, measurable, and time-bound interventions.
   b. The Client Treatment Plan must clearly address the symptoms, behaviors, and/or impairments identified in the most current Assessment and utilize the client's strengths to achieve his/her goals.
   c. There must be evidence of the client's participation in the treatment planning process.
   d. The Client Treatment Plan must be completed within 7 days of the initiation of services, unless there is documentation supporting the need for more time. Extensions are granted on a case by case basis.
   e. The Client Treatment Plan is not final until signed/dated by the appropriate staff and client/responsible adult.
      i. Required Staff Signatures:
         1. Authorized Mental Health Discipline (AMHD)
         2. Writer of the objective.
         3. For all Medication Support Services interventions, a staff person within scope of practice.
      ii. Required Client/Responsible Adult Signatures:
         1. For all objectives, the client or a parent, Authorized Caregiver, Guardian, LPS Conservator, or personal representative for treatment.

f. The Client Treatment Plan must be updated at least annually, and possibly more frequently depending on the case.
g. Any changes to the Client's Treatment Plan goal(s) must be re-signed by the client and staff prior to the start date of the goal and approved by the Supervisor.
h. If signature of the client is not obtained within the appropriate deadline, supporting documentation must state why signatures were not obtained (i.e. client refused, client cancellation, etc.).
i. Client Treatment Plan must be written by an Authorized Mental Health Discipline (AMHD) for whom the services are within scope of practice.

Interviewing Process

Motivational Interviewing Techniques to assist in gathering information for Assessments:

1. Asking permission: Communicates respect for clients.
   Example: "Do you mind if we talk about [insert behavior]?"

2. Eliciting/Evoking Change Talk: Can be used to address discrepancies between client's words and actions.
   Example: "What will happen if you don't change?"

3. Exploring importance and Confidence: Gives information on how clients view the importance of changing.
   Example: "How would your life be different if you moved from poor grades to good grades?"

4. Open Ended Questions: Allows for a richer, deeper conversation.
   Example: "Tell me more about when the problems started."

5. Reflective Listening: Build empathy.
   Examples: "It sounds like...."
   "What I hear you saying...."

6. Normalizing: Communicates that change is difficult.
   Example: "It's difficult to control your anger when you feel so mad."

7. Decisional Balancing: Identifies the positive of behaviors and the costs to giving behavior; up.
   Example: "What are some of the good things about [insert problem behavior]?"

8. Columbo Approach: Points out discrepant, contradictory information.
   Example: "On the one hand you're saying that you want to graduate, and on the other hand you are not doing your school work."

9. Statements Supporting Self-Efficacy: Elicits statements that support self-confidence.
   Example: "Based on your report, you have not been smoking pot daily. You only smoked 1 day last week. How were you able to do that?"

10. Readiness to Change Ruler: Assesses how ready the client is to change.
    Example: "On a scale from 1 to 10, where 1 is definitely not ready to change and 10 is definitely ready to change, what number best reflects how ready you are to change [insert problem behavior]?"

11. Affirmations: Statements to recognize clients' strengths and successes.
    Example: "Your commitment really shows by "insert a reflection about what the client is doing]"

12. Advice and Feedback: Educates the client.
    Example: "What do you know about how your drinking affects your health?"

13. Summaries: Helps to move clients on to other topics.
    Example: "It sounds like you are concerned about your meth use because it is costing you a lot of money and there is a chance that you can end up in juvenile hall. You also said that quitting will probably mean not associating with your friends any more. That doesn't sound like an easy choice."

14. Therapeutic Paradox: Assists in helping clients argue for the importance of changing.
    Example: "Maybe now is not the right time for you to make changes."

Tricks:

- Prepare the family/client - Let the family/client know ahead of time how long the appointment will be.
- Bring snacks or petty cash (to order food).

POLICY NO: Q1.9
APPLICATION: Quality Assurance
DATE OF POLICY: 10/24/2013
DATE OF REVISION: 2/8/2016

POLICY TITLE:

Medication Support Services Documentation

POLICY STATEMENT:

It is the policy of BY&FS Mental Health program to provide, clear, concise documentation of services rendered to our clients receiving Medication Support Services. It is important that the information accurately reflects the services rendered and completion of all required forms.

PROCEDURE:

1. An outpatient medication review or medication consent form must be completed when medication is prescribed, and when there is a change in medication, and on an annual review.

2. All documentation must be documented in the Welligent EHR system, unless stated otherwise by the QA Department.

3. All documentation must be clear and detailed, with use of complete sentences (one word phrase is not acceptable).

4. All diagnosis must have the accurate current DSM codes and full descriptions without abbreviations.

5. If the client is not on medication, he/she should not be seen on a monthly basis until client is re-referred by the clinician for re-assessment.

6. Documentation must include the following elements:
    a. Observed and/or reported medication reactions
    b. Medication errors (if applicable)
    c. Review of past medication use, including:
        i. Effectiveness
        ii. Side effects
        iii. Allergies or adverse reactions
    d. Identification of alcohol, tobacco, and other drug use.
    e. Use of over the counter medications.
    f. Use of medications by women of child bearing age (if applicable).
    g. Use of medications during pregnancy (if applicable).
    h. Special dietary needs and restrictions associated with medication use.
    i. Necessary laboratory studies, tests, or other procedures.
    j. When applicable, documented assessment of abnormal involuntary movements at the initiation of treatment and every six months thereafter for the client receiving typical antipsychotic medications.
    k. When possible, coordination with the physician(s) providing primary care needs.

l. Review of medication use activities, including medication errors and drug reactions, as part of the quality monitoring and improvement system.

7. Clients on medication must have a completed Client Treatment Plan for Medication Support services and the following component must be completed:
    a. Initial Coordination Plan must be completed by the Psychiatrist immediately following the initial medication assessment.
    b. Client Long Term Goal(s), as indicated in the words and the informed choice of the client and the parent/guardian is present in the client's treatment.
    c. Short-term Goals/Objectives must have specific, measurable/quantifiable, attainable, realistic, observable, and time-bound goals tied to the presenting behaviors and current DSM diagnosis determined in the assessment.
    d. Proposed intervention(s) that will significantly diminish the impairment, prevent significant deterioration, be consistent with the client plan goals, and frequency of the intervention.
    e. Evidence of client's involvement and degree of participation to the treatment.
    f. Evidence of family involvement (if applicable).
    g. Client plan must be completed and signed by both the psychiatrist and client upon completion of the care plan.
    h. This form is to be updated as needed and rewritten annually, and is due prior to the client's cycle start date with psychiatrist and client's signature.
    i. Client was offered a copy of the Client Treatment Plan
    j. If a client is in the process of being discharged or due for an annual review the outcome measures section has to be completed.
    k. Any changes to the client's care plan goal(s) must be resigned by the client and psychiatrist prior to the start date of the goal.
    l. If signature is not obtained within the appropriate deadline, supporting documentation must state why signatures were not obtained (i.e. client refused).

8. A complete list of client's medication must include the name of medication, dosage, and frequency (this includes PRNs).

MEDICATION CONSENT FORM
(Bayfront Youth and Family Services)

I have talked with my psychiatrist, Dr. _____, who has recommended that I/my child receives(s) medication(s) to treat symptoms of:

_____

_____

The type(s) of medications prescribed is ☐ Antidepressant ☐ Anxiolytic ☐ Mood Stabilizer ☐ Antipsychotic ☐ Other _____

Medication(s):

1 _____ 2. _____

3. _____ 4. _____

I understand the dosage(s) and when to take the medication(s), and that any changes in medication dosage and/frequency during the course of treatment will be discussed with me. I have been informed that some side effects are possible, including:

☐ Muscle stiffness/tremor	☐ Sexual problems	☐ Dizziness
☐ Nausea/appetite changes	☐ Pregnancy issues	☐ Weight gain
☐ Drowsiness	☐ Diabetes	☐ Dry mouth
☐ Blurred vision	☐ Constipation	☐ Involuntary movement
☐ Liver problem	☐ Heart problem	☐ other_____
☐ Psychotic symptoms	☐ Interactions with other drugs/food/health condition	

Please read and initial the following statements:

_____I understand that these are common side effects, and that there may be other less common ones. I also understand that I should promptly inform my psychiatrist or other staff member about changes in my condition, if I become pregnant, and/or any new medications I may be prescribed for other conditions.

_____I understand that with some anti-psychotics that there is a possible side effect, *tardive dyskinesia*, which may cause involuntary movement of the tongue, face, neck, limbs, or torso and may persist even after stopping the medication.

_____I understand that the decision to take medication is up to me, but that I should always first discuss with my psychiatrist any decision to stop taking medication.

_____I understand that my psychiatrist believes this medication will help me, but there is no guarantee as to the results.

_____I understand that I must continue to see my psychiatrist once a month for medication evaluation.

_____I understand that my psychiatrist will not re-fill my prescription if I miss 2 consecutive appointments.

_____I understand that medication refill is not an emergency and will be refilled on the day the doctor is in the office.

_____I understand in the case of emergency (suicidal ideation, homicidal ideation, and severe side effects to medication) to contact 911.

_____I understand that if this is an urgent matter, I will contact my assigned therapist.

The information on this form has been explained to me, and I agree to take the medication(s) as prescribed. My psychiatrist has explained the benefits, side effects, and risks of the medication(s) listed above, applicable alternative treatments available, method of administration, and has obtained the client's/responsible adult's informed consent.

Client Name: _____

Client signature: _____ **Date:** _____

Parent/Legal guardian signature: _____ **Date:** _____

Psychiatrist signature: _____ **Date:** _____

Documentation Tracking Tool (Example)

Yellow= Due This Month
Green=Completed Red=Overdue

Client Name	Staff	DOE	Assessment	Tx Plan	Diagnosis Information	Annual Tx Plan
Intentionally Left Blank		05/12/14				
		12/15/14				
		12/15/14				
		12/24/14				
		01/06/15				
		01/15/15				
		02/10/15				03/10/16
		02/18/15				03/18/16
		03/13/15				04/07/16
		04/16/15				05/16/16
		08/24/15				09/23/16
		08/24/15				09/17/16
		08/31/15				10/01/16
		09/04/15				09/22/16
		09/09/15				09/23/16
		09/16/15				10/14/16
		09/30/15				10/13/16
		10/27/15				11/15/16
		12/03/15				01/01/17
		12/04/15				01/02/17
		12/15/15				01/13/17
		12/17/15				01/15/17
		12/28/15				01/26/17
		01/12/16	02/11/16	02/11/16	02/11/16	02/10/17
		01/19/16				02/17/17
		01/22/16				02/20/17
		02/01/16				03/02/17
		02/01/16			03/02/16	03/02/17
		02/04/16	03/05/16	03/05/16	03/05/16	03/05/17

(6)

State of California - Health and Human Services Agency — Department of Mental Health
SB 785 Client Plan
MH 5122 (rev. 3/09)

CLIENT PLAN

HOST COUNTY: Los Angeles
Mental Health Plan

COUNTY OF ORIGIN: Fresno
Mental Health Plan

CHILD'S NAME (First)	(Middle)	(Last)	**DOB:** (mmddyyyy)	**Age Today:**

SSN. _ _____ (111223333)

Identification Number: _____

Other coordinated services/agencies involved (with contacts if known): ☐ None Known

1. Fresno County Probation — Contact _____
2. Zinsmeyer Academy — Contact _____
3. _____ — Contact _____

TREATMENT GOALS

Specific observable and/or quantifiable goals (include the current Baseline)	Modalities and Interventions	Within what time frame (Duration)
Client will decrease displays of impulsive bxs (remaining focus in groups, school, and daily tasks) from 8X per week to 4X per week.	Identify situations, thoughts and feelings that trigger impulsive bxs,and problem behaviors. Client will learn and implement coping skills, such as, using a journal, implementing counting techniques as a part of managing reactions to low frustration. Therapist will encourage the exploration of alternative solutions and encourage the identification of causes of impulsive bxs and withdrawing from groups, school, and other tasks.	5/20/2014-8/20/2014

Decrease displays of verbal and physical aggression (angry outbursts, irritability, defiance towards peers and staff, verbal threats towards peers and staff, hitting, punching, kicking) from 5x weekly to 0x weekly	Client will learn alternative ways to think about and manage anger and misbehavior. Therapist will assist the client in reconceptualizing anger as involving difference components (cognitive, physiological, affective, and behavioral) that go through predictable phases (demanding expectations not being met leading to increased arousal and anger leading to acting out) that can be managed. Identify situations, thoughts and feelings that trigger angry feelings, and problem behaviors. Client will learn and implement coping skills, such as, using a journal, implementing calming strategies as a part of managing reactions to frustration and the use of physical activity when triggered. Therapist will encourage the exploration of alternative solutions and encourage the identification of causes of physical and verbal aggression	5/20/2014-8/20/2014
Decrease use of mood altering substances on a regular basis from 5x week to 0 x a week.	Client will identify the negative consequences of drug and alcohol abuse, decrease the level of denial around using as evidenced by fewer statement about minimizing amount of use and its negative impact on life. Client will learn to make "i" statements that reflect a knowledge and acceptance of chemical dependence. Therapist will model and reinforce statements that reflect the client's acceptance of his chemical dependence and its destructive consequences for self and others.	5/20/2014-8/20/2014

I participated in the development of this plan and was offered a copy.

electronic signature	5/21/2014		
Child/Youth Signature*	Date	Caregiver Signature	Date
/-ELectronic Signature	5/21/2014		
Provider Signature (Lic/Reg)	Date	LPHA (Lic/Rec) Co-Signature (if required)	Date
562-719-9250			
Provider Phone Number		Provider Phone Number	

*Child/Youth refuses or is unavailable to sign. Please explain the refusal or unavailability here:

BAYFRONT YOUTH AND FAMILY SERVICES
SUPERVISION NOTE

☐ Outpatient ☐ Residential ☐ Corporate

Staff Name and Title:	**Date:**
Client Crisis *(what occurred, what intervention was provided, what was the outcome)*	
Case discussion *(any cases discussed, what intervention was provided, formulation of treatment and direction)*	
Productivity & Documentation *(URC, Progress Notes, Assessments/Treatment plans, POCs, Minutes)*	
Professional Competencies *(current strengths and challenges, long term goals, administrative issues, any performance concerns discussed, along with action steps identified for improvement)*	
Legal and Ethical Areas *(either relative to the case or raised for discussion)*	
Cultural Competency Issues *(address barriers, conflict)*	
Plan for next Supervision *(indicate if training was scheduled)*	

Supervisee Signature: _____

Supervisor name and title: _____

Supervisor Signature: _____

Treatment Goal Examples with Correction Notes

Client 1

1. To decrease client's depressive symptoms such as feelings of sadness, difficulty making decisions, poor decision making, hopelessness, indecisiveness, and feelings of guilt from 4x to 2x per week .
2. To increase positive social contact with community and peers from 1x to 3x per week.
3. To increase socially appropriate verbal communication without (i.e. yelling, screaming, using inappropriate languages) from 2x to 4x per week.
4. Client will be linked to community resources from 0x to 2x per month. (peer social group, church, medical help, gym, recreation, ILS programs, etc).

Commented [MM1]: Impossible to measure. A better example would be "Client will decrease the number of days that she cries from 5 times per week to 1 times per week as reported by client."

Commented [MM2]: Impossible to measure.

Client 2

1. Client will decrease use of physical aggression (hitting, spitting) from 3x to 0x per week.
2. Client will decrease not telling the truth from 7x to 1x per week.
3. Client will increase her participation in positive social activities outside of school from 0x per week to 2x per week.

Commented [MM3]: This can't be measured. Client likely tells the truth thousands of times per day.

Client 3

1. Client will decrease verbal aggression (i.e. using curse words) from 3x to 0x per week as evidenced by parent's and teacher's reports.
2. Client will increase the number of times he follows directions when asked from 2x to 5x per week as evidenced by caregiver's reports.

Commented [MM4]: Too vague and unmeasurable.

Client 4

1. Client will decrease physical aggression (i.e. hitting, grabbing knives) from 5x to 0-1x per week with foster care family and school peers.
2. Client will decrease verbal aggression (i.e. talking back, yelling, cursing, etc.) from 5x to 0-1x per week with foster care family and school peers.
3. Client will increase the number of times she follows directions when asked from 0x to 4x per week.
4. Client will increase positive social interactions with peers from 2x to 5x per week.
5. Client will increase her participation in activities that will increase her knowledge about her cultural heritage from 0x to 2x per month.

Commented [MM5]: DMH has no interest in paying for clients to learn about their cultural heritage. They expect us to be addressing symptoms and behaviors that create medical necessity.

Client 5

1. Client will decrease physical aggression (i.e. hitting and destroying house hold property/personal items) from 4x to 0-1x per week with family members.
2. Client will decrease verbal aggression (i.e. foul language) from 4x to 0-1x per week with family members.
3. Client will increase the number of times she follows directions when asked from 0x to 4x per week.
4. Client will increase positive social interactions with peers from 2x to 5x per week.

Commented [MM6]: For physical aggression, or high risk behaviors like cutting, the goal should always be to reduce the frequency to 0. Don't use "reduce from 4 times a week to 0 or 1 times per week", just reduce to a single number to avoid any confusion.

Commented [MM7]: Unmeasurable.

Commented [MM8]: Impossible to measure – Client likely engages in thousands of positive social interactions each day.

5. Client will increase her participation in positive social activities outside of school from 0x to 2x per week.

Commented [MM9]: This goal should include some examples of the types of structured activities that the team has in mind e.g. Boys and Girls Club, Basketball practice, Art Class, etc.

Client 6

1. Client will decrease the number of times he is suspended from school from 1x to 0x per week as reported by teacher and school staff.
2. Client will engage in alternative behaviors (i.e. playing football, completing community service hours) to stealing and vandalizing property from 0x to 5x a week as reported by football coach and sign-in sheet.

Client 7

1. Client will decrease verbal aggression (i.e. having attitude) from 5x to 0x per week as evidenced by caregiver's reports.
2. Client will decrease the number of time she smokes marijuana from 3x to 0x per week as evidence by caregiver's reports.

Commented [MM10]: "Having attitude" is not a good example of verbal aggression. Making threats to peers and adults, yelling, cursing would be behaviors that indicate that there is medical necessity.

Client 8

1. Client will decrease self-harm (i.e. cutting) from 2x to 0x per month as evidenced by caregiver's reports.
2. Client will increase the number of time she identifies and expresses thoughts and feelings from 0x to 2x per week as evidence by caregiver's reports.

Commented [MM11]: Un-measurable as written. Client expresses thoughts and feelings thousands of times per day.

Client 9

1. Client will decrease verbal aggression (i.e. yelling and throwing tantrums) from 7x to 2x per week with family members as reported by client's parents.
2. Client will increase the number of times she follows directions when asked from 0x to 5x per week as reported by her parents.

Commented [MM12]: All kids follow and don't follow dozens of directions to varying degrees each day. This goal would be impossible to measure. This type of goal needs to be specific and there needs to reflect some sort of medical necessity. An example would be "Client will increase the number of times that she gets ready for school by 8am from 2 times per week to 5 times per week as evidenced by caregiver's report"

Client 10

1. Client will decrease physical aggression (i.e. break things and punch walls) from 5x to 0x per week as evidenced by caregiver's reports.
2. Client will decrease verbal aggression (i.e. curses and makes threats) from 5x to 0x per week as evidenced by caregiver's reports.
3. Client will decrease the number of time he uses methamphetamines from 3x to 0x per week as evidence by caregiver's reports.

Client 11

1. Client will decrease verbal aggression (i.e. yelling) from 5x to 3x per week as evidenced by parents' reports.
2. Client will increase the number of times she comes home from school on time from 2x to 5x per week as evidenced by parents' reports.

Revised
7/23/13

CHART REVIEW TOOL

County of Los Angeles – Department of Mental Health

Type of Review:
☐ Initial Intake
☐ Annual

Provider Number_____ **Service Area** ____

Admission Date: _____ **Review Date**_____

Primary Contact_____ **Review Period for Annual** (3-month period prior to cycle month)_____

Supervisor's Name_____ **Date of Last Claimed Service**_____

Yes = Meets Requirements **No** = Requires Follow-Up Corrective Action Plan (CAP) **N/A** = Not Applicable

***Items marked with an asterisk (*) are to be completed by an AMHD ONLY**

REQUIREMENT	FINDING	CORRECTIVE ACTION PLAN
ADMINISTRATIVE / REQUIRED FORMS		
1. Ensure the following DMH forms are present and completed, if applicable: a. ☐ MH 224A Client Face Sheet b. ☐ MH 224B Open Episode Form (does current diagnosis match the IS diagnosis?) c. ☐ MH 281 Payor Financial Information (PFI) (renewed annually) d. ☐ MH 500 Consent for Services e. ☐ MH 635 Advanced Health Care Directive (clients over 18 years old) f. ☐ MH 612 Account Tracking Sheet g. ☐ MH 601 Acknowledgement of Receipt – HIPAA "Notice of Privacy" Form	☐ All present and completed, if applicable ☐ Missing	
ASSESSMENT (A)		
2. a. Is there a complete Assessment **(Initial Intake)**? OR Is there a complete Annual Assessment Update **(Annual Review)**? b. Is it signed by an AMHD with his/her license number present?	Yes ☐ No ☐ Yes ☐ No ☐	
If No to #2, staff must be required to complete the assessment immediately.		
3. Is the documentation legible?	Yes ☐ No ☐	
4. Are allergies or lack of known allergies documented?	Yes ☐ No ☐	
5. For the **Initial Intake Review,** a. Is the **COJAC** form complete (adults) or Is the Self-Evaluation and Parent/Caregiver Questionnaire complete (child/adol.) (Under age 11, not required to do substance abuse screener unless substance use suspected). b. Is the **COD Assessment** complete, if indicated by the Substance Use/Abuse sections on either the Adult or Child/Adolescent Assessment forms?	Yes ☐ No ☐ Yes ☐ No ☐	
6. * Is the diagnosis supported by the information in the Assessment?	Yes ☐ No ☐ **AMHD Initials:** ____	
7. If the **Annual Assessment Update (AAU)** indicates that the diagnosis has changed **(see item #5 on the AAU)** then answer the following: a. has a Diagnosis Information form been completed? **and** b. is the diagnosis changed in the IS?	No change in dx ☐ Yes ☐ No ☐ Yes ☐ No ☐	
If No to # 6 or # 7, staff must be required to correct the disconnect and/or complete necessary documentation immediately.		

CHART REVIEW TOOL

County of Los Angeles – Department of Mental Health

REQUIREMENT	FINDING	CORRECTIVE ACTION PLAN
ASSESSMENT (A)		
8. If client is identified as Non-English speaking in the Assessment, is there documentation showing that services were provided in his/her preferred language in the Client Care Plan and/or Progress Notes?	Yes ☐ No ☐ English is Primary Language ☐	
9. Other than language, if cultural considerations (e.g., cultural identity, client's cultural explanation of his/her illness, role of religion/spirituality in providing support) **or** special service needs (e.g., hearing impaired, blind, access issues) were identified in the Assessment, is there documentation showing that services addressed these issues in the Client Care Plan and/or Progress Note?	Yes ☐ No ☐ No cultural considerations identified ☐	
10. **Medical Necessity:** Is there an "Included" Diagnosis?	Yes ☐ No ☐	
11. * **Medical Necessity:** Are impairments in life functioning and their relationship to the client's symptoms/behaviors documented?	Yes ☐ No ☐ **AMHD Initials:** _____	
If No to #10 or #11, claiming must be immediately discontinued and **services not claimed to Medi-Cal.**		
CLIENT CARE / COORDINATION PLAN (CCCP)	**Not Required per:** ☐ Episode will be closed prior to intake/review period ☐ Other (please specify)_____	
12. Is there a completed CCCP for the period being reviewed?	Yes ☐ No ☐	
If No to #12, complete and date at next client contact. Please Note: A Client Care Plan should be in place when treatment is provided within 30- or 60-day period		
13. *Are the objectives in the CCCP related to the symptoms/behaviors or impairments that are identified in the Assessment?	Yes ☐ No ☐ **AMHD Initials:** _____	
If No to #13, staff must be required to correct the disconnect immediately (i.e., add to Assessment, rewrite/add objective to CCCP)		
14. Is there a SMART (specific, measureable, attainable, realistic, and time bound) objective associated with each type of service provided or expected to be provided?	Yes ☐ No ☐	
15. a. Are there specific interventions and modality (e.g. individual therapy, group rehab) identified for the types of services checked (e.g., MHS, TCM, MSS)? b. Is the frequency of each type of service documented?	Yes ☐ No ☐ Yes ☐ No ☐	
16. Is there an AMHD signature present for all objectives?	Yes ☐ No ☐	
17. For medication support objectives, is there a MD, DO, and/or NP signature present?	Yes ☐ No ☐	
18. Is documentation legible?	Yes ☐ No ☐	
19. a. Has the client/representative signed the CCCP? b. If not, is there regular documentation of attempts to obtain signature?	Yes ☐ No ☐ Yes ☐ No ☐	
If No to #16, #17, #18 and/or #19, claiming must be immediately discontinued until signature(s) and/or appropriate / legible documentation is in place.		

CHART REVIEW TOOL

County of Los Angeles – Department of Mental Health

REQUIREMENT	FINDING	CORRECTIVE ACTION PLAN
CLIENT CARE / COORDINATION PLAN (CCCP)		
20. Is it documented (box checked) that a copy of the CCCP was either given to or declined by the client?	Yes ☐ No ☐	
21. If client is Non-English Speaking, was the CCCP interpreted in his/her preferred language? (box checked)	Yes ☐ No ☐ English is Primary Language ☐	
PROGRESS NOTES (PN)		
22. a. Is there a completed Progress Note for each claimed service provided? (Refer to appropriate IS Report and Direct Service Detail Report), AND b. Is the Rendering Provider eligible to use that procedure code (scope of practice)?	Yes ☐ No ☐ Yes ☐ No ☐	
23. a. Is the Procedure Code accurate for the service documented? b. Are all data element fields complete (date of service, face-to-face/other time, telephone contact?	Yes ☐ No ☐ Yes ☐ No ☐	
24. a. Is there a staff intervention noted? b. Is the staff intervention an assessment contact, crisis service or service related to the CCCP? c. Is the client's response to the intervention noted?	Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐	
25. For any service involving multiple staff, is the intervention of each staff identified?	Yes ☐ No ☐	
26. Is the service **SOLELY** vocational, socialization, recreational, clerical, transportation or personal care?	**Yes ☐ No ☐	
**If Yes to #26, then these services should NOT be claimed to Medi-Cal.		
27. Is each note signed, dated and discipline/payroll title, and license number (if applicable) indicated by the Rendering Provider (RP)?	Yes ☐ No ☐	
28. Is documentation legible?	Yes ☐ No ☐	
If No to #27 and/or #28, signature(s), missing discipline/payroll titles, license numbers and/or appropriate or legible documentation must be completed.		
MEDICATION SUPPORT SERVICES (MSS)	N/A ☐	
29. Is the Outpatient Medication Review form completed and signed by client/representative and staff?	Yes ☐ No ☐	
30. Are all prompts in the medication notes complete?	Yes ☐ No ☐	
31. Is the medication note signed by MD/DO, NP, RN, CNS or LPT and his/her license number present?	Yes ☐ No ☐	
32. Is a procedure code present?	Yes ☐ No ☐	
33. Is documentation legible?	Yes ☐ No ☐	
If No to any of the above, signature(s), missing discipline/payroll titles, licence numbers and/or appropriate or legible documentation must be completed. (Concerns involving incomplete medication notes and/or lack of medication objectives on the Client Care Plan should be reported to the Supervising Psychiatrist by the Committee Chairperson, Supervisor or Program Manager).		

CHART REVIEW TOOL
County of Los Angeles – Department of Mental Health

STAFF SIGNATURE PAGE

Please submit completed review tool to QA via fax (213) 351-7688 or email at QA@dmh.lacounty.gov

TO BE COMPLETED BY REVIEWER(S):

Reviewer's Signature/Discipline/Title	Printed Name of Reviewer	Date of Review

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TO BE COMPLETED BY SUPERVISOR: **Date**

1. Received Primary Contact's Chart Review Tool from Committee Chairperson: ☐ YES ☐ NO _____
2. Reviewed Corrective Action Plan with Primary Contact: ☐ YES ☐ NO _____
3. Verified Primary Contact's completed/resolved Corrective Action Plan: ☐ YES ☐ NO _____

Supervisor's Signature _____ Printed Name Supervisor _____

Comments: _____

TO BE COMPLETED BY PRIMARY CONTACT: **Date**

1. Reviewed Corrective Action Plan with Supervisor: ☐ YES ☐ NO _____
2. Completed/resolved Corrective Action Plan: ☐ YES ☐ NO _____

Primary Contact's Signature _____ Printed Name Primary Contact _____

Comments: _____

BAYRONT YOUTH & FAMILY SERVICES

Memo

To: ALL USERS

From: CYNTHIA SARMIENTO

cc: MARYAM RIBADU

Date: June 1, 2015

Re: CLIENT PLAN AND COPY

Effective immediately, staff must offer and indicate on the client treatment plan that they have offered the client a copy of the treatment plan. In addition, the treatment plan should show whether or not the client accepted a copy. Staff who violate this policy will be subject to disciplinary action up to and including termination.

Please feel free to call or meet with me if there are any questions or concerns regarding this memo. My number is 562.595.8111 ext. 223, cell 562.277.6882.

POLICY NO: Q1.19
APPLICATION: Quality Assurance
DATE OF POLICY: 6/1/2016
DATE OF REVISION: 1/21/2016

POLICY TITLE:

Utilization Review Committee (URC)

POLICY STATEMENT:

It is the policy of Bayfront Youth & Family Services to ensure clinical records exceed county, state, and federal regulations in documenting and providing appropriate services and care. The Utilization Review Committee (URC) is established to provide on-going systemic reviews of records for compliance with regulatory bodies and funding agencies.

PROCEDURE:

1. The URC for Outpatient Services consists of the Quality Assurance Director (Chairperson) or designee (licensed staff), clinical supervisors and directors, and the TBS Coordinator. All direct claiming staff must be part of the committee at least once per year on a rotational basis.

2. The URC will meet to review audited charts at least once per month as scheduled by the QA designee.

3. Staff who wish to have their charts reviewed or to have a case consultation with the URC shall e-mail the QA Director or designee at least one business day prior to the meeting to ensure adequate time set aside during the meeting.

4. At least two weeks before the URC meeting, the Quality Assurance team will use the DMH Chart Review Tool and any relevant audit tools to conduct a preliminary audit of random client charts selected from any client that has passed 30 days of admission.

5. At least two weeks before the URC date, the Quality Assurance team will e-mail the completed audit tools and deficiencies to the Director of Outpatient Services and Head of Services.

6. The directors are responsible for informing their staff and supervisors of the audit deficiencies in a timely manner. Corrections must be made prior to the URC meeting date in order for the chart to pass URC.
   a. The staff member responsible for correcting a deficiency must submit all corrections directly to his or her supervisor.
   b. The supervisor must review the corrections. If corrections are approved, the supervisor must indicate approval via his or her signature on the DMH Chart Review Tool and any relevant audit tools that were provided.
   c. Drafts and/or unsigned documents are considered incomplete.
   d. The directors are expected to return the signed audit tools to the Quality Assurance team at least one day prior to the URC meeting in order to provide the Quality

Assurance team enough time to verify corrections and to avoid the chart being counted as deficient.

e. All deficiencies for a chart must be complete and correct by the URC meeting date in order for the chart to pass.

7. Requests for extensions must be based on extenuating circumstances and must be made prior to the URC meeting date. Extensions will be considered on a case by case basis.

8. URC audit results are reported during CQI meetings and consist of 1) number of charts audited, 2) number of charts with deficiencies, and 3) number of charts given extensions.

9. During the URC meeting, the results of the charts reviewed for corrected deficiencies will be discussed.
   a. Charts that are found with no deficiencies will pass the audit.
   b. If a deficiency is found, the directors will ensure that the staff/supervisor responsible will make the necessary corrections as soon as possible, but no later than the next URC date.
   c. Deficient charts are reviewed during the next scheduled URC.
   d. Extension deadlines are determined on a case by case basis.

10. All actions and decisions during URC meetings are documented in the URC Meeting Minutes and include the following information:
   a. Call to order
   b. Participants
   c. Last URC chart audits and outcomes
   d. New chart audits and outcomes
   e. Results and Trends
   f. Adjournment

POLICY NO: Q.1.15.0
APPLICATION: Quality Assurance
DATE OF POLICY: 2/14/2013
DATE OF REVISION: 1/6/2015

POLICY TITLE: Q-1.11.0 – Progress Note Guidelines for Day Treatment Intensive (DTI)

POLICY STATEMENT:

It is the Policy of Bayfront Youth and Family services Day Treatment Intensive program to provide clear and concise documentation of services rendered to our clients. It is important that the information accurately reflects the services rendered and documented in the progress note. A sign-in sheet must be attached to every service provided to reflect client's participation in the DTI program.

PROCEDURE:

To submit progress notes and sign-in sheet in a timely manner and ensures the client's clinical files are complete for prompt submission of claims rendered to Los Angeles County Department of Mental Health and other Federal and Government agencies. DTI requires a daily progress note on groups attended, individual therapy and a weekly clinical summary.

I. Progress notes

1. Progress notes must be documented into the Welligent EHR system.
2. Social Service - Primary therapists are responsible for the completion and documentation of progress notes associated with daily groups, individual therapy sessions, and weekly summaries.
3. Rehabilitation Therapists are responsible for rehabilitation group progress notes for activities provided on the weekend.
4. All progress notes must be electronically signed by the author of the progress note and a co-signature from the Clinical Director or assigned supervisor.
5. Avoid "observational" or "narrative" (i.e. purely descriptive) notes that detail what was observed but provide no intervention, redirection or action taken.
6. When using abbreviations in documentation, they must meet industry standards.
7. All direct services must be documented in the progress notes within a 24 to 72 hour time frame, dependent on the type of service provided.

    a) Individual Psychotherapy (24 hours)
    b) Skill Building Group (72 hour)
    c) Adjunctive Therapy Group (72 hour)
    d) Process Group (72 hour)
    e) Weekly Summary (Tuesday before 5pm)

POLICY TITLE: Q-1.11.0 (Continued)

8. Client absence must be documented in the EHR stating the reason for the absence and clinical interventions implemented in an effort to prevent the current absence and future absences.
9. All groups must have a client sign-in sheet submitted to the business office within 24 hours from the date of service.

II. Progress note and sign in sheet submission timeline

10. Progress notes are submitted within the 24 to 72 hour time frame from the date of service and dependent on type of service
11. All progress notes are turned in to department's supervisor or delegated supervisor by the end of the 24-72 hour time period, no later than 5 pm.
12. Supervisors then approve the progress note by attaching their electronic signature
13. If corrections are needed, the supervisor will return the progress note to the therapist with an explanation of necessary corrections. The therapist must make the requested corrections within 24 hours and return the corrected progress note to the supervisor for final approval.
14. Sign-in sheets are due 24 hours from the date of service to the Business office.
15. Revised and/or any progress notes turned in after the deadline are considered late and may result in disciplinary action.

(13)

POLICY NO: DTI-100.0
APPLICATION: DAY TREATMENT INTENSIVE
DATE OF POLICY: 6/5/12
DATE OF REVISION:

POLICY TITLE: **COMMUNITY MEETINGS**

A. POLICY STATEMENT: Community meetings will occur at a minimum once a day, but may occur more frequently as necessary, to address issues pertinent to the continuity and effectiveness of the treatment milieu.

B. PROCEDURES:

1. The meeting will include a staff person whose scope of practice is psychotherapy.
2. The content of the meeting will include but not limited to:
   - Schedule of the day
   - Individual issues clients or staff wish to address
   - Conflict resolution within the milieu
   - Planning for: the day, the week or for special events
   - Old and unfinished business from previous meetings
   - Processing previous day treatment experiences
   - Debriefing of any incidents or problematic events
   - Wrap-up of past issues

POLICY NO: DTI-100.4
APPLICATION: DAY TREATMENT INTENSIVE
DATE OF POLICY: 6/5/12
DATE OF REVISION: 1/6/15

POLICY TITLE: **STAFFING REQUIREMENTS**

POLICY STATEMENT:

It is the policy of Bayfront Youth & Family Services that at least one Staff will be present and available to the group in the therapeutic milieu for all scheduled hours of operation.

PROCEDURE:

A) A minimal ratio of eight clients to one staff during the period the program is open.
B) Our list of qualified staff include: Physician, Psychiatrist, Registered Nurse, mental health rehabilitation specialist, Licensed Marriage and Family Therapist, Licensed Clinical Social Worker and Marriage and Family Therapist interns
C) For groups over 12 clients will have at least one person from each of two of the above groups of qualified staff
D) Staffing pattern is monitored daily by the Rehabilitation Coordinator and/or Clinical Director
E) A daily census is distributed to all staff before the commencement of the day
F) A staff ratio of eight clients to at least one staff member is present and available to the group in the therapeutic milieu for all scheduled hours of operation

BAYFRONT YOUTH AND FAMILY SERVICES

Day Treatment Intensive (DTI)

Program Description

The Bayfront Youth and Family Services (Bayfront YFS) DTI Program is a 40 bed residential facility (RCL 14) located at 4151 Fountain Street Long Beach CA 90804. The facility is an intensely structured, unlocked group home that meets the requirements of Community Care Licensing. Bayfront Youth & Family Services (Bayfront YFS) serves children and adolescents in the Service Planning Area 8 (SPA 8) of Los Angeles County.

Bayfront YFS was established in the City of Long Beach as a 501(c)(3) organization in 1999 by a group of Clinicians (Board of Directors). The program purpose was to provide an intensively structured program for those adolescents aged 11 to 18 who had not been able to be treated in existing community care residential facilities within Los Angeles County, as well as counties outside of Los Angeles.

Bayfront YFS supports a family-centered, strength-based, and needs-driven planning process. Service delivery objectives are to assist clients in returning home and successfully remaining home; preventing future disruption or placements, symptom reduction as well as overall improvement of family functioning and preventing psychiatric hospitalization or the need for re-entry to acute levels of care. Family voice, choice and ownership of strategies to return or maintain clients in their community with normalized and inclusive community options, activities and opportunities are the focus.

All clients referred for Residential Services at Bayfront YFS are expected to receive an individually-prescribed array of DTI services. The exact nature of these services will be identified during the course of the intake process at Bayfront YFS' RCL 14 group home. Upon admission to the group home the intake process will be coordinated by the client's primary therapist and may include, in addition to DTI, medication support, and TBS. All clients referred to the Bayfront YFS have unmet needs for stability, continuity, emotional support, nurturing and permanence. They need intervention and advocacy for behavioral improvement and emotional and educational stability. These needs are evidenced by residents' substantial difficulty functioning successfully in the family, school, and community.

All residents at Bayfront YFS are expected to participate in all individual therapeutic activities and groups offered and admission is contingent upon their consent to do so. (There will be no waiting period as all residential services clients qualify and will be automatically enrolled in the DTI program at their time of intake to the residential facility). At this time, each client will be introduced to his/her Primary Therapist who will be involved in developing and/or refining the client's individualized care plan that specifies the strengths and needs of each DTI participant. The primary therapist will also initiate strategy development in preparation for the client's discharge from the residential setting to the community living setting. Utilization of discharge groups will enable each member an opportunity to begin establishing community connections to resources such as community-based self-help and family support groups, health/medical/emergency services, benefits establishment, independent living skills enhancement, legal, housing and living, vocational options, cultural/spiritual and mental health linkages just to name a few. In most cases after specific needs have been identified and initial goals have been created, the client and their Primary Therapist (or that person's designee) will begin

traveling together into the community to introduce (or in some case re-introduce) the client with their future residential surroundings. The client will begin to get a feel for healthy independence and self-empowerment as their primary Therapist will work side-by-side with each client to encourage assertiveness and facilitate making community connections.

Types of Services

1. **Therapeutic Milieu:** The therapeutic milieu includes therapeutic programs that are structured by well-defined service components with specific activities being performed by identified staff. It
   a. Takes place for the continuous scheduled hours of operation,
   b. Creates a supportive and nurturing interpersonal environment that teaches, models, and reinforces constructive interaction,
   c. Supports peer/staff feedback to clients on strategies for symptom reduction, increasing adaptive behaviors, and reducing subjective distress,
   d. Empowers clients through involvement in the overall program and the opportunity for risk taking in a supportive environment, and
   e. Supports behavior management interventions that focus on teaching self-management skills that children, youth, adults, and older adults may use to control their own lives, to deal effectively with present and future problems, and to function well with minimal or no additional therapeutic intervention.

   Group services are provided to two or more individuals focusing on mental health needs in a group setting. Clients in the DTI program participate in multiple groups per week that focus on improving social skills, addressing intra-psychic conflicts that interfere with achievement of individual goals, and provide opportunities for the practice of social behaviors that will prepare the clients for successful functioning in their school/home/community environments.

2. **Therapeutic Milieu Service Components:** The following menu of services are available during the course of the therapeutic milieu for at least an average of three hours per day:
   a. **Skill Building Groups:** Staff help clients to identify barriers/obstacles related to their psychiatric/psychological experiences and, through the course of group interaction, become better able to identify skills that address symptoms and behaviors and to increase adaptive behaviors.
   b. **Adjunctive Therapies:** Staff and clients participate in non-traditional therapy that utilizes self-expression (art, recreation, dance, music, etc.) as the therapeutic interventions. Participants do not need to have any level of skill in the area of self-expression, but rather be able to utilize the modality to develop or enhance skills directed towards client plan goals.
   c. **Psychotherapy:** Psychotherapy means the use of psychosocial methods within a professional relationship to assist the person or persons to achieve a better psychosocial adaptation, to acquire greater human realization of psychosocial potential and adaptation, to modify internal and external conditions that affect individuals, groups, or communities in respect to behavior, emotions, and thinking, in respect to heir intrapersonal and interpersonal processes. Psychotherapy is provided by licensed, registered, or waivered staff practicing within their scope of practice. It does not include physiological interventions, including medication intervention. All clients participate in individual psychotherapy sessions a minimum of two times per week with their primary therapist. To the extent permitted by the client's individual circumstances, every effort is made to include parents, caregivers, and significant adult relatives in the psychotherapy process, making them aware of the client's

progress in the program, and assuring that interventions in the Day Treatment Program are related or meaningful to the caregivers to whom the clients will be returning.

d. **Process Groups:** Staff facilitate these groups to help clients develop the skills necessary to deal with their individual problems/issues by using the group process to provide peer interaction and feedback in developing problem-solving strategies and to assist one another in resolving behavioral and emotional problems.

3. **Community Meeting:** All clients in DTI the program participate in daily Community Groups that focus on orienting clients to the here-and-now, reviewing progress toward the achievement of individual goals, and anticipating social and/or emotional challenges that will be faced (or were faced) during the day. Community meetings address issues pertinent to the continuity and effectiveness of the therapeutic milieu. Group Services may be delivered in the context of field trips in the community that focus on practicing and demonstrating appropriate community behaviors. Additional Group interventions may include the opportunity for parents or caregivers to participate in Parent support Groups that will address planning for (or reviewing) issues that could come up (or did come up) during home visits/passes.

4. **Individual Rehabilitation:** Individual rehabilitation services include assistance with maintaining or restoring the client's daily living skills, medication education and compliance, independent and transitional living skills, leisure and community activities necessary to support and meet treatment goals, and individual/family counseling re: these services and outcomes.

5. **Contact with Significant Support Persons/Collateral Services:** Clients have at least one contact per month with a family member, caregiver, or significant support person and/or legally responsible adult as applicable. The contacts and involvement focus on the role of the significant support person in supporting the client's community reintegration. Collateral services include, but are not limited to, individual contacts with parents or caregivers, parenting classes, phone contacts with community stakeholders, and consultations school personnel.

6. **Plan Development:** Development and approval of treatment/service plans and monitoring the ongoing progress of treatment.

7. **Case Management:** Case management services will consist of activities that are provided by program staff to access medical, educational, social, or other needed community services for children and their families.

8. **Crisis Response:** The DTI program has an established protocol for responding to clients experiencing a mental health crisis. For more information, please see subsections Crisis Planning and Crisis Intervention Services immediately below, and the "Crisis Intervention Services" on page 5.
   a. **Crisis Planning:** Crisis planning will begin at the time of intake and will include solution-focused, problem solving strategies that support prevention, management, and stabilization of a crisis with the objective of successfully maintaining the client in the least restrictive environment and mainstream school setting. The crisis plan addresses both family and school situations with the objectives of de-escalation and problem-solving.
   b. **Crisis Intervention Services:** Crisis intervention services' objective is to prevent hospitalization and disruption of placement. Preventative, strategic planning enable clients

and families to employ coping skills to avoid crisis from occurring while in their home or any other community setting. Crisis intervention services include stabilization of the presenting emergency and include, but are not limited to, assessment, evaluation, and collateral linkage and services, as well as therapy and medication compliance. Implementation of a crisis plan during the transition group, along with trained parent/caregivers and staff will aid in de-escalation of a situation to avoid placement disruption and/or hospitalization.

9. **Schedule:** Program schedules are made available to clients and their families, caregivers, or significant support persons. Schedules identify when and where the service components of program will be provided and by whom. The schedule also specifies the program staff, their qualifications, and the scope of their responsibilities. Along with the schedules, the program includes the detailed group activity descriptions for each activity listed on the schedule.

10. **Staffing Ratios:** Staffing ratios are consistent with requirements in Title 9, CCR, Sections 1840.350 and 1840.352 and include at least one staff whose scope of practice includes psychotherapy. Please refer to page 6 "Staffing Profile" for more detailed information.

11. **Outcomes Measurement:** Bayfront YFS currently tracks outcome measures through the agency's Continuous Quality Improvement (CQI) monthly report. CQI tracks the following data:
    - Client GAF from admission to discharge
    - Client satisfaction survey
    - Positive discharge to a lower level of care (this includes discharge to a level 12 or lower, reunification with family/caregiver, and independent living)
    - Client incident reports (these incidents include client containments, client to client assaults, client to staff assaults, AWOL's, 5585's, self-injurious behaviors, and use PRN's).

Bayfront YFS also implements three types of measurements: Youth Outcome Measures Self Report (Y-OQ SR), Beck Depression Inventory II (BDI-II), and Beck Anxiety Inventory (BAI). These measurements allow for a more streamlined treatment and are administered on intake, quarterly, and at discharge.

Medication Support

Medication support services include prescribing and monitoring of psychiatric medication necessary to alleviate the symptoms of mental illness, decrease psychiatric hospitalizations, decrease placement disruption, decrease transition into higher levels of care, and stabilize clients at the lowest level, least restrictive environment. A psychiatrist oversees medication support services. All DTI clients have an initial assessment meeting with one of the consulting psychiatrists within 7-14 days of admission, and regular monthly follow-up visits if they have been prescribed medication. Since the consulting psychiatrists participate in regular team meetings, more frequent contacts can be arranged if necessary.

Service Linkage

The client that is admitted to the DTI program will have been linked to resources that were identified when the client was residing at the group home and entered the discharge group. When the client leaves the group home, to the extent permitted by program resources, personnel will be available to assist with transporting the client to his or her home should the client request. The Primary Therapist will be available to work collaboratively with all of the client's support services and be ready to assist

the client with making connections with new resources should new needs unfold. Discharge from the program will be dependent on whether or not the client has met his or her goals and all needed linkages are in place. For Probation-referred clients, the purpose of the DTI Program is to provide coordinated, integrated, and intensive psychotherapy and rehabilitation interventions to clients whose past and current behavior demonstrates that they need to participate in, and will benefit from, a structured, multimodal treatment program that is offered at least six days per week.

Crisis Intervention Services

Crisis Intervention services are available as part of the DTI package of services. Crisis intervention services outside of the hours of the normal DTI program are provided by the residential services personnel, with back-up available the PMRT 911 as necessary. Once the client has begun a transition to their home from living at the group home, they will have become familiar with how to access services in case of an emergency or a crisis situation. During this period, each client is aware that they can contact their program resources and a licensed/waivered clinician will offer assistance immediately until the crisis is resolved and further interventions can continue on a regular basis. If the referral cannot be resolved by the on-call therapist, a referral to 911, PMRT, and if needed, the local hospitals, etc. will be made. If the crisis is medication related, a treatment team representative can assist with linkage to emergency medication services if the client's current psychiatrist is unavailable. Support and follow up will continue until the client and the family's informal support systems are secure with the process.

Crisis intervention services' objective is to prevent hospitalization and disruption of placement. Preventative, strategic planning enable client and families to employ coping skills to avoid crisis from occurring while in their home or any other community setting. Crisis intervention services include stabilization of the presenting emergency and include but are not limited to assessment, evaluation, and collateral linkage and services, as well as therapy and medication compliance. Implementation of a crisis plan during early engagement, along with trained parent/caregivers and staff will aid in de-escalation of a situation to avoid placement disruption and/or hospitalization. Bayfront YFS DTI Program personnel have the resources to link and/or provide emergency respite for clients should they be unable to de-escalate or remain safe. Safety is the priority and appropriate referrals will be explored. For clients on home visits, clients and families are provided with contact numbers for the Psychiatric Mobile Response Team (PMRT) in their county of residence. As needed, program personnel will participate in the transitional planning and support if the client is hospitalized and discharging back home.

Staff Training

On-going trainings are conducted and topics covered include specific training on cultural diversity to help staff increase awareness of cultural and ethnic differences and sensitivities as well as increase skills in order to respond to and interact appropriately to the different cultural background of clients. These trainings are conducted through in-service, webinar, and videos within the company and also by employing outside professional speakers. Procedural orientation covers topics in confidentiality, child abuse reporting, field safety, HIPAA, sexual and workplace harassment, company policies and procedures, Pro-Act and Non-Violent/Verbal De-escalation and Crisis Management, neglect, abuse, and misappropriation issues, child/adolescent development, attachment issues, boundaries, active listening, stress management, client and family empowerment, crisis intervention, behavioral and therapeutic interventions and behavioral modification techniques, mental health, family relations,

developmental disabilities, referral processes, substance abuse, cultural diversity, employee training handbook (which includes fire & disaster procedures, accident, illness & injury prevention), rights of persons served, Title 22 and State regulations, to name a few. Once the employee completes the company orientation and training, they are trained by their specific department head. The Head of Services and the various department heads including the company staff developer covers training specific to each department. All program policies & procedures, crisis response intervention & management, psychotropic medication and DSM-IV TR disorders and diagnosis, and documentation requirements are presented. Day Treatment-specific material is introduced as well. Such material includes a regular review of the dynamics of team functioning as well as an overview of "assessment, and time frames for completion of assessments for Family Safety, need for crisis support, development of Family Safety and Crisis Plans, and Family strengths, use of services that are directly linked to Child and Family preferences, choices, values and culture, examining extended Family systems to identify Family supports and services that can be obtained or purchased from within the family structure, specific methods for helping children and families build the skills needed to meet their specific needs and result in greater self-sufficiency, and provision monitoring, timely consultation, and ongoing coaching to promote skill acquisition and enhancement by experienced supervisors/program managers or subject matter experts."

Staffing Profile

Bayfront's staffing profile is as follows: 9 MA-level, Licensed/Waivered clinicians, 8 BA-BA Level Rehabilitation Counselors which meets and exceeds the DTI program client staffing ratio of 1:8. Each client will have a primary clinician who is responsible for ensuring that all the strengths and needs are identified; that all the identified services are provided in a timely and appropriate manner; is the contact point for children, families, service providers, and the community; and to ensure that the county representative(s) has adequate opportunities for input and access to the client and family and planning process. The Primary Therapist provides targeted interventions with family, and client and collaborates with community and county agencies as well as, interacts with school personnel. Staffing will be sufficient to assure that the required 1:8 ratio will be met 6-days per week.

The Director of Clinical Services is a licensed Marriage & Family Therapist with 4 years post licensure and supervisory experience. The Director of Clinical Services is responsible for client coordination and mental health services provided by Bayfront YFS and will oversee implementation of all needs and services plans. The Director of Clinical Services collaborates with the Administrator in the coordination of clinical and administrative functions.

Overall Mission and Vision

The goals of the program are to ensure that all clients have access to an individually prescribed array of coordinated interventions that are designed to promote and demonstrate the clients' readiness for successful community living. It is also a goal of the program that, upon discharge from the group home, all clients will be linked to community-based services and resources so as to promote stable and safety for community living, as well as safely reduce future reliance on out-of-home care. These clients will be linked and secured with an array of comprehensive services specific to each individual's needs.

JULY GROUPS (EXAMPLE)

GROUP NAMES	DESCRIPTION	INTERVENTIONS
BUILDING CHARACTER	Clients will develop and understand various components that make up character building. Client will learn healthy coping and adaptive skills to increase positive character traits like being polite, offering to help, respectful, positive outlook, and caring for others resulting in a decrease in aggressive behaviors and an increase in mood stability when challenged emotionally. Rehab Therapist will assist clients in developing positive communication skills and learn empathy through various vignettes and cooperative games and exercises to utilize problem solving process.	1) Rehab Therapist will demonstrate to group effective ways of communicating with peers and establishing positive social interactions. Therapists will psycho-educate clients on accountability for their actions and to increase empathy and sensitivity to how bullying, assault and threats negatively impact others. This is also an exercise in teaching clients to accept responsibility for their actions and decrease intimidating and assaultive behaviors. Rehab staff will encourage client to maintain patience, stay on task, and follow directions, and develop positive interaction with peers during group activities. 2) Rehab Therapist will discuss the impact that relationships have on emotional triggers. Clients will demonstrate knowledge through appropriate communication skills and process personal experience of social pressures. Clients will further practice problem solving regarding individual's fears as well as responding to triggers of social pressures can be harmful to us and how we can meet our emotional needs and develop alternative ways to satisfy that need. 3) Clients will participate in peer nonverbal and verbal communication interaction through group discussions and provide feedback to peers. Group facilitator will encourage clients to interact positively and build healthy relationship with peers. 4) Facilitators will recap positive communication and adaptive skills that group members have learned and have practiced in group and focus on each member's strengths. Clients will continue to develop social and communication skills by participating in activities with other group members.
iCR8 Create	Support the utilization of self-expression through art in order to find positive outlets for frustration, environment stressors, and trauma. Clients are encouraged to explore and process their feelings of emotional distress and how it affects their everyday lives. Additionally, clients will focus on the associated behaviors to their feelings	1) Rehab Therapist will encourage group members to participate in a teamwork activity to increase positive interpersonal relationships with peers, build healthy relationships, and demonstrate the ability to stay focused, be patient, and follow directions. Rehab Therapist will role-play positive communication skills, appropriate interaction, and provide feedback to client. 2) Rehab Therapist will encourage group members to participate in an activity. Rehab Therapist will assist group members to identify their triggers when dealing with frustrations and peer pressures. Group members will use their imagination to express and process their emotional distress through creative projects that will emphasize patience, attention to detail, following directions, and teamwork. 3) Rehab Therapist will encourage group members to participate in individual activity of exploring interactive activity for positive affirmations. Rehab Therapist will role-model positive social skills when interacting within a group (i.e assisting others without yelling, providing feedback without putting others down). Group members will participate in a creative project that will emphasize patience, attention to detail, and following directions. 4) Rehab Therapist will assist client to use their imagination to express and process their emotional distress when dealing with pressure. Rehab Therapist will provide an activity to clients that will assist them in increasing their self-esteem by completing unfinished projects to promote a positive likeness of themselves.

Seeking Safety	Identifying triggers and Development of Safety Plan	1. Therapist will discuss with clients effective ways to ask for help when dealing with substance abuse triggers (i.e. guilt after engaging in risky/unsafe behaviors, redirections by authority figures, negative peer interactions, reminders of abuse). Therapist will rehearse how to ask and seek for help (i.e. role play, developing a safety plan). Therapist will explore client's experiences in asking for help to increase the use of coping skills. 2. Therapist will discuss the concept of safe self-nurturing as it relates to impact of inadequate self-care on substance abuse. Therapist will assist client in identifying areas needing improvement when meeting basic needs (i.e. social, spiritual, physical, intellectual, creative, emotional). Therapist will motivate clients to commit to immediate action on at least one self-care need by identifying one pleasurable activity to be completed in between sessions. Client will learn to increase pleasurable activities. Safe self-nurturing will be distinguished from unsafe self-nurturing (e.g, use of substances or other "cheap thrills"). 3. Therapist will discuss the impact of destructive self-talk on substance abuse. Therapist will learn the importance of compassion in recovery. Therapist will assist clients on contrast harsh versus compassionate self-talk (ie. blaming vs. loving/understanding, ignores self vs. listens to self). Clients will engage in rehearsal of compassionate self-talk. 4. Therapist will help client identify signs of danger (red flags/triggers) and safety (green flags/coping skills). Client can identify their triggers and safe coping skills to utilize when in different situations. Therapist will create a safety plan with client and discuss typical patterns of relapse. Client will review "chapter of my life" quotation. Client will complete "Signs of Danger versus Safety" worksheet.
Where I came from	ATTACHMENT RELATIONSHIPS & BEHAVIOR	1. Therapist will assist client in identifying how attachment (healthy vs unhealthy relationships with others) can affect their behavior (increase negative behavior such as self-harm, depression, aggression). Clients will be encouraged to participate in discussion about how their attachments affect their behaviors. 2. Therapist will facilitate discussion on attachment (healthy vs unhealthy relationships with others) and behavior (positive or negative) through handouts and you tube video to highlight the topic. Therapist will lead a discussion on how attachment and behaviors are related. 3. Therapist will facilitate discussion regarding different aspects of unhealthy attachment such as inconsistency in relationships, control, trust issues, hurt, the barriers to identification (such as denial), recognizing the physical and behavioral symptoms. Assist clients in identifying the connection between depressive mood and behavior and attachment. 4. Therapist will assist client in "throwing away the behaviors" and understanding the consequences of the behaviors such as aggression, depression or self-harm. "Throwing It Away" allows the client to "let go" of their resulting behaviors (aggression, depression, self-harm) related to their attachment.

TOGETHER WE STAND	Clients will be assisted in evaluating the maladaptive behaviors they currently possess, finding alternative methods to cope, and exploring more positive responses to the different emotions they encounter on a daily basis. Rehab Therapist will utilize group discussions, and group creative projects to explore the different areas and situations where these emotions are encountered. Clients will be expected to provide feedback during every activity as a means of building the positive communication, adaptive, and social skills needed to interact appropriately with peers. Clients will work on learning more positive coping skills, and the tools necessary to build more healthy and effective relationships. Clients will be given the opportunity to voice their frustrations, and process any emotional distress they may feel openly in a group setting.	1) Clients will process and communicate daily situations by expressing feelings about individual life experiences (good and bad) through individual skits and open discussion. Therapist will encourage clients to express their feelings to the group and offer feedback. Clients will focus on strengthening communication, and team building skills.. 2) Clients will process and communicate daily situations by expressing feelings about individual life experiences (good and bad) through individual skits and open discussion. Therapist will encourage clients to express their feelings to the group and offer feedback. Clients will focus on strengthening communication and team building skills. 3) Clients will process and communicate daily situations by expressing feelings about individual life experiences (good and bad) through individual skits and open discussion. Therapist will encourage clients to express their feelings to the group and offer feedback. Clients will focus on strengthening communication and team building skills. 4) Facilitators will recap positive communication and adaptive skills that group members have learned and have practiced in group and focus on each member's strengths. Clients will continue to develop social and communication skills by participating in activities with other group members.
	BELOW ARE THE CLINICAL GROUPS AND CORRESPONDING INTERVENTIONS FOR THE WEEK.	
About Me	Clients will discuss and gain a better understanding about the importance of having a healthy degree of differentiation from their family and peers. Clients will gain insight about how to gain control of their thoughts, emotions, and behaviors by having healthy boundaries in their relationships. Through experiential interventions teenagers gain understanding of life events, gain control and mastery over things that are or were overwhelming and out of their control in real life (for example, natural disasters, trauma, divorce, and so on), resolve their situations in ways that they want (that is, they can change what happens or the ending), and feel empowered . Clients will use different hands-on activities to gain a better understanding of their independence as individuals and their responsibilities to self-regulate and differentiate from people and situations.	1. Therapist will use a hands-on activity for clients to recognize compassionate and harsh self-talk - "The Be Nice Game". Therapist will encourage clients to use the power of words to be compassionate to themselves when dealing with life situations which they can't control. Educate client about their power to control their emotions by owning one's feelings and coping with them. Client will learn about the cumulative effect (i.e numbness, detachment, pessimism, insecurity, etc) of several losses and how to use compassion to decrease guilt and unsafe behavior when coping. 2. Therapist will use a hands-on activity "The System" for clients to know how they have control and how they affect their relationships in everyday life. Therapist will encourage client to recognize destructive behavior patterns and how they can be substituted by safe behaviors and positive coping skills. Therapist will help client identify currently available sources of positive support like personal therapy, stress management activities, positive beliefs, and humor. 3. Therapist will use a hands-on activity "My Power" to help clients gain understanding of the importance of recovery thinking and reframing one's behaviors. Clients will discuss how recovery thinking can help them make progress in their personal goals and run their program. Therapist will validate the clients when expressing their feelings and reframe negative and unsafe behaviors and thoughts through creative interventions. 4. Therapist will use a three-step model ("Motivate, Contain, and Listen") to manage anger before, during, and after it occurs. Therapist will use a hands on activity - "MCL Game". Encourage self-forgiveness and forgiveness towards people involved in the loss and grief process. Therapist will validate clients' feelings and opinion and reframe them during group, to help clients gain insight about the importance of healing from anger.

Expressing Emotions	Introduce clients to art-based coping mechanisms that can be utilized to help clients decrease symptoms related to their behavioral and mental health issues.	1. Clients will be encouraged to share their reactions to activity with peers. 2. Clients will be encouraged to share their work with peers and process how their mood is impacted by different types of music. 3. Therapist will encourage clients to process feelings, thoughts, and reactions to safe place activity with group members. 4. Therapist will help clients to share and process their work with others.
How do you cope?	Clients will be introduced to different kinds of coping skills.	1. Therapist will engage clients in identifying different forms of physical activity that can be used as a coping skill. Clients will engage in an activity to practice utilizing physical activity. Therapist will process why physical activity helps people feel better. 2. Therapist will engage client in discussing what makes them laugh. Therapist will process how laughter makes feel better. Clients will engage in an activity to foster laughter. Therapist will process why laughter helps people feel better. 3. Therapist will process with clients different activities that can be utilized for relaxation. Clients will engage in an activity to practice utilizing relaxation as a coping skill. Therapist will explore what client does to relax and when they utilize this coping skill. 4. Therapist will engage client in discussion regarding how art helps people feel better. Clients will discuss how different elements art. Clients will engage in an art activity in order to foster as a coping skill. Clients will share their completed art project with their peers and discuss why they chose their particular element as their coping skill.
I am	Focusing on the BODY	1. Clients will receive the opportunity to plant a flower that best represents who they are. Therapist will facilitate a discussion on the process it takes and the care that's needed for a flower to blossom in season. Therapist will assist client in recognizing that same process is needed to heal from past traumas. Therapist will encourage clients to process their feelings with peers. 2. Clients will engage in a self-care activity. Clients and therapist will discuss other ways client has provided themselves with healthy "self-care" and its benefits. 3. Clients will view a music video and discuss the influence the media has on the American teenager's self-image. 4. Clients will play various childhood games during group, UNO, (I Declare War, Go- Fish, Heads Up Seven Up, Sorry, Monopoly, and Operation), Double Dutch, and Hop Scotch. While playing the board and card games client and facilitator will discuss their feelings while engaging in childhood games. Facilitator will also provide opportunities to discuss other things related to childhood. Client will process how lack of self-care leads to maladaptive behaviors. Therapist will encourage client to express their feelings (negative or positive) and provide feedback to others.

Picking up the Pieces	Skills for Success in the Community	1. Therapist will assist clients in developing a relapse prevention plan (practicing coping skills in order to avoid returning back to placement.). Therapist will engage client in a discussion regarding the possible obstacles (conflicts with family/friends, inability to obtain financial resources, unsafe behaviors such as aggressive behaviors/self-harm) that may prevent client's from living in the community long-term. 2. Therapist will assist client in developing attainable, realistic short-term and long-term goals in developing a transition plan. Therapist will process with client the variety of new experiences that client may encounter in client's new setting for the purpose of reinforcing appropriate coping skills and decreasing negative/high risk behaviors. 3. Therapist will provide psychoeducation regarding the difficulties of change (why change can be challenging in that it disrupts the normalcy of the environment). Therapist will engage client in practicing progressive relaxation techniques (deep breathing exercises, counting to 10) to alleviate the stress and anxiety about the change and to prevent sabotage of progress. 4. Therapist will provide client with psychoeducation regarding the importance of having a positive support system in the community. Therapist will assist client in identifying the characteristics of healthy and unhealthy relationships (appropriate boundaries vs. enmeshment). Therapist will lead clients in role-play activity practicing different ways to build relationships
Problem solving	Different Types of Anger Management	1. Therapist provided psychoeducation regarding family dynamics in contributing to aggressive behavior (i.e. parental modeling of aggressive behavior; sexual, verbal, or physical abuse of family members; substance abuse in home; neglect; disengaged parents). 2. Therapist validated client's feelings and provided psychoeducation on the healing nature of crying i.e. provides an opportunity to express sadness, takes the edge of anger, and helps to induce calmness after crying subsides). 3. Therapist assisted client in making connection between underlying painful emotions such as depression, anxiety, fear, helplessness, and angry outburst or assaultive aggressive behaviors. Therapist assisted client in identifying unmet needs and expressing them to others. 4. Therapist engaged client in "letter writing" which focused on forgiveness to a significant other that has contributed to their feelings of anger. Therapist assisted client in identifying irrational thoughts that contribute to the emergence of assaultive/aggressive behavior. Therapist assisted client with replacing irrational thoughts with more adaptive ways of thinking to help control anger.

POLICY NO: DTI-100.1
APPLICATION: DAY TREATMENT INTENSIVE
DATE OF POLICY: 6/5/12
DATE OF REVISION:

POLICY TITLE: **THERAPEUTIC MILIEU**

A. POLICY STATEMENT: Bayfront Youth & Family Services provides each client with an individualized program of educational, therapeutic, experiential, and recreational groups and activities. Bayfront Youth & Family Services offers over 28 hours, at least 4 hours a day, of day treatment groups, programming and activities each week (evenings and after school and 5 hours a day on weekends, holidays and vacation periods) through an experienced staff of registered Marriage and Family Therapist Interns and Rehabilitation Staff. The Director of Rehabilitation is responsible for the planning, supervision, and implementation of activities. A schedule of activities is posted each week for minors to review. The Group Home Administrator/Clinical Director and or his/her designee will approve all activities and outings prior to engagement.

B. PROCEDURE:

Due to the serious and complex nature of client challenges, Bayfront Youth & Family Services clients require an intensive and varied mental health program. Consequently, the program includes groups related to the improvement, maintenance and restoration of personal skills. The enhancement of each is focused on the individuals' capacity to adapt to the learning module and include in the client's Needs and Services Plan. The following therapies are inclusive to treatment:

1. Clients participate in daily **Community Meetings** to discuss topics of interest and facility or program related issues. Clients are encouraged through this forum to give their input and to express their likes or dislikes within the program. Clients can make requests or complaints and may do so without fear of consequence. The facility provides weekly money management groups as well as Life skills groups that are geared at assisting clients with basic skills such as grooming, hygiene and organization.

2. **Process Groups** assist clients to bring to the forefront issues and past painful experiences that inhibits growth and progress towards their goals and aspirations. Sharing with peers and others and encourage the client's ability to resolve conflict, assist clients in overcoming the challenges of getting his/her needs met appropriately and help clients learn supportive behaviors for strong peer relationships. Process groups allow clients the opportunity to express themselves positively, gain self-esteem and accept feedback for behavior change and growth.
3. **Adjunctive Therapies** include alternative activities (besides direct process groups) such as arts and crafts, gardening, ceramics, movement, music, dance, and group

project that stimulate creativity. These adjunctive therapies access undisclosed traumas and pains through unobtrusive therapeutic modalities. Leisure and recreation activity promote relaxation and assist clients in reducing anxiety and frustration.

4. **Skill Building Therapies** involve self management skill and empowers clients to take responsibility. For personal choices, education and reducing stigma associated to mental health problems. Clients learn money management skills, personal care and grooming and are encouraged in the personal selection of clothing items as well as personal clothing maintenance. Clients receive pre-vocational and vocational counseling and staff assists clients in becoming self sufficient by accessing community resources, such as transportation systems e.g., bus and airports, banking, libraries or medical services: each of which enhances decision making. Social skills are practiced through activities and groups such as student council, daily community meetings and supervised socials. Bayfront Youth and Family Services provides a therapeutic environment. From the four components of the Department of Mental Health's Day Treatment Intensive Service program. A Qualified Mental Health Person is responsible for the direction of each group and the documentation of the client's ability, level of participation, response to program goals as well as staff interventions used to encourage client success

5. **Psychotherapy:** for the improved awareness of psychological adjustment and social functioning and to promote competency in areas where progress has been impeded. The improvement of communication skill, self expression and crisis management in addition to intrapersonal and interpersonal process' development is central focus. Clients focus on perceived barriers to growth and gain insight into physical or environmental factors that challenge emotional or cognitive functioning. Clients learn to develop coping mechanisms that promote a healthy return to routine activity. Youngsters with difficulties participating in the traditional verbal group therapies can be referred to the special adjunctive therapies of Art, Music and Movement therapy groups offered by trained therapists in these fields.

6. Bayfront Youth & Family Services clients participate in organized recreational sports activities and are encouraged through teamwork to support each other in core values. Bayfront Youth & Family Services' program is inclusive of a Health and Wellness program which focus on preventative and continued maintenance of health. Group topic's are related to weight management, fitness and exercise along with proper body mechanics. The Health and Wellness Program provides each client with an individualized health maintenance plan. The plan is tailored to client needs and health concerns and personal goals identified by each client. The plan is prepared in conjunction with the client to assist each in developing quality health habits, improve self image and assist the clients in understanding the importance of the combination of positive selection of nutritional foods, routine fitness, medication support and how each affects their overall health and attitude.

6. Bayfront Youth & Family Services is committed to ensuring the educational goals of each minor are addressed. Minors attend Zinsmeyer Academy off-site Monday through Friday from 7:50 A.M. To 1:30 P.M. The high school provides tutoring services on an individualized basis. Homework hours are scheduled during evening hours and youth counselors are available to assist those minors who need additional help outside of classroom hours.

7. The facility encourages clients to use free-time as a time to relax and connect with family and friends Clients are able to access dayrooms when not actively participating in any group or scheduled activity.

8. If a client is experiencing a mental health crisis the Shift Manager will be notified and will contact the case manager assign to that client. If the crisis is critical then the Clinical Director and the Administrator will be contacted and implement a crisis intervention plan, which may include contacting the on-call psychiatrist or PET. The Case Manager will follow-up with auxiliary outside resources.

Bayfront Youth & Family Services: Spring 2014 DTI Schedule

April, May, June

PROGRAM OUTLINE

DAY / TIME	TYPE	PROGRAM NAME	CLIENT	LOCATION	STAFF ASSIGNMENT
MONDAY-270min					
1:00-2:05	Psychotherapy	(A) Small Steps	Girls	Rehab Bungalow	Ruqayyah/Rosalyn
	Psychotherapy	(B) Teen Bullying & Aggression	Girls	Girls Day Room	Michelle, Shandra/Ashley
	Psychotherapy	(C)Distress Tolerance	Boys	Boys Day Room	Ashley, Dache/Jesus
	Psychotherapy	(D) Teen Bullying & Aggression	Boys	Dining Room	Chelsea/Dache
5min. Break no billable					
2:10-3:15	Psychotherapy	(A) Teen Bullying & Aggression	Girls	Girls Day Room	Michelle Monique/Aziza
	Psychotherapy	(B)Distress Tolerance	Girls	Dining Room	Ashley, Rosalyn
	Psychotherapy	(C) Teen Bullying & Aggression	Boys	Boys Day Room	Chelsea, Dache/Saul
	Psychotherapy	(D) Small Steps	Boys	Rehab Bungalow	Ruqayyah, Jesus/Brandon
5min. Break no billable					
3:20-4:25	Adjunctive	Warriors	Boys	Dining Room	Brandon, Dache/Jesus
	Adjunctive	Stress Management	Girls	Rehab Bungalow	Aziza/Shandra
Dinner Break 5:26-6:30					
4:30-5:35	Process	Kitchen Aces	Boys	Dining Room	Brandon, Dache/Saul
	Adjunctive	Culinary "Arts"	Girls	Rehab Bungalow	Aziza/Shandra/Rosalyn
TUESDAY-270min					
1:00-2:05	Psychotherapy	(A) Attachment	Girls	Girls Day Room	Ally, Ashley
	Psychotherapy	(B) Attachment	Girls	Rehab Bungalow	Michelle, Shandra
	Psychotherapy	(C) Expressive Art II	Boys	Boys Day Room	Cheyenne, Jesus
	Psychotherapy	(D) Distress Tolerance	Boys	Dining Room	Patricia, Dache
5min. Break no billable					
2:10-3:15	Psychotherapy	(A) Distress Tolerance	Girls	Dining Room	Patricia, Rosalyn
	Psychotherapy	(B) Expressive Arts	Girls	Girls Day Room	Darunee, Ashley
	Psychotherapy	(C) Attachment	Boys	Boys Day Room	Ally, Dache
	Psychotherapy	(D) Attachment	Boys	Rehab Bungalow	Michelle, Jesus
5min. Break no billable					
3:20-4:25	Adjunctive	Stress Management	Boys	Quad	Dache, Saul
	Adjunctive	Stress Management	Boys	Quad	Brandon
	Skill Building	As I Am	Girls	Dining Room	Rosaylyn
	Skill Building	As I Am	Girls	Dining Room	Morgan, Monique
Dinner Break 5:26-6:30					
4:30-5:35	Adjunctive	Face2Face Part 2	Boys	Rehab Bungalow	Saul, Dache
	Adjunctive	Face2Face Part 2	Boys	Boys Day Room	Jesus, Brandon
	Adjunctive	iArt	Girls	Girls Day Room	Aziza, Patricia
	Adjunctive	iArt	Girls	Dining Room	Monique, Shandra
WEDNESDAY-270min					
1:00-2:05	Psychotherapy	(A) Substance Use III	Girls	Girls Day Room	Patricia, Rosalyn
	Psychotherapy	(B) Substance Use III	Girls	Dining Room	Ashley, Ashley
	Psychotherapy	(C) Small Steps	Boys	Rehab Bungalow	Ruqayyah, Dache
	Psychotherapy	(D) Expressive Art	Boys	Boys Day Room	Chelsea, Jesus
5min. Break no billable					
2:10-3:15	Psychotherapy	(A) Expressive Art	Girls	Girls Day Room	Chelsea,Rosalyn
	Psychotherapy	(B) Small Steps	Girls	Rehab Bungalow	Ruqayyah, Shandra
	Psychotherapy	(C) Substance Use III	Boys	Boys Day Room	Patricia, Jesus
	Psychotherapy	(D) Substance Use III	Boys	Dining Room	Ashley Dache
5min. Break no billable					
3:20-4:25	Adjunctive	Stress Management	Girls	Quad	Dache, Rosalyn
	Adjunctive	Stress Management	Girls	Quad	Morgan, Sue
	Skill Building	Mini Trucking	Boys	Rehab Bungalow	Brandon
	Skill Building	Mini Trucking	Boys	Boys Day Room	Jesus, Saul
Dinner Break 5:26-6:30					
4:30-5:35	Process	Poetry "Creative Writing"	Boys	Rehab Bungalow	Saul, Jesus
	Process	Poetry "Creative Writing"	Boys	Rehab Bungalow	Brandon
	Adjunctive	Patch Work	Girls	Dining Room	Sue
	Adjunctive	Patch Work	Girls	Dining Room	Aziza, Shandra
THURSDAY-270min					
1:00-2:05	Psychotherapy	(A) Conflict Resolution	Girls	Rehab Bungalow	Darunee
	Psychotherapy	(B) Seeking Safety II	Girls	Girls Day Room	Adriana, Rosalyn
	Psychotherapy	(C) Conflict Resolution	Boys	Boys Day Room	Ally,Dache
	Psychotherapy	(D) Seeking Safety II	Boys	Dining Room	Cheyenne, Jesus
5min. Break no billable					
2:10-3:15	Psychotherapy	(A) Seeking Safety II	Girls	Girls Day Room	Cheyenne, Shandra
	Psychotherapy	(B) Conflict Resolution	Girls	Dining Room	Darunee, Rosalyn
	Psychotherapy	(C)Seeking Safety II	Boys	Rehab Bungalow	Adriana, Jesus

	Psychotherapy	(D) Conflict Resolution	Boys	Boys Day Room	Patricia, Dache
5min. Break no billable					
3:20-4:25	Adjunctive	Stress Management	Boys	Quad	Saul
	Adjunctive	Stress Management	Boys	Quad	Jesus, Dache
	Adjunctive	iArt	Girls	Dining Room	Aziza
	Adjunctive	iArt	Girls	Rehab Bungalow	Monique, Shandra
Dinner Break 5:26-6:30					
4:30-5:35	Skill Building	Warriors	Boys	Dining Room	Saul
	Skill Building	Warriors	Boys	Boys Day Room	Dache, Brandon
	Skill Building	Journey 2.0	Girls	Rehab Bungalow	Shandra
	Skill Building	Journey 2.0	Girls	Girls Day Room	Aziza
FRIDAY-270min					
1:00-2:05	Psychotherapy	(A) Family Ties	Girls	Girls Day Room	Darunee, Sue
	Psychotherapy	(B) Grief and Loss	Girls	Rehab Bungalow	Adriana, Monique/Aziza
	Psychotherapy	(C)Grief and Loss	Boys	Boys Day Room	Michelle, Saul/Brandon
	Psychotherapy	(D) Family Ties	Boys	Dinning Room	Cheyenne, Jesus/Dache
5min. Break no billable					
2:10-3:15	Psychotherapy	(A) Grief and Loss	Girls	Girls Day Room	Adriana, Aziza/Monique
	Psychotherapy	(B) Family Ties	Girls	Dinning Room	Cheyenne, Sue
	Psychotherapy	(C) Family Ties	Boys	Boys Day Room	Darunee, Saul/Brandon
	Psychotherapy	(D) Grief and Loss	Boys	Rehab Bungalow	Ashley, Dache/Jesus
5min. Break no billable					
3:20-4:25	Adjunctive	Poetry "Creative Writing"	Boys	Rehab Bungalow	Brandon, Dache/Saul, Jesus
	Adjunctive	Stress Management	Girls	Quad	Dache, Monique /Aziza, Shandra
Dinner Break 5:26-6:30					
4:30-5:35	Adjunctive	Face 2 Face Part 2	Boys	Boys Day Room	Brandon, Dache/Saul, Jesus
	Adjunctive	As I Am	Girls	Rehab Bungalow	Monique, Morgan/Aziza, Shandra
SATURDAY-270min					
1-2:10	Process	Mini Trucking	Boys	Boys Day Room	Brandon, Dache/ Saul, Jesus
	Adjunctive	Patch Work	Girls	Rehab Bungalow	Monique, Rosalyn/Aziza, Shandra
5min. Break no billable					
2:15-3:25	Skill Building	Warriors	Boys	Rehab Bungalow	Brandon, Dache/Saul, Jesus
	Skill Building	Stress Management	Girls	Basketball Court	Monique, Morgan/Aziza, Shandra, Rosalyn
5min. Break no billable					
3:30-4:40	Skill Building	Stress Management	Boys	Basketball Court	Brandon, Dache/Saul, Jesus
	Skill Building	Journey 2.0	Girls	Rehab Bungalow	Monique, Morgan/Aziza, Shandra, Rosalyn
4:45-5:55	Skill Building	Kitchen "Aces"	Boys	Rehab Bungalow	Brandon, Dache/Saul, Jesus
	Skill Building	Culinary "Arts"	Girls	Dining Room	Monique, Morgan/Aziza, Shandra

Clients is given a 5 minute break between groups for personal use

Psychotherapy
Skill Building
Adjunctive
Process

Michell M.-IMFT
Adriana L-IMFT
Chelsea C-IMFT
Patricia M-IMFT

Ally Thompson-IMFT
Ruqayyah Samia-IMFT
Darunee Prasomsri-IMFT
Jennifer Vachet-IMFT
Shajuana Taylor-IMFT
Prerna Rao-LMFT
Cheyenne Vasquez-IMFT
Ashley Dunn-IMFT
Sue Jang-B.A 15yrs

Brandon Harrison- Rehab Therapist/A.A 10yrs
Saul Rios-Rehab Therapist/B.A 4yrs
Aziza Hunter- Rehab Therapist/B.A 4yrs
Monique Palmer- Rehab Counselor/M.A 4yrs
Roshandra Edwards- Rehab Counselor/B.A 1yr
Jesus Chavez-Rehab Counselor/B.A 1yr
Dache Fance-Rehab Counselor/B.A
Elizabeth Morgan Nadeau/B.A

Attachment K
Expiring Document Report

Department of Behavioral Health
Expiring Documents

MM-00132
Data Date: 4/5/2016
This report shows the client's most recent assessment date and Fresno Treatment Plan date. It can be run by client, case manager, caseload type or supervisor. Assessment date is calculated by the most recent assessment billed in Avatar. If that assessment is expired or there is no assessment bileld, it checks for an Exodus admission. Treatment Plan dates are taken from the Fresno Treatment Plan. If the assessment or plan is expired, the date is in Red, if it will expire in 2 months, the date is in yellow, otherwise it is in green.
The report is run by Supervisor:

Client	Assessment	Tx Plan	Case Manger	Caseload Type

Attachment L
QA Fresno Treatment Plans Core Assessments Not in Final Status Report

Department of Behavioral Health

QA - Fresno Treatment Plans/Core Assessments not in Final Status

MM-00083
Data Date: 4/5/2016
This report lists all the Fresno Treatment Plans and Core Assessments that are currently in Draft/Unknown/Pending Approval status. Unknown status is the same as Draft status.

[redacted], MFT Intern — 1 Documents

Core Assessment

Doc Date	Data Entry	Days in Status	Status	PATID	Client Name	Co-Signer
3/28/2016	4/3/2016	8	Draft			

[redacted]n, MFT Intern — 2 Documents

Core Assessment

Doc Date	Data Entry	Days in Status	Status	PATID	Client Name	Co-Signer
3/23/2016	3/23/2016	13	Draft			
4/5/2016	4/5/2016	0	Draft			

[redacted], MFT Intern — 1 Documents

Core Assessment

Doc Date	Data Entry	Days in Status	Status	PATID	Client Name	Co-Signer
10/30/2015	11/2/2015	158	Draft			

[redacted], MFT Intern — 2 Documents

Core Assessment

Doc Date	Data Entry	Days in Status	Status	PATID	Client Name	Co-Signer
4/4/2016	4/4/2016	1	Draft			
3/31/2016	3/31/2016	5	Draft			

[redacted], MFT Intern — 1 Documents

Treatment Plan

Doc Date	Data Entry	Days in Status	Status	PATID	Client Name	Co-Signer
1/25/2016	1/25/2016	71	Draft			

[redacted], MD — 1 Documents

Treatment Plan

Doc Date	Data Entry	Days in Status	Status	PATID	Client Name	Co-Signer
3/16/2016	3/16/2016	20	Draft			

[redacted], MFT Intern — 3 Documents

Core Assessment

Doc Date	Data Entry	Days in Status	Status	PATID	Client Name	Co-Signer
3/30/2016	4/1/2016	6	Draft			
3/29/2016	4/1/2016	7	Draft			
3/29/2016	4/4/2016	7	Draft			

[redacted], MFT Intern — 2 Documents

Core Assessment

Doc Date	Data Entry	Days in Status	Status	PATID	Client Name	Co-Signer
3/30/2016	3/30/2016	6	Draft			

Treatment Plan

Doc Date	Data Entry	Days in Status	Status	PATID	Client Name	Co-Signer
3/30/2016	3/30/2016	6	Draft			

Carole Parks, LMFT — 2 Documents

Treatment Plan

Doc Date	Data Entry	Days in Status	Status	PATID	Client Name	Co-Signer
2/19/2016	2/25/2016	46	Draft			
2/19/2016	2/19/2016	46	Draft			

Attachment M
Assessment and Treatment Plan Trainings
2015

Training 6/26/15
YWC

Targeted Documentation Training: Assessment and Treatment Planning

Objectives of This Targeted Training

1. Define **"medical necessity"** and identify 3 needed components to establish, and explain the need for documenting **ongoing medical necessity** in treatment

2. Review the essential elements of a **clinical assessment** and describe how to demonstrate the presenting problem, diagnosis, and impairment to support medical necessity within a well written assessment

3. List the required components of a well written **Plan of Care,** including **demonstration of client participation** in creating the treatment plan.

4. Define "SMART" goals and apply to **behavioral goals in treatment** as based on primary diagnosis.

5. Distinguish between **types of service contact** and articulate how to identify and

Attendees

Jennifer Mitchell MFT YWC
Brenda Saicoe MFT YWC
Chun-Hsiu Hsu SLMHC YWC
Amber Allred MFTI OP
Dalila Jimenez MFTI OP
Ka Bao Vang MFT I OP
Matin Langroodi SLMHC OP
Clara Flint MFTI OP
Eunice Medina MFTI SBT Rural
Gabe Gomez QI
Alex Betancourt Clinical Sup Rural
Joyce Vasquez SLMHC SBT Rural

September 28, 215
Training Hospital follow ups/Assessment/POC

Learn at Lunch:
Let's Talk Assessment!

Cynthia Hager Clinical Sup OP
Lesby Flores Clinical Sup OP
Clara Flint MFTI OP
Maria Amezola MFTI OP
Dalila Jimenez MFTI OP
Matin Langroodi SLMHC OP
Margarita Escalante SLMHC OP
Dina Wise SLMHC OP
Brenda Saicoe- Youth Wellness
Chun-Hsiu Hsu SLMHC YWC
Aimie Rojas SLMHC OP
Lupe Taylor SLMHC OP
Rande Wood SLMHC OP
Mary Negrete LMHC OP
Eunice Medina MFTI SBT Rural
Gloria Hayes MFTI OP
Chery McCarter SLMHC OP
Adolph Vidal LMHC OP
Staci Hernandez LMHC OP
Alex Betancourt Clinical sup Rural
Chris Weatherby- clinical Sup School based

Targeted Documentation Training: Assessment and Treatment Planning

Katherine Rexroat, LMFT and Linda Sereda, RN/LMFT
Utilization Review Specialists
FCMHP Managed Care
Fresno County Department of Behavioral Health

Objectives of This Targeted Training

1. Define **"medical necessity"** and identify 3 needed components to establish, and explain the need for documenting **ongoing medical necessity** in treatment
2. Review the essential elements of a **clinical assessment** and describe how to demonstrate the presenting problem, diagnosis, and impairment to support medical necessity within a well written assessment
3. List the required components of a well written **Plan of Care,** including **demonstration of client participation** in creating the treatment plan.
4. Define "SMART" goals and apply to **behavioral goals in treatment** as based on primary diagnosis.
5. Distinguish between **types of service contact** and articulate how to identify and describe on the Plan of Care.

Setting Sail on a Sturdy Ship: Good Documentation = Good Client Care

- **Why good documentation = good client care**
- **Benefits of good documentation (Integrity of work; Scope of Practice, Scope of Competence and the story of my gardener)**
- **Items to exclude from documentation**

THE BUSINESS of MENTAL HEALTH

V.

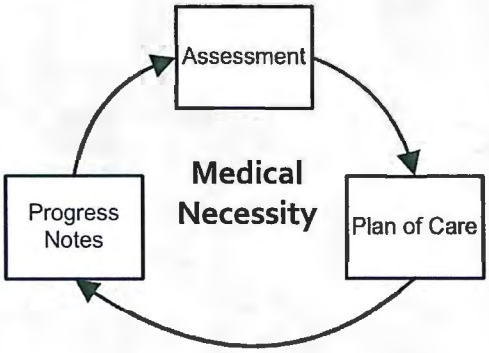
THE PRACTICE of MENTAL HEALTH

Accountable care -> based on 'what' was done and 'why'

*Complete and accurate documentation of important clinical concepts of you client's care is a requirement of **good** client care.*

Establishing Need for the Voyage: Assessing and Setting a Course

Assessment, Treatment Plan and Treatment: A Circle Around Medical Necessity



Medical necessity is the principal criterion for determining need for treatment and course of treatment.

All three components required for medical necessity:

- Presence of a DSM diagnosis (Note: for many managed care entities, there exists "excluded" diagnosis)
- Presence of some level of impairment in at least one area of life functioning
- Condition will not be responsive to physical health-based treatment alone; sx and impairments would be responsive to MH treatment

Assessment = Snapshots During Voyage

Clinical Assessment = where the client is RIGHT NOW

NOT a "living" document

Establishes ***medical necessity*** by painting a *clear, detailed* picture of an individual's ***Strengths, Needs, Abilities, and Preferences (SNAP)***

Standard *Required* Elements of an Assessment

- Documentation of **presenting problems** and relevant conditions affecting the consumer's physical health and mental health status; precipitating event or onset
- **Psychosocial History**: living situation, daily activities, or social support. (Impairments?)
- Describes the **consumer's strength** in achieving plans or goals (for example: motivated for treatment; insight into present situation; support of family, friends or caregivers; history of treatment compliance).
- **Special status situations that present a risk to consumer or others** are prominently documented and updated as appropriate.
- **Relevant physical health conditions.** Documentation includes **medications, diagnoses, dates of initial prescriptions and refills, dosage of each medication**, and documentation of informed consent for medications.
- Consumer's **self-report of allergies and adverse reactions** to medications, or lack of known allergies or sensitivities, is clearly documented.
- A **mental health history** is documented, including:
  - Previous treatment dates and providers
  - Therapeutic interventions and responses
  - Sources of clinical data
  - Relevant family information
  - Relevant laboratory tests
  - Consultation reports.
- Documentation includes **past and present use/abuse of tobacco, alcohol, and caffeine, as well as illicit, prescribed, and over-the counter drugs.**
- **For children and adolescents,** a complete developmental history is required, including prenatal and perinatal events.
- A relevant **mental status examination** is documented.
- **A fully supported diagnoses from the most current DSM**
- **Assessing clinician's dated signature**

Diagnosis

- **Provisional Diagnosis**
- Based on DSM-IV TR criteria – and new DSM 5 criteria
- Primary, secondary, and tertiary – diagnostic strings
- Mental health, AOD, and trauma-informed
- **The "Evolving Diagnosis"**
  - Update with re-assessment or complete progress note
  - Rule-Outs

Diagnosis and Medical Necessity

- **Medical necessity** = included diagnosis + identified impairment+ responsive to MH treatment
- **Demonstrated in assessment**
  - ***Explicit description*** of the sx and impairments that reflect criteria of diagnoses (all – MH; AOD; Trauma-informed)
  - ***Baselines*** of sx/impairment
- **Applying SNAP**

- Example: **Attention Deficit Hyperactivity Disorder –** how would you show:
  - *A persistent pattern of inattention and/or hyperactivity-impulsivity that interferes with functioning or development…*
    - *Note: Sx are not solely a manifestation of oppositional bx, defiance, hostility, or failure to understand*
  - *Inattention: 6 or more of the sx from DSM present for at least 6 months to a degree inconsistent with developmental level*
  - *Hyperactivity and impulsivity: 6 or more of the sx from DSM present for at least 6 months to a degree inconsistent with developmental level*
  - *Several symptoms present prior to age 12*
  - *Several symptoms present in 2 or more settings*
  - *Clear evidence that symptoms interfere with functioning in at least one life domain*
  - *Symptoms not better explained by another mental disorder*

How and Where to Incorporate Trauma Issues into an Assessment

- **In the body of the assessment**
  - **On the DBH Core Assessment (found in Avatar):**
    - **Presence of identified stressor or precipitating event – can be noted in "Presenting Problem": "Psycho-Social History: Legal History" "Living Situation" and/or "Social/Relational Functioning Comments. May also include under "Additional Risks", especially for small children.**
    - **Look for correlations between stressors/precipitating events and reactive symptoms ("When did you notice these angry outbursts first began?")**
- **Think trauma-informed diagnoses**
  - Refer to DSM 5 – *Trauma- and Stressor-Related Disorders* and *Other Conditions That May Be a Focus of Clinical Attention* containing relational problem codes, abuse and neglect codes, as well as housing, educational, housing and economic codes

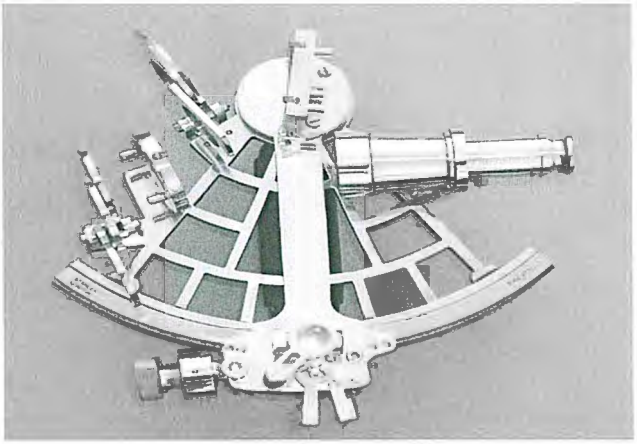
Be aware of the impact on treatment! Trauma- and Stressor-Related Disorders are often misdiagnosed as other mood disorders or neuro developmental disorders – especially ADHD! – when precipitating events and stressors are not clearly identified. Impacts types of therapy, medication supports and levels of care needed for recovery.

How and Where to Incorporate AOD Issues into an Assessment

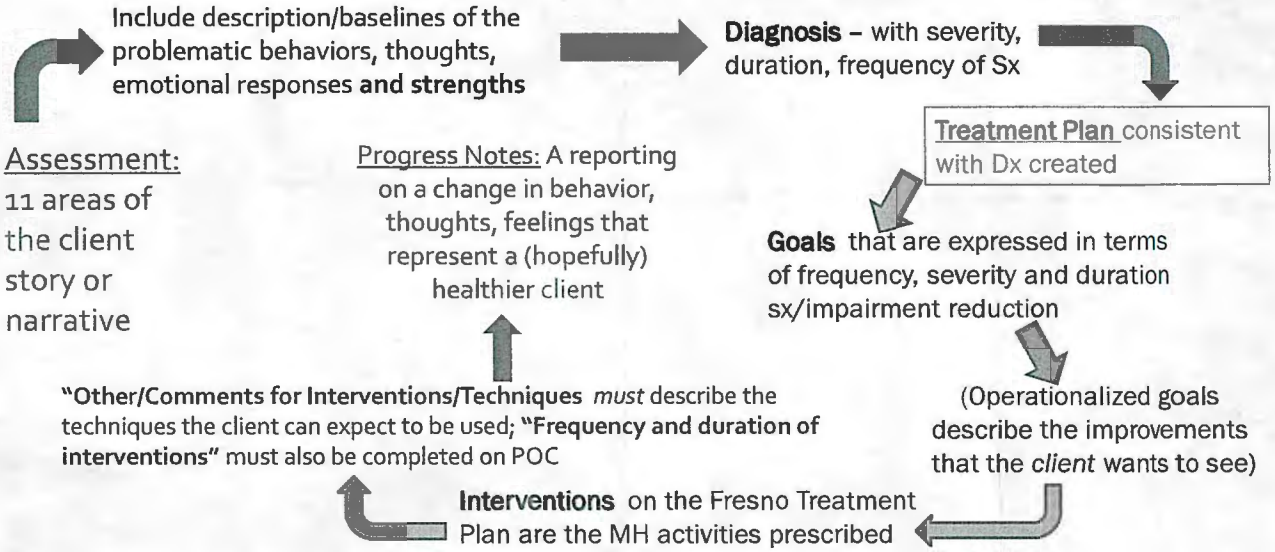
- In the body of the assessment
  - **On the DBH Core Assessment (found in Avatar):**
    - **Client AOD Use – can be noted in "Presenting Problem": "Psycho-Social History: Legal History" and/or "Social/Relational Functioning Comments: *Always* under "Substance Abuse".**
    - **Family AOD issues – family history, current and past, should be noted in "Psycho-Social History", including "Living Situation" and "Social/Relational Functioning" as appropriate. May also include under "Additional Risks", especially for small children.**
- Include co-occurring AOD diagnosis (*listed as secondary or tertiary, never first/primary)* in diagnostic string as appropriate.
- Consider integrated treatment (treating MI and AOD at the same time by the same program) when appropriate

Plan of Care (POC)

Mapping the course, created collaboratively by the MH professional and client, to address both *symptoms* and *impairments.* A good POC gives direction to treatment and the final destination – the client's desired goals!



Relationship Between the Assessment and POC



Relationship Between Assessment and POC

Ollie the Sailor – Let's assess

- Presenting problem
  - Weight, height, BMI, etc
- SNAP (Strengths, Needs, Abilities, Preferences)

Planning with Ollie's Goals

- Specific, measurable goals
- How is he going to get there?
  - Who can help him?
  - What type of diet should he try?
  - What additional interventions would ensure success? How often and with whom?

Why is mental health treatment so different from Ollie's care?

Let's Play "Guess the Diagnosis"!

(Taken from actual Plan of Care documents)

Patient One – Treatment Goals

1. *Improve parenting strategies; Caregiver will learn and be able to cite appropriate developmental behaviors and expectations. She will review these expectations during session at least one time per month. Caregiver will learn how to utilize positive reinforcement one time during a role play in session…She will then practice using these skills at least one time per week and review them in session monthly*
2. *Improve social skills; Caregiver will identify positive social skills and identify area to improve…will demonstrate knowledge of functional behavior and management technique by identifying and reporting the use of management techniques weekly.*
3. *Improve anger management technique; Caregiver will learn how to identify and describe anger and its role in individual life and family life….caregiver will learn three relaxation strategies and practice one strategy in session weekly.*

Patient Two – Treatment Goals

1. Reduce the negative impact that the traumatic event has had AEB recurring, intrusive images, thoughts, and vivid memories of the event; sense of hypervigilance when out in public places, and poor concentration at home and work, from x2-3/day to x1-2/week within 6 months.
2. Demonstrate an ability to remain calm when exposed to situations similar to original event, from zero to daily within 6 months.
3. Verbalize realistic hopes and plans with no suicidal thoughts from x1/week to x4-5/week within 6 months.

Let's Play "Guess the Diagnosis"!
(Taken from actual Plan of Care documents)

Clients come to you in therapy because they are in distress. They continue to come back when they experience relief from the "aches and pains" of their mental health symptoms (and impairments).

Goals for treatment must always be *consistent with the determined diagnosis*, and the destination of the journey in treatment is relief from their distress based on this diagnosis. *Goals should be written in such a way that the client can understand and follow his/her own journey to relief with your assistance.*

Both Patient One and Patient Two are adult females – mothers experiencing distress. Both were in treatment for Posttraumatic Stress Disorder.

It is likely only one will find relief…

The Treatment Plan/Plan of Care

Setting Sail: Treatment Plan Development

- After the mental health assessment is completed and medical necessity of specialty mental health services is met
- Goals on Plan of Care (aka Treatment Plan, Client Plan) are *Outcome Goals*
  - *Process Goals* (establishing rapport, providing a nonthreatening environment) are the therapist's responsibly only
  - *Outcome Goals* (life changes your client hopes to accomplish) are developed by both the client and therapist working together. *Must address symptoms/impairments directly.*
- Four important functions of outcome goals
  - Motivational
  - Educational
  - Evaluative (for the client)
  - Assessment of treatment itself

The absence of a Plan of Care (includes *expired* POC's, POC's without client or clinician's signatures) is a common reason for disallowance during medical record reviews. Reviewers also compare progress in each session to stated outcome goals on a treatment plan.

SMART Goals

Specific Measurable Achievable/Attainable

Realistic Time-bound

SMART Goals

S= (Depression): decrease thoughts of hopelessness, sadness; reduce expressions of low self-worth ("Increase," "Decrease," Reduce,"; AEB)

M= Put in concrete numbers; From daily to 0-1x/week; From several times a day to 0-1x/day; self-reported scaling; think "baseline" to "target"

A = "Can this client achieve this?" Based on the client's Strengths, Needs, Abilities, Preferences (SNAP)

R = Individual life circumstances, factors may determine; "healthy baselines" from assessment; Based on the client's

Strengths, Needs, Abilities, Preferences (SNAP)

T = Within 3 months; within 6 months

(Different goals on same POC may have different timeframes)

Plan of Care : Addressing Symptoms and Impairments

Symptoms – A sign or an indication of disorder or disease, especially when experienced by an individual as a change from normal function, sensation, or appearance (thefreedictionary.com)

- Referred to as criteria for diagnosing
- Presenting problems (Specific to the client's presentation)

Impairment – Significant dysfunctions in daily living, impacting affective, cognitive, occupational, social, or other functioning for which the client needs mental health services.(Wiger, 2005)

- Usually noted as *functional impairments*, such as *living arrangement, employment, daily activities, social relationships, and health.*

Both reduction of symptoms and improvements in areas of impairment should be addressed on the Plan of Care, and then carried forward when documenting progress of the client.

POC Examples from Recent Reviews

Taken from actual Plan of Care for a minor diagnosed with ODD:

Behavioral Goals:

1. **Reduce the use of negative coping skills (AEB: cutting, other self-harming behaviors, suicidal ideations, medication refusal, being destructive to property or aggressive, etc.) from 6x/weekly to 3x/weekly within 12 months.**
2. **Improve ability to follow directives at home and from probation (AEB: attending school daily, taking medication as prescribed, avoiding incarceration, avoiding drug use, etc.) from 2-3x/weekly to 5x/daily within 12 months.**
3. **Improve interactions with adults AEB initiating positive and respectful conversations with his grandparents, school staff, ACT team member, probation, etc., from 1x /week to 4x/week within 12 months.**

NOTE: In the next section listing interventions, under "Individual Therapy Non-MD: Techniques to Achieve Goals", clinician wrote, "Behavioral Therapy (including anger management, communication skills building, conflict resolution skills, praise), Cognitive Behavioral Therapy (including cognitive restructuring, relaxation techniques, etc.), narrative therapy, solution-focused therapy (including…) and other modalities as needed.

1930

POC Examples from Recent Reviews

Taken from actual Plan of Care for an adult diagnosed with Dysthymic Disorder, with a Rule Out for Obsessive-Compulsive Disorder:

Behavioral Goals:

1. **Reduce feelings of sadness from daily to one time per week by client self-report, observed by other[s] and use of BDI-II measurement**
2. **Reduce feelings of irritability from daily to one time per week by client self-report, observed by other[s] and use of scaling sx.**
3. **Explore obsessive thoughts and compulsions to one time per week as self-report by client.**

NOTE: In the next section listing interventions, under "Individual Therapy Non-MD: Techniques to Achieve Goals", clinician wrote, "Use of CBT – explore distorted thinking patterns that contribute to SX, journaling, progressive relaxation, thought stopping, explore family of origin patterns, explore underlying assumptions and beliefs that contribute to sx and behaviors. Estimated Duration of Treatment was one year, with discharge noted as, "CL is able to recognized and manage Sx without disruption to daily living."

Plan of Care: Interventions

- *All planned mental health activities* that will be submitted for claims *must first be prescribed on the collaboratively created POC prior to the provision of services*
  - Individual psychotherapy; group psychotherapy; family/couples psychotherapy; *case management;* collateral; medication support activities; and *plan development*
  - Assessment and crisis intervention activities are excluded, as these are not considered "planned"

"PRN" or "as needed" is not acceptable!

Just like a physician writes a prescription , MH clinicians should indicate ***frequency*** (how often this intervention will occur) and **duration** (timeframe of how long this intervention will be provided).

- ***Techniques/modalities*** to achieve the behaviors goals for each intervention/type of mental health activity must be included.

Plan of Care: Dated Signatures

- *"...documentation of beneficiary or legal guardian participation in the plan or written explanation of the beneficiary's refusal or unavailability to sign ..." (DHCS Reasons for Recoupment for FY 2014-2015)*
- **Signature of client/legal guardian that *the client/guardian has dated* fulfills this requirement.**
- **Dated signature of licensed/registered mental health professional *also must be present* to indicate onset of treatment plan activities**
  - If written by case manager, student trainee, someone other than clinician overseeing treatment, POC is *finalized* only when co-signed.
  - Dated signature must include name, licensure, unique identifier number

Cause for Recoupment

Plan of Care: Dated Signatures

- *"...documentation of beneficiary or legal guardian participation in the plan or written explanation of the beneficiary's refusal or unavailability to sign ..." (DHCS Reasons for Recoupment for FY 2014-2015)*
- **When client/legal guardian signature is absent, there must be a written explanation on the POC for the absence**
  - ***"Client refused to sign"*** **(With follow-up documentation in chart showing therapist's continuing efforts to acquire collaboration with signature)**
  - ***"Authorized per Fresno County Court Order dated XX/XX/XXXX"*** **(With legible copy of current Court Order in the client record)**
- ***For minor clients involved with open CWS: Foster parent signature is not valid without Court Order specifying mental health services***

Plan of Care: Expiration

- Plans of Care are valid for *up to one year.*
- Treating clinician directing care may indicate less based on treatment needs
- Estimated length of treatment must be indicated on the signed Plan of Care
- Expired Plan of Care cannot be utilized to justified ongoing care.
  - It is the provider's responsibility to verify before any clinical interaction that the intervention is prescribed on the POC, and the clinical interaction occurs within the specified timeframe of the valid POC.

Charting in the Right Direction: Program and Client Specific Interventions on POC

- As an FCMHP organizational provider, program's POCs are specific to:
  - Features of a multidisciplinary team (i.e. psychotherapy, rehabilitation, medication support services)
  - *Evidence-Based Practices* as determined by your unique target population
  - Sometimes unique services
    - New "Katie A." services of *Intensive Care Coordination (ICC)* activities and Intensive Home-Based Services
    - Inclusion of "Peer Support" or "Family" Partners (not billed to Medi-Cal directly but covered by program's contractual framework with agreement by family)

All components of your mental health care needs to be part of the written Plan of Care, both for claiming purposes and *to determine if client treatment needs are being addressed.*

What Kind of Ship is This? Type of Service Contact is Documented on POC

- **Assessment**
  - Not considered a "planned" MH activity, so does not need to be on POC
- **Plan Development**
  - Only after medical necessity has been established by way of a completed assessment
  - Creation of treatment plan
  - Monitoring/updates of POC
  - Plan Development is a *planned* MH activity (authorized on POC)

- **Psychotherapy**
  - Individual (1:1), family, group
  - Processing, therapeutic interventions & client response
  - Must include description of "techniques to achieve goals", even if you are not going to be the treating clinician
- **Collateral**
  - Involves "Significant Support Person"
  - Training to support client's needs
  - "Techniques..." should describe specifically what the SSP will be receiving

What Kind of Ship is This?
Type of Service Contact is Documented on POC

- **Case Management**
  - Consultation, monitoring, linkage
  - Parent, Spouse, Adult Child, Caregiver; OR social worker, teacher, other professional
  - Include what kinds of linkage or consultations; how often client can expect to be "monitored"
- **Rehabilitation**
  - *Skill building* with the client
  - Individual, Group

- **Medication Support Services**
- **Therapeutic Behavioral Health Services (TBS)**
  - Though provided be outside provider, considered a supplemental MH service that is authorized by primary POC
- **"Katie A." Services (Other)**
  - Intensive Care Coordination
  - Intensive Home-Based Services

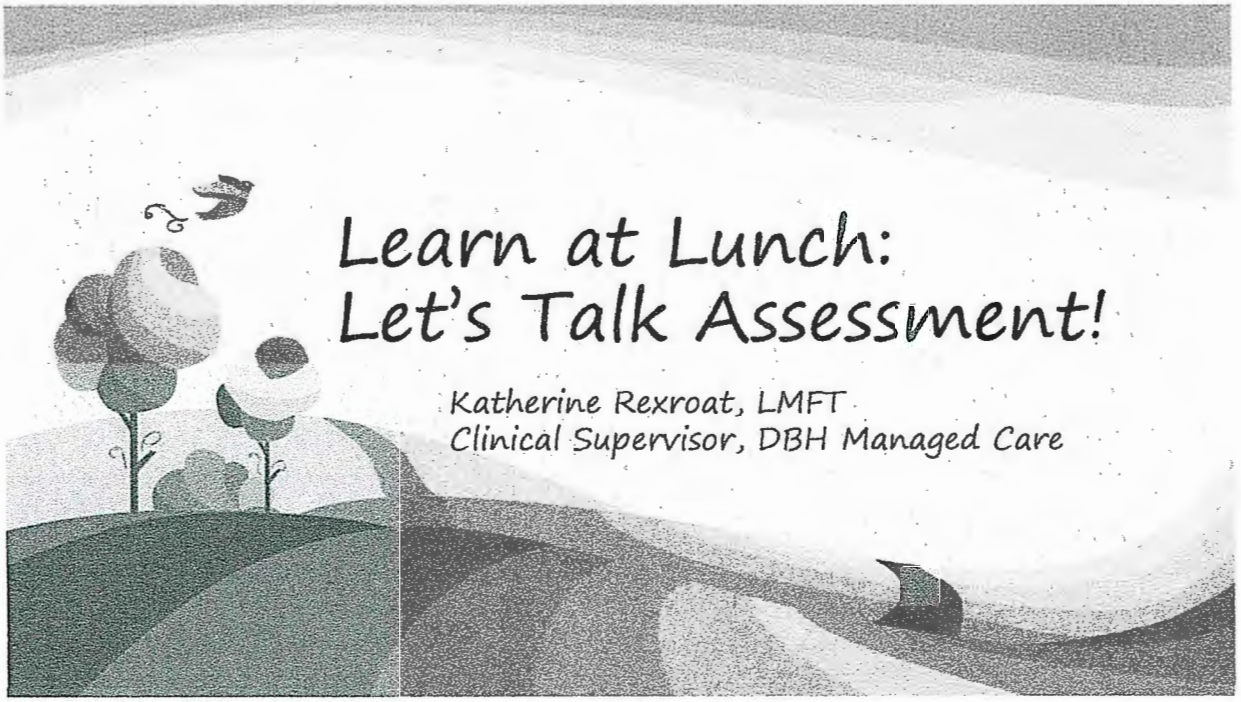
The end of our journey, as the client is now ready for treatment....

Questions?

Thank you for attending this Targeted Documentation Training!

References

- California Code of Regulations, Title 9. Rehabilitative and Developmental Services. Division 1. Department of Mental Health
- California Department of Health Care Services Program Oversight and Compliance: Annual Review Protocol for Consolidated Specialty Mental Health Services and Other Funded Services FY 2014-2015 (Revised 09/24/2014)
- California Department of Health Care Services: Reasons for Recoupment For FY 2014-2015
- Fresno County Department of Behavioral Health (2012) *Fresno County Mental Health Plan: Documentation and Billing Handbook.*
- Donald E. Wiger (2005) *The Psychotherapy Documentation Primer, Second Edition.* Hoboken, New Jersey. John Wiley & Sons. Inc
- David J. Berghuis, Arthur E. Jongsma, Jr. (2003) *The Severe and Persistent Mental Illness: Progress Notes Planner.* Hoboken, New Jersey. John Wiley & Sons. Inc.
- Arthur Jongsma, Jr, Mark Peterson (2006) *The Complete Adult Psychotherapy Treatment Planner.* Hoboken, New Jersey. John Wiley & Sons, Inc.
- Harold L. Hackney, Sherry Cormier (2009) *The Professional Counselor: A Process Guide to Helping.* Upper Saddle River, New Jersey. Pearson Education, Inc.



Learn at Lunch: Let's Talk Assessment!

Katherine Rexroat, LMFT
Clinical Supervisor, DBH Managed Care

Checking In

- Assessment sets up your clinical decision-making
  - Establishes medical necessity (identifying a diagnosis and impairments, AND establishing that condition would be responsive to treatment)
  - Tells your client's story! Provides a portrait or "snapshot"
  - Provides direction for treatment planning and ongoing care for ALL mental health providers involved with this client
- Assessments are time consuming, and require you the author to learn the skills to write this story

Assessing children

What are we after – Communicating what you hear and observe

A good assessment goes beyond "just getting the client in the door" by identifying an acceptable (or "included") diagnosis!

It should be individualized to the client, what he/she is experiencing right now, what he/she needs, and what he/she possesses as strengths and resources to get him/her to a point of wellness and recovery.

New – Follow Up Assessments from Exodus Recovery & CSPHF

Exodus Recovery (Crisis Stabilization)

- Green flow sheet
- Adolescent/Youth Inter-Disciplinary Screening
- Risk Assessment
- Printout: Demographic Information
- Printout: MyAvatar Master Client Report (Hx of MH services)

Central Star PHF (Inpatient Hospitalization)

- Green flow sheet
- Fresno County MH Referral for Outpatient Therapy
- Psychiatric Evaluation
- Clinical Mental Health Assessment
- Central Star Aftercare instructions

ACCESS Packets are blue

Hospital/Exodus Packets are green

Chief Complaints and Presenting Problems (comments section)

Chief complaints should be more than just a laundry list!

- List first those symptoms and problem behaviors that finally brought the client in (will become initial focus at the beginning of treatment)
- Explore and then include additional symptoms and behaviors (pull out your DMS Desk Reference if necessary – it's OK ☺)
- Do not have to use clinical jargon! Client phrasing/descriptor can be just as telling

Presenting Problems/comments: Describe, describe, describe! By specific examples, client's words, unique experience every symptom/problem behavior identified

Chief Complaints and Presenting Problems (comments section)

Chief complaints should be more than just a laundry list!

- Comments section must start with **why are you doing the assessment at this time**
  - Is this a follow up to a crisis episode at Stars PHF/Exodus Recovery?
  - Referred by school psychologist or pediatrician?
  - Parent or child cannot tolerate (which) symptoms anymore?
- More information should be forthcoming in later sections of the assessment, but it is critical that an assessment as a result of a crisis event is noted, as it tells everyone involved there is an urgency to starting care.

Chief Complaints and Presenting Problems (comments section)

- History of Presenting Problems
  - **For each symptom/problem behavior, get client and family to estimate how long it has been a problem.** Include any precipitating event(s), triggers and stressors here.
  - For Exodus Recovery/Stars PHF follow up assessments: Indicate what symptoms or behaviors led to the 5150 hold

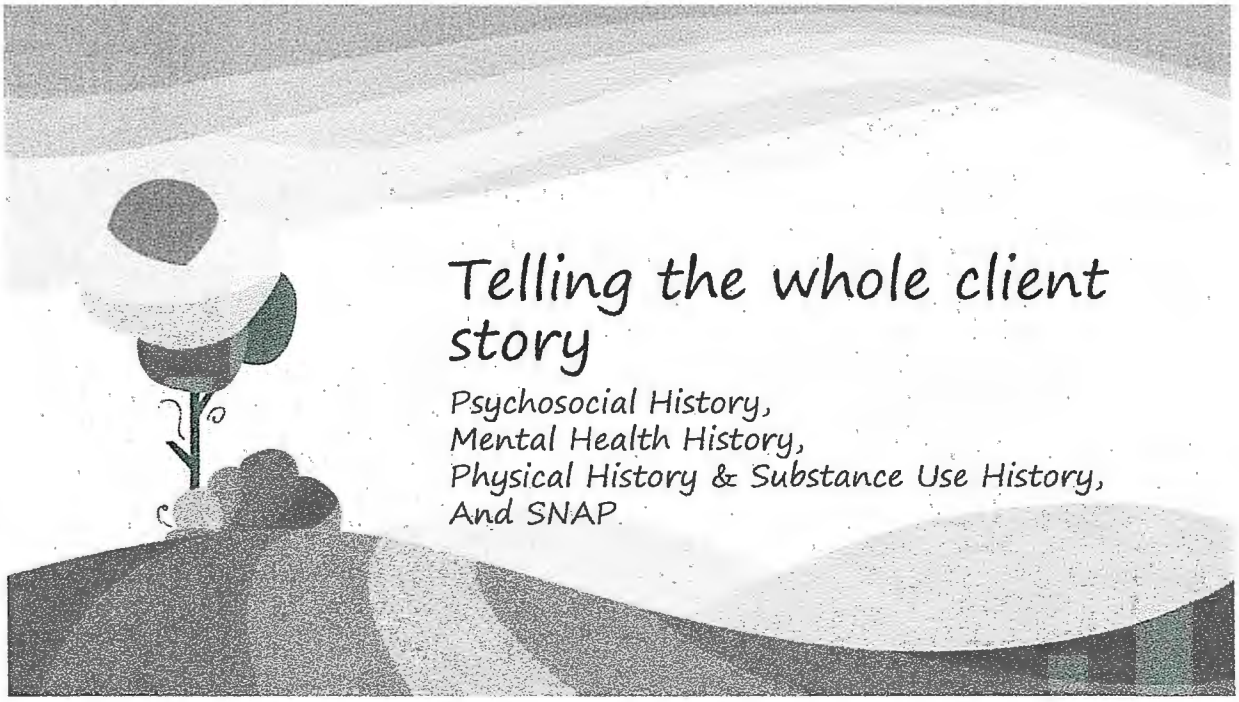
Did you know? Time spent reviewing clinical documentation provided by Exodus Recovery/Stars PHF prior to your assessment interview is claimable time! Considered collateral information, it helps you target your exploration for additional information when read first

Chief Complaints and Presenting Problems (comments section)

- History of Presenting Problems
  - Don't forget!
    - Provide comments from both the client and parent/legal guardian and use quotes (Sometimes we see assessments and wonder if the minor client was even present during assessment interview)
    - Follow up on all the symptoms identified in the "Exodus Adolescent/Youth Inter-Disciplinary Screening" and explore if there are any new symptoms

Chief Complaints and Presenting Problems =

What the client is experiencing right now



Telling the whole client story

Psychosocial History,
Mental Health History,
Physical History & Substance Use History,
And SNAP

Introducing SNAP: Strengths, Needs, Abilities, and Preferences

Your client's story is not only one of deficits (symptoms, problems, poor behaviors, negative thoughts)

When incorporating "Wellness and Recovery," just as much attention should be given to the client's strengths, needs, abilities, and preferences (SNAP).

New optional SNAP survey tool can help your client and you identify other important elements to your comprehensive assessment (especially after a crisis event!)

Telling the whole client story...

- Client's personal history
  - Not limited to "lives in house with mom, dad, two dogs and a turtle."
  - Do they live with biological parents, foster parents, other relatives? How many siblings, what are their ages, and how do they get along? What do mom/dad do for a living (how are the family's needs met?) And barriers – transportation, negative family relations, income struggles?
  - Situations that present a risk (Past SI and attempts; MH or AOD in the home
- Strengths/Abilities
  - Do not only rely on SNAP form – explore with the client and parent
- Cultural/Spiritual
  - How does the client identify self? (Hint: use client's words here)
  - Besides formal religious affiliation, ask, "What makes you feel connected to something bigger than yourself?"
- Academic/education
  - Besides grade, and brief statement of "good student" or "likes school," what's his/her favorite subject? How many friends? Afterschool activities?

Telling the whole story...

- Mental Health History
  - History of Present Illness: State in MH history if not clearly stated in Presenting Problem. Clearly identify precipitating event(s) and stressors
  - Previous Treatment and hospitalizations – Look up in the client's Master Client Report.
  - Always indicate dates client participated in treatment (i.e. "from January 2014-December 2014") and list specific dates of previous hospitalizations.
- Physical Health History
  - Relevant physical health conditions. Documentation includes medications, diagnoses, dates of initial prescriptions and refills, dosage of each medication, and documentation of informed consent for medications.
- Full Developmental History
- Substance Use History
  - Documentation includes past and present use/abuse of tobacco, alcohol, and caffeine, as well as illicit, prescribed, and over-the counter drugs

Providing Direction for Treatment: The Clinical Summary

Clinical Summary

- Recommended formula for your clinical summary:
  - Paragraph one: Review who the client is; what brought him/her to you (indicate recent CSU/hospitalization visit, referral or client reason); Review all symptoms/problem behaviors with frequency and/or intensity (these are your baselines for later treatment plan), and how long each symptom has been present.
  - Paragraph two: Your conceptualization – what do you believe to be the cause; from your theoretical perspective, how do you explain your client's situation?
  - Paragraph three: Full diagnostic string and recommendations for care
    - "Based on the presentation at the time of this assessment along with collateral information provided by/through...the client currently meets criteria for the diagnosis of:..."
    - Rule-Outs should be listed in clinical summary, but not entered in Avatar
    - Be specific as to what interventions should be included in recommended treatment

Final Notes

- Recent DHCS training stated that determining medical necessity is critical
  - Not just enough to have a diagnosis on the approved list
  - Diagnostic criteria is still spelled out in DSM
  - Must demonstrate current symptomology that is related to the specific diagnosis
  - A complete, thoughtful, and comprehensive case formulation relevant to the current diagnosis is required (often see diagnosis with no matching symptoms or criteria)
  - Keep in mind certain diagnosis (e.g. Adjustment D/O; Unspecified mental health conditions) are time limited

Attachment N
Medication Consent Form, Medication Monitoring Tool, and Schedule

Compliance Program Documentation Review Dates-

Name:	ID #:	Provider: _____ CC: _____
	CCN:	Dates of Service: ___/___/___/___/___/___/___
DX:	DOB:	Duration: ___/___/___/___/___/___/___

1. **Consent for Treatment (Disallowance: if not properly executed)**
   - ☐ Client Signature ☐ *Conservator/Guardian/Parent* Signature
   - ☐ Client Dated: _____
     - ☐ *Conservator/Guardian/Parent* Dated: _____
   - ☐ Notice of Privacy: Dated _____
   - ☐ Legal document _____ (Dated)_____

2. **Psychiatric Evaluation Date: _____ done minimum of every 2 years or current Mental Status Exam**
   - ☐ All pages signed (either electronically or manually)
   - ☐ Included Dx (needed for ongoing Tx)
   - ☐ Substance Abuse/dependence addressed

3. **Plan of Care (Disallowance if not current & properly executed)**
   - ☐ Services within 60 days of initial assessment
   - ☐ Current **POC** Date: _____ ☐ Current **PPOC** Date: _____
   - ☐ Signed & Dated by ☐ Client ☐ *Conservator/Guardian/Parent*
   - ☐ Signed & ☐ Dated by Staff
   - ☐ Includes services /interventions (Tx. modality on POC)provided
   - ☐ Behavioral Goals tied to services and Dx
   - ☐ Medical Necessity (Impairment/Deterioration/Delay Criteria)

4. **Review Medication/Safety Issues: Informed Medication Consent (Quality of Care Issue: if not properly executed)**
   - ☐ Signed and properly executed
   - ☐ JV-223 req. ☐ JV-220A Box 3 checked if emergent
   - ☐ Medication orders: dosage, schedule, quantity, duration
   - ☐ Medication is appropriate for diagnosis or treatment of symptoms.
   - ☐ Response of target symptoms to medication documented.
   - ☐ Adherence is addressed.
   - ☐ Required lab work **ordered** to monitor psychotropic medications
   - ☐ Unusual concomitant prescribing not present.
   - ☐ AIMS survey current (minimum done yearly if on antipsychotics)
   - ☐ Allergies noted
   - ☐ Prescribed Medications **listed on consent match ones on Info Scriber**

5. **Progress Notes (PN)**
   - ☐ Signed by provider w/licensure
   - ☐ Dx claimed match the Dx of PN
   - ☐ Date of Service(DOS) match date of PN
   - ☐ Units claimed match units on PN
   - ☐ Service code (POV)claimed match content of PN
     - ☐ 170/190 (Psychiatric Eval. w/visit)
     - ☐ 172/192 (MD visit med stabilization after 1 yr.)
     - ☐ 173/193 (MD visit med stabilization 6mo.- over 1 yr.)
     - ☐ 47 (Physician phone call)
   - ☐ Dx missing (Disallowance for Medicare ONLY ☐)
   - ☐ Dx on PN ☐ Includes all required digits
   - ☐ Signature date **present but different** from service date.
   - ☐ Legible ☐ Difficult to Read ☐ Not Legible (Disallowance)
   - ☐ Face-to-face time recorded
   - ☐ Other billable time (travel & documentation) recorded

Comments

☐ **Claim OK** ☐ **Correction Required** ☐ **Disallowances**

Reviewed by: _____, Managed Care

Initials: _____ Date: _____

List of Doctors, Attending's, NP's, Telemed's & Residents to Be Audited
For Medication Monitoring 2014, 2015
(Review period in red)

MD	Date of Review	Practice Location
Ahmed 1/1/15 – 6/30/15 025675	2/4/2016	Metro
Akhbarati 10/1/13-3/31/14	5/6/2014	Metro
Arrieta 023163		Metro
Arrieta-Zorro 10/1/13-3/31/14	5/22/2014	Heritage
Atwal 026129		Heritage
Borchardt 11/1/13-04/30/14	7/3/2014	Heritage
Chu 11/1/13-04/30/14	6/23/2014	Metro (SEES)
Collado 12/01/13-05/31/14	7/17/2014	Metro
Garcia 02/01/14-07/31/14	9/4/2014	Metro
Gaur 03/01/14-08/31/14	10/6/2014	Heritage
Luu 03/01/14-08/31/14	10/27/2014	Metro
Hayat 03/01/14-08/31/14	10/1/2014	Heritage
Mallada 1/1/15 – 6/30/15 016459	12/4/2015	Metro
Murillo 04/01/14-09/30/14	7/17/2014, 10/29/2014	Metro
Raypon 12/1/12 – 5/31/2013		Metro
Rauf 05/01/14-10/31/14	12/31/2014	Heritage
Salazar 1/15/2015-6/30/15 007649	12/16/15	Metro
Santy 05/01/14-10/31/14	12/31/2014	Metro
Szpyt-Domanska 07/01/14-12/31/14	1/30/2015	Heritage
Tan 1/01/15 -6/30/15 017120 or 901368	12/15/15	Metro
Vaadyala 022748 or 900266	Pending	Metro
Wong, James (SEES) 024591	Pending	Metro
Weissberg 901535	Pending	Older Adult
Alimasuya 10/1/13-3/31/14	5/22/2014	Heritage (no longer here)
NP		
Fox 002398	Pending	Heritage
Parker 901681		Older Adult
Tsang 003703	Pending	Older Adult
Telemed		
Balog (term 12/13/15)	---	Metro
Brooks 11/1/13-04/30/14	7/3/2014	Metro
Connor 02/01/14-07/31/14	9/8/2014	Older Adult
Kim 901682		Metro
Parker 901681		Metro
Rambo 901542	Pending	Metro
Webber-Klein 901079	Pending	Metro
Wong, Donovan 901316	Pending	Metro
Schaeffer – owner of telemed company Stefanovic 900150	7/30/2014 3/26/2014	

List of Doctors, Attending's, NP's, Telemed's & Residents to Be Audited
For Medication Monitoring 2014, 2015

(Review period in red)

Strong	900898	12/10/2013, Pending	
Zhu	901138	12/11/2013, Pending	
Residents			
Beauchene	11/1/13-04/30/14	6/23/2014	Metro
Quest	901262	Pending	Metro
Ramsinghani	901513	Pending	Metro
Reddy	901514	Pending	Metro
Sethuram	901515	Pending	Metro

The purpose of Medication Monitoring is to review the medication regimen and current standards of practice for efficacy and appropriateness based upon diagnosis, symptoms and treatment. The review will consist of two components: Quality of Care and Utilization Review. Managed Care Utilization Review Specialists (URS) conduct these reviews of medication services provided by county DBH doctors, tele-psychiatrists, attending doctors, nurse practitioners, and residents.

1. The URS reviews medical records and audits for disallowances and non-compliance. The client's treatment history of claimed services (paid and unpaid claims) will be compared with documentation of medication services delivered.
2. Claims reviewed are limited to these medication services: Medication Evaluation Management – Assessment; Medication Evaluation Management Brief; Medication Evaluation Management Follow-up; Medication Evaluation Management – Telemedicine; Medication Evaluation Management Brief – Telemedicine; Medication Evaluation Management Follow-up – Telemedicine, and; Medication Support by phone
3. The audit sample size is the lesser of 10% or 30 claims by a medical practitioner. The review period is the date range of services to be reviewed. This includes the six (6) most recent months of claimed services from the month of review. For example, if the review is being performed in June 2015, claims reviewed will be for the dates of service from December 2014 to May 2015. Unpaid claims will be considered "paid" at Medi-Cal rates.

FRESNO COUNTY MENTAL HEALTH PLAN
DEPARTMENT OF BEHAVIORAL HEALTH
INFORMED CONSENT FOR MEDICATION

This is to acknowledge that I have had a discussion with my/my child's provider, concerning my/my child's prescription(s) of the following checked medication(s). This discussion included, but was not limited to the following:

- The reasons for taking such medication(s);
- Reasonable alternative treatments available such as Individual or Group psychotherapy, Evidence Based Treatments: Dialectical Behavioral Therapy, Trauma-Focused Cognitive Behavioral Therapy;
- The type, frequency, dosage, route (e.g. oral, injection, patch, or nasal spray), and duration of taking the medication; probable side effects; possible additional side effects which may occur when taking such medication beyond three (3) months;
- This consent, once given, may be withdrawn at any time by me either verbally or written;
- Regular blood testing done for specific medication blood level as needed.

☐ Antipsychotic _____
Medication, dosage or range, frequency, method (oral or injection), duration and indication

Some possible side effects: nausea, vomiting, dizziness, metabolic syndrome-significant weight gain and if your blood sugar is very high, you might experience signs and symptoms of diabetes which may include elevated blood sugars/lipids, increased thirst and urination, fatigue and blurred vision), sedation, seizures, sexual problems, restlessness, tremor, stiff muscles, **tardive dyskinesia** (involuntary movements of face, mouth or head, neck, arms, hands and feet are potentially irreversible and may appear even after these medications have been stopped), **neuroleptic malignant syndrome** (also called "NMS", a rare medical emergency marked by high fever, rigidity, delirium, circulatory and respiratory collapse), increased risks of stroke or cardiovascular accidents. Additionally for **clozapine**: seizures; lowered white blood cell count leading to infections (**requires regular blood checks**); and, rarely, damage to heart. **Black-Box warning for suicidality and increased mortality risk when used for dementia-related psychosis and youth.**

☐ Anti-Extrapyramidal (EPS) Medication _____
Medication, dosage or range, frequency, method (oral or inject), duration and indication

Some possible side effects: for Benztropine (Cogentin); Trihexyphenidyl (Artane) and diphenhydramine (Benadryl): Blurred vision, fatigue, mental dulling, dizziness, trouble urinating, dry mouth, constipation, etc.

☐ Antidepressant _____
Medication, dosage or range, frequency, method (oral or injection), duration and indication

Some possible side effects: mania, nausea, vomiting, appetite/weight changes, headaches, dizziness, sedation, sleep disturbances, dry mouth, sexual/erectile problems, seizures, abnormal internal bleeding, serotonin syndrome-(having high levels of serotonin in the body) resulting from taking a selective serotonin reuptake inhibitor (SSRI) or overdosing on a SSRI at the same time with illicit drugs, over the counter cough/cold meds, anti-nausea medications, and/or some pain medications. This may cause muscle rigidity, fever, seizures, agitation, confusion and shivering, persistent pulmonary hypertension of the newborn. ***In youth: Suicidal thoughts and behavior, mood changes, sleep disturbances, irritability, outbursts, hostility, and violence may occur.***

☐ Antianxiety/Hypnotic_____
Medication, dosage or range, frequency, method (oral or injection), duration and indication

Some possible side effects: drowsiness, trouble concentrating, confusion, clumsiness, dizziness, weakness, decreased reflexes, difficulty driving, operating machinery and loss of inhibition, addiction, respiratory depression (especially when combined with other medications or alcohol).

☐ Mood Stabilizer_____
Medication, dosage or range, frequency, method (oral or injection), duration and indication

Some possible side effects: nausea, vomiting, skin rash, weight gain, thyroid/kidney problems, dizziness, confusion, tiredness and birth defects. Additionally for **Divalproex (Depakote):** liver/pancreas problems, ovarian problems, birth defects; for **Carbamazepine (Tegretol); Lamotrigine (Lamictal)**: potential life-threatening skin rash (**Steven-Johnson Syndrome)**

☐ Lithium_____

Medication, dosage or range, frequency, method (oral or injection), duration and indication

Some possible side effects: nausea, vomiting, diarrhea, tiredness, mental dulling, confusion, weight gain, thirst, increased urination, tremors, acne, thyroid disorder, birth defects, heart conduction problems, potentially lethal in overdose, **requires regular medication blood levels checks.**

☐ ADHD Medications_____

Medication, dosage or range, frequency, method (oral or injection), duration and indication

Some possible side effects: loss of appetite, decreased growth, trouble sleeping, restlessness, nausea, changes in blood pressure/heartbeat, risk of sudden unexplained death. **Additionally** for **Strattera**: rare liver injury with possible jaundice (yellow skin and eyes) abdominal pain, itchy skin, flu-like symptoms, dark urine. Additionally for **Amphetamine, methylphenidate, guanfacine formulations (Adderall, Concerta, Daytrana, Tenex, Intuniv):** risk of sudden unexplained death, primarily with (undetected) underlying cardiac structural abnormalities, visual hallucinations. **Clonidine:** AV Block, orthostatic hypotension. ***Especially in youth: Suicidal thoughts and behavior, mood changes, sleep disturbances, irritability, outbursts, hostility, and violence.***

☐ Others_____

Medication, dosage or range, frequency, method (oral or injection), duration and indication

☐ I understand that the following medication(s) is not FDA-approved for the purpose for which it is being prescribed, and is being prescribed "off-label". I accept the risk in this treatment as both my provider and I both believe that the potential benefits outweigh the risks.

"Off-label" medication(s): _____

Intended benefit(s):_____

Possible common or serious side effects: _____

☐ I was offered printed materials or oral explanation in my preferred language about my current medications, dosages, and side effects.

☐ I have read this form ☐ This form has been read to me by _____.

☐ This form was interpreted in _____for me.

If a translated version of this Form was signed by the client and/or guardian, the translated version must be attached to the English version.

_____ _____ _____

Client/Parent/Guardian/Conservator Signature | Legal Relationship | Date

☐ Copy given ☐ Copy refused

☐ Patient consents to the use of psychotropic medication(s) but refuses to sign a written consent form (Title 9, Div. 1, § 852) Authority cited: section 5325; 5325.1 and 5326.95 WIC.

I have explained the benefits, risks and alternative therapies as well as side effects of the medication listed above and have obtained the clients/responsible adult's informed consent.

Signature: _____ **Date:** _____

Psychiatrist/NP/PA

☐ I withdraw this consent

NAME: _____

Attachment O
Expiring Treatment Plans by Caseload Report

Department of Behavioral Health

Missing or Expiring Treatment Plans by Caseload

MM-00096

Data Date: 1/24/2014

This report lists the clients who are missing a treatment plan, have an expired treatment plan or his/her treatment plan is going to expire within 60 days of current date. The report queries the Fresno Treatment Plan and the Medical Plan of Care and the Brief Treatment Plan Information form and uses the latest expiration date. It is either run by supervisor caseload or individual user caseload. The client row is color coded:

Red = Plan Expired

Yellow = Expires in 60 days

Silver = No Treatment Plan on file

This report is run by supervisor for Lesby Flores, LMFT

Staff: Adolph Vidal, ASW

Client Name	PATID	Caseload	Plan Expiration Date
[redacted]	[redacted]	CHILDRENS CLINICIANS	3/25/2014

Staff: Aimie Rojas, LCSW

Client Name	PATID	Caseload	Plan Expiration Date
[redacted]	[redacted]	CHILDRENS CLINICIANS	
[redacted]	[redacted]	[redacted]	

Staff: Chery Mccarter, LMFT

Client Name	PATID	Caseload	Plan Expiration Date
[redacted]	[redacted]	CHILDRENS CLINICIANS	
[redacted]	[redacted]	CHILDRENS CLINICIANS	
[redacted]	[redacted]		
[redacted]	[redacted]	CHILDRENS CLINICIANS	
[redacted]	[redacted]		

Attachment P
Disallowance Report

Department of Behavioral Health
Submitted Scarfs

MM-00087
Data Date: 4/8/2016

Request Still Pending

Requesting Program: 2230Y-DT-Bayfront Youth & Family Srvs **Service Type:** Individual Service

Submitter Phone Number: 600-4663 **Date of Service:** 7/1/2014

Request Type: Service Adjustment

Client or Group Specified: [redacted]

Service To Edit: ORIG_JOIN_ID: 63369.001 Service Date: 7/1/2014 Service Code: 62-Day Tx Intensive (full-day) Program: 2230Y-DT-Bayfront Youth & Family Srvs Location: Group Home Practitioner: VASQUEZ,CHEYENNE Duration: 0.00 F2F Time: 0 OB Time: 0 Co-Practitioner ID: Co Practition Duration: 0.00 Co F2F Time: 0 Co OB Time: 0 Primary Diagnosis: Client ID: [redacted] Client Name: [redacted] Episode: 4-2230Y-DT-Bayfront Youth & Family Srvs Entry Screen: Client Charge Input Data Entry Date: 8/19/2014 Data Entry Time: 01:27 PM # of Clients in Group: 0.00 Note ID:

Fields to Edit: Delete Service

Identify the data that needs to change: No updated client plan in the medical record

Specify Diagnosis: **Specify New Episode:**

Reason for UR Adjustment:

UR Adjustment Comments:

Request Date: 4/4/2016

Pending Resolution Comments:

Completion Comments:

Date Request Completed:

Last Data Entry By: Dee Howell, PRS
Last Data Entry Date: 4/4/2016
Last Data Entry Time: 03:20 PM
SCARF Filed under User ID: ROCHOA

Request Still Pending

Requesting Program: 2230Y-DT-Bayfront Youth & Family Srvs **Service Type:** Individual Service

Submitter Phone Number: 600-4663 **Date of Service:** 7/2/2014

Request Type: Service Adjustment

Client or Group Specified: [redacted]

Service To Edit: ORIG_JOIN_ID: 63370.001 Service Date: 7/2/2014 Service Code: 62-Day Tx Intensive (full-day) Program: 2230Y-DT-Bayfront Youth & Family Srvs Location: Group Home Practitioner: VASQUEZ,CHEYENNE Duration: 0.00 F2F Time: 0 OB Time: 0 Co-Practitioner ID: Co Practition Duration: 0.00 Co F2F Time: 0 Co OB Time: 0 Primary Diagnosis: Client ID: [redacted] Client Name: [redacted] Episode: 4-2230Y-DT-Bayfront Youth & Family Srvs Entry Screen: Client Charge Input Data Entry Date: 8/19/2014 Data Entry Time: 01:27 PM # of Clients in Group: 0.00 Note ID:

Fields to Edit: Delete Service

Identify the data that needs to change: No updated client plan in the medical record

Specify Diagnosis: **Specify New Episode:**

Reason for UR Adjustment:

UR Adjustment Comments:

Request Date: 4/4/2016

Pending Resolution Comments:

Completion Comments:

Date Request Completed:

Last Data Entry By: Dee Howell, PRS
Last Data Entry Date: 4/4/2016
Last Data Entry Time: 03:24 PM
SCARF Filed under User ID: ROCHOA

Request Still Pending

Requesting Program: 2230Y-DT-Bayfront Youth & Family Srvs **Service Type:** Individual Service

Submitter Phone Number: 600-4663 **Date of Service:** 7/3/2014

Request Type: Service Adjustment

Client or Group Specified: [redacted]

Service To Edit: ORIG_JOIN_ID: 63371.001 Service Date: 7/3/2014 Service Code: 62-Day Tx Intensive (full-day) Program: 2230Y-DT-Bayfront Youth & Family Srvs Location: Group Home Practitioner: VASQUEZ,CHEYENNE Duration: 0.00 F2F Time: 0 OB Time: 0 Co-Practitioner ID: Co Practition Duration: 0.00 Co F2F Time: 0 Co OB Time: 0 Primary Diagnosis: Client ID: [redacted] Client Name: [redacted] Episode: 4-2230Y-DT-Bayfront Youth & Family Srvs Entry Screen: Client Charge Input Data Entry Date: 8/19/2014 Data Entry Time: 01:27 PM # of Clients in Group: 0.00 Note ID:

Fields to Edit: Delete Service

Identify the data that needs to change: NO UPDATED CLIENT PLAN IN THE MEDICAL RECORD

Specify Diagnosis: **Specify New Episode:**

Reason for UR Adjustment:

UR Adjustment Comments:

Request Date: 4/4/2016

Pending Resolution Comments:

Completion Comments:

Date Request Completed:

Last Data Entry By: Dee Howell, PRS

Last Data Entry Date: 4/4/2016

Last Data Entry Time: 03:27 PM

SCARF Filed under User ID: ROCHOA

Request Still Pending

Requesting Program: 2230Y-DT-Bayfront Youth & Family Srvs **Service Type:** Individual Service

Submitter Phone Number: 600-4663 **Date of Service:** 7/5/2014

Request Type: Service Adjustment

Client or Group Specified: [redacted]

Service To Edit: ORIG_JOIN_ID: 63373.001 Service Date: 7/5/2014 Service Code: 62-Day Tx Intensive (full-day) Program: 2230Y-DT-Bayfront Youth & Family Srvs Location: Group Home Practitioner: RIOS,SAUL Duration: 0.00 F2F Time: 0 OB Time: 0 Co-Practitioner ID: Co Practition Duration: 0.00 Co F2F Time: 0 Co OB Time: 0 Primary Diagnosis: Client ID: [redacted] Client Name: [redacted] Episode: 4-2230Y-DT-Bayfront Youth & Family Srvs Entry Screen: Client Charge Input Data Entry Date: 8/19/2014 Data Entry Time: 01:28 PM # of Clients in Group: 0.00 Note ID:

Fields to Edit: Delete Service

Identify the data that needs to change: NO UPDATED CLIENT PLAN IN THE MEDICAL RECORD

Specify Diagnosis: **Specify New Episode:**

Reason for UR Adjustment:

UR Adjustment Comments:

Request Date: 4/4/2016

Pending Resolution Comments:

Completion Comments:

Date Request Completed:

Last Data Entry By: Dee Howell, PRS

Last Data Entry Date: 4/4/2016

Last Data Entry Time: 03:29 PM

SCARF Filed under User ID: ROCHOA

Request Still Pending

Requesting Program: 2230Y-DT-Bayfront Youth & Family Srvs **Service Type:** Individual Service

Submitter Phone Number: 600-4663 **Date of Service:** 7/7/2014

Request Type: Service Adjustment

Client or Group Specified: [redacted]

Service To Edit: ORIG_JOIN_ID: 63375:001 Service Date: 7/7/2014 Service Code: 62-Day Tx Intensive (full-day) Program: 2230Y-DT-Bayfront Youth & Family Srvs Location: Group Home Practitioner: VASQUEZ,CHEYENNE Duration: 0:00 F2F Time: 0 OB Time: 0 Co-Practitioner ID: Co Practition Duration: 0.00 Co F2F Time: 0 Co OB Time: 0 Primary Diagnosis: Client ID: [redacted] Client Name: [redacted] Episode: 4-2230Y-DT-Bayfront Youth & Family Srvs Entry Screen: Client Charge Input Data Entry Date: 8/19/2014 Data Entry Time: 01:27 PM # of Clients in Group: 0.00 Note ID:

Fields to Edit: Delete Service

Identify the data that needs to change: NO UPDATED CLIENT PLAN IN THE MEDICAL RECORD

Specify Diagnosis: **Specify New Episode:**

Reason for UR Adjustment:

UR Adjustment Comments:

Request Date: 4/4/2016

Pending Resolution Comments:

Completion Comments:

Date Request Completed:

Last Data Entry By: Dee Howell, PRS

Last Data Entry Date: 4/4/2016

Last Data Entry Time: 03:31 PM

SCARF Filed under User ID: ROCHOA

Request Still Pending

Requesting Program: 2230Y-DT-Bayfront Youth & Family Srvs **Service Type:** Individual Service

Submitter Phone Number: 600-4663 **Date of Service:** 7/8/2014

Request Type: Service Adjustment

Client or Group Specified: [redacted]

Service To Edit: ORIG_JOIN_ID: 63376:001 Service Date: 7/8/2014 Service Code: 62-Day Tx Intensive (full-day) Program: 2230Y-DT-Bayfront Youth & Family Srvs Location: Group Home Practitioner: VASQUEZ,CHEYENNE Duration: 0:00 F2F Time: 0 OB Time: 0 Co-Practitioner ID: Co Practition Duration: 0.00 Co F2F Time: 0 Co OB Time: 0 Primary Diagnosis: Client ID: [redacted] Client Name: [redacted] Episode: 4-2230Y-DT-Bayfront Youth & Family Srvs Entry Screen: Client Charge Input Data Entry Date: 8/19/2014 Data Entry Time: 01:27 PM # of Clients in Group: 0.00 Note ID:

Fields to Edit: Delete Service

Identify the data that needs to change: NO UPDATED CLIENT PLAN IN THE MEDICAL RECORD

Specify Diagnosis: **Specify New Episode:**

Reason for UR Adjustment:

UR Adjustment Comments:

Request Date: 4/4/2016

Pending Resolution Comments:

Completion Comments:

Date Request Completed:

Last Data Entry By: Dee Howell, PRS

Last Data Entry Date: 4/4/2016

Last Data Entry Time: 03:33 PM

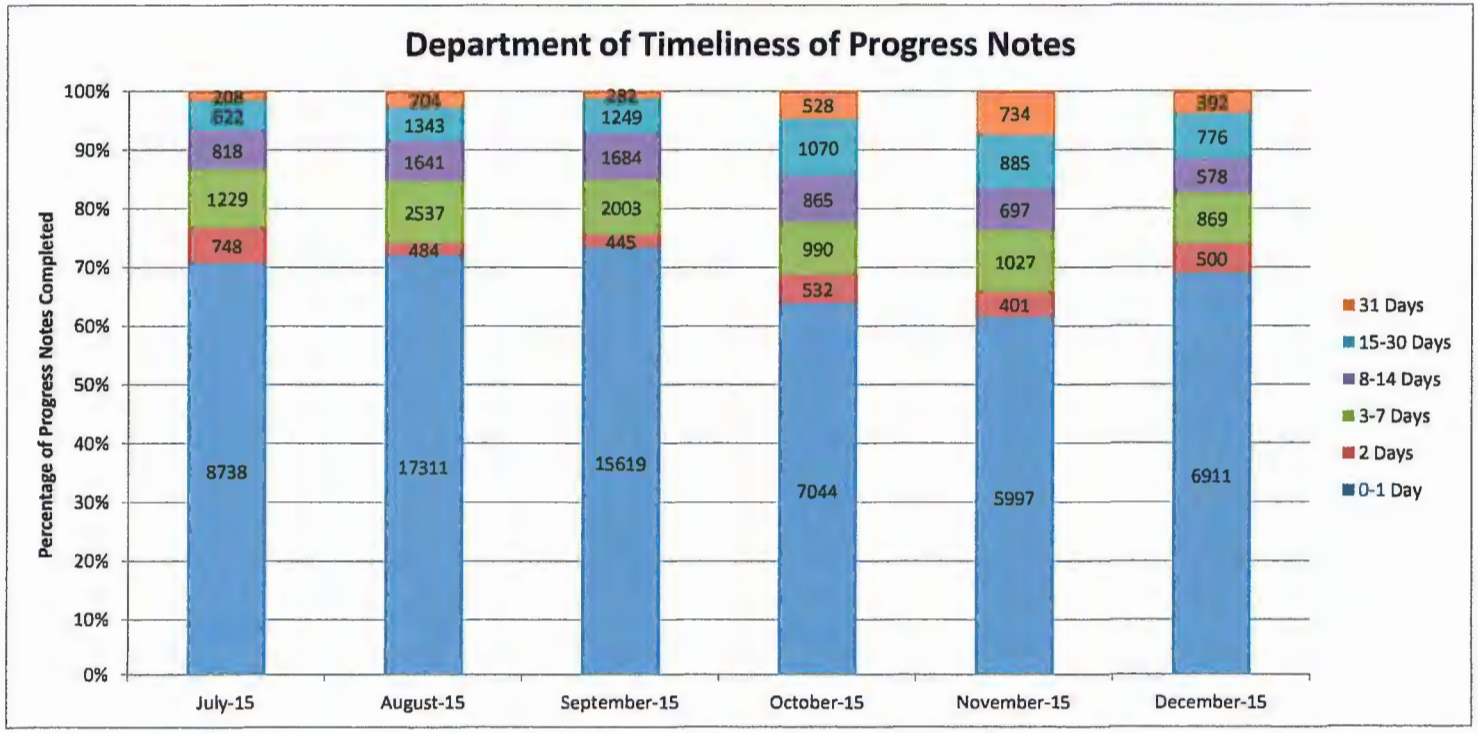
SCARF Filed under User ID: ROCHOA

Attachment Q
Timeliness of Progress Notes Report

Timeliness of Progress Notes Report
Department

# of Progress Notes Completed

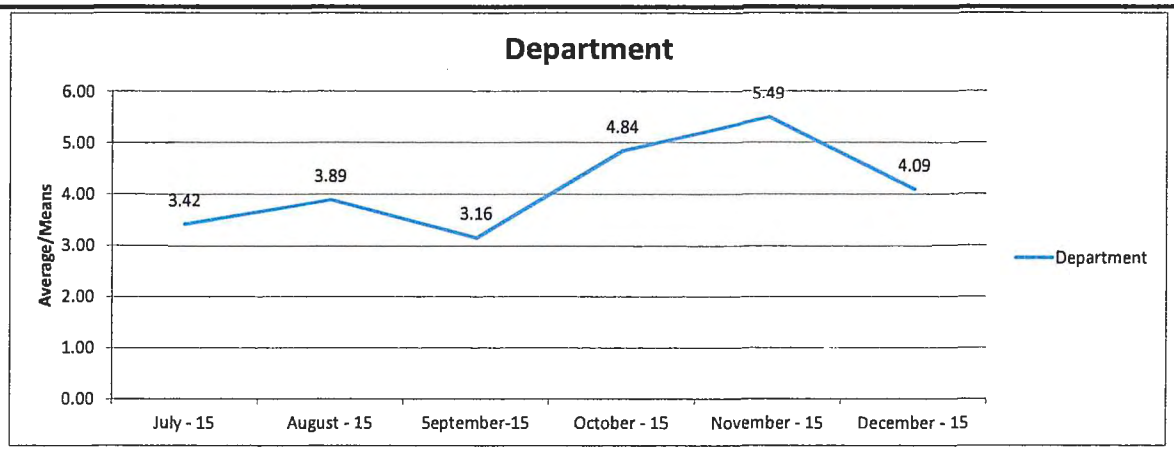
Days Took To Compl	July-15	%	August-15	%	September-15	%	October-15	%	November-15	%	December-15	%
0-1 Day	8738	70%	17311	72%	15619	72%	7044	64%	5997	62%	6911	69%
2 Days	748	6%	484	2%	445	3%	532	5%	401	4%	500	5%
3-7 Days	1229	10%	2537	10%	2003	8%	990	9%	1027	10%	869	9%
8-14 Days	818	7%	1641	7%	1684	8%	865	8%	697	7%	578	6%
15-30 Days	622	5%	1343	6%	1249	8%	1070	10%	885	9%	776	7%
31 Days	208	2%	704	3%	282	1%	528	4%	734	8%	392	4%
Total	12,363	100%	24,020	100%	21,282	100%	11,029	100%	9741	100%	10,026	100%
					DMS-5 & ICD 10 issue		DMS-5 & ICD 10 issue					



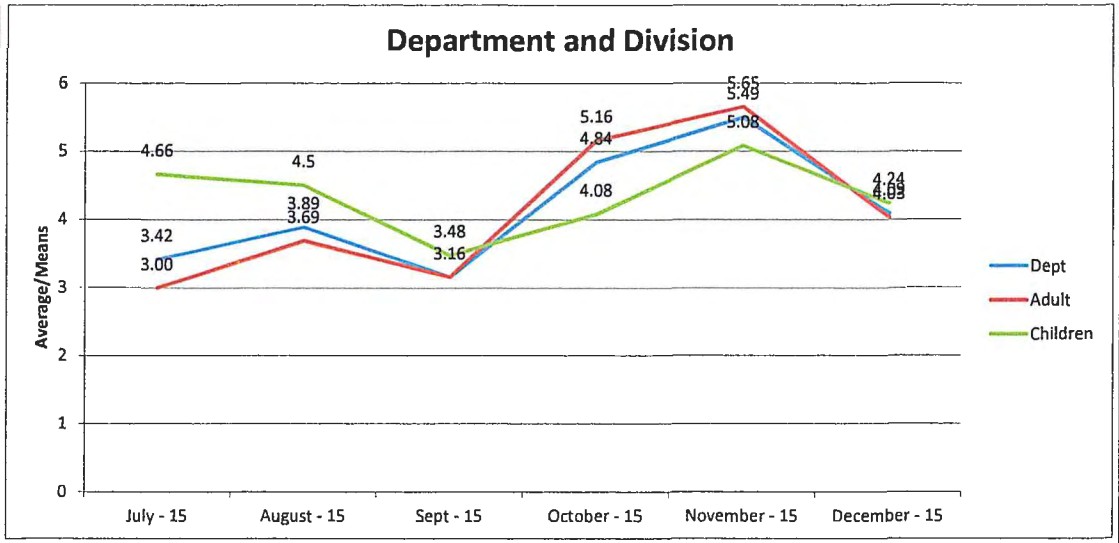
Submitted by Sue Ann N 1/5/16

Month	Department	
July - 15	3.42	
August - 15	3.89	
September-15	3.16	had DSM-5 & ICD-10 issue
October - 15	4.84	had DSM-5 & ICD-10 issue
November - 15	5.49	
December - 15	4.09	

% of Change since July-15 ↑19%



Month	Dept	Adult	Children
July - 15	3.42	3.00	4.66
August - 15	3.89	3.69	4.5
Sept - 15	3.16	3.16	3.48
October - 15	4.84	5.16	4.08
November - 15	5.49	5.65	5.08
December - 15	4.09	4.03	4.24



Created by Sue Ann 1/05/16

Data Entry By	Practitioner Name	Service Charge Code	Service Duration	Service Program Value	Data Entry Date	Date of Service	Date Diff	Work Days	Number of Days Diff in Group
		40	21	0-Admissions-Adult Doc	12/29/2015	12/29/2015	0	1	0-1
		173	37	0-Admissions-Adult Doc	12/9/2015	12/9/2015	0	1	0-1
		205	28	0-Admissions-Adult Out	12/31/2015	11/16/2015	45	31	31 Days and Over
		173	30	0-Admissions-Children's	12/3/2015	12/3/2015	0	1	0-1
		385	180	2110-Exodus Crisis Sta	12/29/2015	12/28/2015	1	2	0-1
		385	180	2110-Exodus Crisis Sta	12/29/2015	12/28/2015	1	2	0-1
		385	310	2110-Exodus Crisis Sta	12/30/2015	12/30/2015	0	1	0-1
		385	310	2110-Exodus Crisis Sta	12/30/2015	12/30/2015	0	1	0-1
		305	5	2116-Employment Serv	12/16/2015	12/15/2015	1	2	0-1
		305	10	2116-Employment Serv	12/3/2015	11/2/2015	31	21	31 Days and Over
		305	10	2116-Employment Serv	12/3/2015	11/3/2015	30	20	15-30 Days
		359	15	2116-Employment Serv	12/29/2015	12/29/2015	0	1	0-1
		385	15	2116-Employment Serv	12/17/2015	12/15/2015	2	3	2 Days
		385	15	2116-Employment Serv	12/17/2015	12/15/2015	2	3	2 Days
		385	15	2116-Employment Serv	12/17/2015	12/17/2015	0	1	0-1
		385	15	2116-Employment Serv	12/17/2015	12/15/2015	2	3	2 Days
		385	15	2116-Employment Serv	12/17/2015	12/15/2015	2	3	2 Days
		385	15	2116-Employment Serv	12/17/2015	12/15/2015	2	3	2 Days
		385	15	2116-Employment Serv	12/17/2015	12/15/2015	2	3	2 Days
		385	15	2116-Employment Serv	12/17/2015	12/15/2015	2	3	2 Days
		385	15	2116-Employment Serv	12/17/2015	12/15/2015	2	3	2 Days
		385	15	2116-Employment Serv	12/17/2015	12/15/2015	2	3	2 Days
		385	15	2116-Employment Serv	12/17/2015	12/15/2015	2	3	2 Days
		385	15	2116-Employment Serv	12/17/2015	12/15/2015	2	3	2 Days
		385	15	2116-Employment Serv	12/17/2015	12/15/2015	2	3	2 Days
		385	15	2116-Employment Serv	12/17/2015	12/15/2015	2	3	2 Days
		373	15	2116-Employment Serv	12/8/2015	12/8/2015	0	1	0-1
		373	15	2116-Employment Serv	12/10/2015	12/10/2015	0	1	0-1
		373	15	2116-Employment Serv	12/1/2015	12/1/2015	0	1	0-1
		373	15	2116-Employment Serv	12/3/2015	12/3/2015	0	1	0-1
		373	15	2116-Employment Serv	12/29/2015	12/29/2015	0	1	0-1
		372	15	2116-Employment Serv	12/8/2015	12/8/2015	0	1	0-1
		385	18	2116-Employment Serv	12/11/2015	12/10/2015	1	2	0-1
		385	19	2116-Employment Serv	12/2/2015	11/17/2015	15	10	15-30 Days
		385	19	2116-Employment Serv	12/2/2015	11/17/2015	15	10	15-30 Days
		385	18	2116-Employment Serv	12/2/2015	11/17/2015	15	10	15-30 Days
		385	19	2116-Employment Serv	12/2/2015	11/17/2015	15	10	15-30 Days
		385	19	2116-Employment Serv	12/2/2015	11/17/2015	15	10	15-30 Days
		385	19	2116-Employment Serv	12/2/2015	11/17/2015	15	10	15-30 Days
		385	19	2116-Employment Serv	12/2/2015	11/17/2015	15	10	15-30 Days
		385	19	2116-Employment Serv	12/2/2015	11/17/2015	15	10	15-30 Days
		385	19	2116-Employment Serv	12/2/2015	11/17/2015	15	10	15-30 Days
		385	19	2116-Employment Serv	12/2/2015	11/17/2015	15	10	15-30 Days
		305	20	2116-Employment Serv	12/3/2015	11/2/2015	31	21	31 Days and Over
		359	20	2116-Employment Serv	12/4/2015	12/4/2015	0	1	0-1
		359	20	2116-Employment Serv	12/28/2015	12/28/2015	0	1	0-1
		359	20	2116-Employment Serv	12/11/2015	12/9/2015	2	3	2 Days
		359	20	2116-Employment Serv	12/28/2015	11/18/2015	40	26	31 Days and Over
		359	20	2116-Employment Serv	12/17/2015	12/17/2015	0	1	0-1
		359	20	2116-Employment Serv	12/28/2015	12/14/2015	14	10	15-30 Days
		359	20	2116-Employment Serv	12/9/2015	12/9/2015	0	1	0-1
		359	20	2116-Employment Serv	12/18/2015	12/18/2015	0	1	0-1
		359	20	2116-Employment Serv	12/28/2015	10/6/2015	83	56	31 Days and Over
		359	20	2116-Employment Serv	12/28/2015	11/9/2015	49	32	31 Days and Over
		305	20	2116-Employment Serv	12/16/2015	12/14/2015	2	3	2 Days
		358	20	2116-Employment Serv	12/4/2015	12/4/2015	0	1	0-1
		305	21	2116-Employment Serv	12/22/2015	12/22/2015	0	1	0-1
		385	22	2116-Employment Serv	12/7/2015	12/3/2015	4	3	3-7 Days
		385	22	2116-Employment Serv	12/7/2015	12/3/2015	4	3	3-7 Days
		385	22	2116-Employment Serv	12/7/2015	12/3/2015	4	3	3-7 Days
		385	22	2116-Employment Serv	12/7/2015	12/3/2015	4	3	3-7 Days
		385	22	2116-Employment Serv	12/7/2015	12/3/2015	4	3	3-7 Days
		385	22	2116-Employment Serv	12/7/2015	12/3/2015	4	3	3-7 Days
		385	22	2116-Employment Serv	12/7/2015	12/3/2015	4	3	3-7 Days
		358	23	2116-Employment Serv	12/14/2015	12/14/2015	0	1	0-1
		305	24	2116-Employment Serv	12/28/2015	12/28/2015	0	1	0-1
		305	24	2116-Employment Serv	12/28/2015	12/28/2015	0	1	0-1
		305	25	2116-Employment Serv	12/2/2015	10/8/2015	55	37	31 Days and Over
		305	25	2116-Employment Serv	12/3/2015	11/6/2015	27	17	15-30 Days
		305	25	2116-Employment Serv	12/3/2015	11/20/2015	13	8	15-30 Days
		305	25	2116-Employment Serv	12/3/2015	11/13/2015	20	13	15-30 Days
		305	25	2116-Employment Serv	12/15/2015	12/15/2015	0	1	0-1
		382	26	2116-Employment Serv	12/24/2015	12/21/2015	3	4	3-7 Days
		382	26	2116-Employment Serv	12/24/2015	12/21/2015	3	4	3-7 Days
		382	26	2116-Employment Serv	12/24/2015	12/21/2015	3	4	3-7 Days
		382	26	2116-Employment Serv	12/24/2015	12/21/2015	3	4	3-7 Days
		382	26	2116-Employment Serv	12/24/2015	12/21/2015	3	4	3-7 Days
		305	30	2116-Employment Serv	12/2/2015	10/9/2015	54	36	31 Days and Over
		305	30	2116-Employment Serv	12/2/2015	10/28/2015	35	23	31 Days and Over
		305	30	2116-Employment Serv	12/3/2015	11/5/2015	28	18	15-30 Days
		305	30	2116-Employment Serv	12/10/2015	12/2/2015	8	7	8-14 Days
		305	30	2116-Employment Serv	12/2/2015	10/22/2015	41	27	31 Days and Over

Attachment R
Staff Billing QA Report

Department of Behavioral Health
Medical Staff Billing QA Report

MM-00042
Data Date: 4/6/2016
This report pulls the billing information from the billable medical notes within a specified data entry date range and shows potential errors. Each error type is color coded.
Data EntryDate Range: 3/1/2016-4/5/2016

E-Signer	Staff ID	Medical Record	DOS	Client ID	EP #	Program	Svs Code	Svs Dur	OBT	Tot Dur
Asha Gaur, MD	019454	Medication Progress Note	2/23/2016		3	2246	47	15	7	22
	Same client and date as another service. Possible Double Entry.									
Asha Gaur, MD	019454	Medication Progress Note	3/24/2016		4	2246	173	45	15	60
	[illegible]									
Asha Gaur, MD	019454	Medication Progress Note	3/24/2016		3	2246	173	30	10	40
	[illegible]									
Asha Gaur, MD	019454	Psychiatric Evaluation	3/10/2016	!	2	2246	170	70	40	110
	[illegible]									
Asha Gaur, MD	019454	Medication Progress Note	3/17/2016	!	5	2246	956	0	0	0
	Same client and date as another service. Possible Double Entry.									
Asha Gaur, MD	019454	Medication Progress Note	3/28/2016	!	3	2246	173	22	8	30
	[illegible]									
Bradley Strong, MD	900898	Medication Progress Note	3/4/2016		6	4519	193	42	10	52
	The Program is not in an applicable program.									
Bradley Strong, MD	900898	Medication Progress Note	3/4/2016		15	4519	193	16	8	24
	The Program is not in an applicable program.									
Bradley Strong, MD	900898	Medication Progress Note	3/4/2016		10	4519	193	19	8	27
	The Program is not in an applicable program.									
Bradley Strong, MD	900898	Medication Progress Note	3/11/2016		16	4519	192	15	6	21
	The Program is not in an applicable program.									
	The Service Code it not an applicable service code.									
Bradley Strong, MD	900898	Medication Progress Note	3/11/2016		8	4519	193	23	7	30
	The Program is not in an applicable program.									
Bradley Strong, MD	900898	Medication Progress Note	3/1/2016	-------	7	4519	193	34	10	44
	The Program is not in an applicable program.									
Bradley Strong, MD	900898	Medication Progress Note	3/11/2016	!	7	4519	192	10	6	16
	The Program is not in an applicable program.									
	The Service Code it not an applicable service code.									
Bradley Strong, MD	900898	Medication Progress Note	3/2/2016		4	4519	193	35	12	47
	The Program is not in an applicable program.									
	Location Problem (Inpatient Psychiatric Health Facility): Either not a valid location for program, not CMHS or Phone and not telemed.									
Bradley Strong, MD	900898	Medication Progress Note	3/4/2016	!	6	4519	193	22	8	30
	The Program is not in an applicable program.									
Bradley Strong, MD	900898	Medication Progress Note	3/2/2016		9	4519	193	19	7	26
	The Program is not in an applicable program.									
Bradley Strong, MD	900898	Medication Progress Note	3/11/2016	-------	22	4519	2EV	35	12	47
	The Program is not in an applicable program.									
Bradley Strong, MD	900898	Medication Progress Note	3/11/2016	!	2	4519	192	10	5	15
	The Program is not in an applicable program.									
	The Service Code it not an applicable service code.									

Attachment S
Group Note EMR Demonstration and Sample

F, 53, 11/18/1962
Ht: 5' 10.2", Wt: 215 lbs, BMI: 30.7

Progress Notes (Group and Individual)

- Individual Progress Notes
- Group Default Notes

Submit

Online Documentation

Date of Service: 04/05/2016 (T) (Y)

Practitioner: HAGER,CYNTHIA (000479)

Progress Note For: New Service

Group Name Or Number: Heritage Middle School Boys (130)

Client Who Attended Group:
- PATIENT,ONE IV (1) Episode: 16
- TOON,KAN (9522522) Episode: 1

Add Client To Group

Client To Be Added To Group:

Episode Number:

Remove Client From Group

Removal Selection:

Service Program (Cost Center): 0-Admissions-Children's Outpatient

Location: Community Mental Health Center

Service Charge Code: Group Therapy (82)

No Show Service Code (Will be applied to all unchecked group members):

Practitioner 1 Service Duration: 30

Practitioner 1 Doc and Travel: 10

Practitioner 1 Total Duration: 40

Group Notes Requires a Co-Signature?: No

Send Co-Signature To-Do Item To:

Co-Practitioner: GABE GOMEZ (015474)

Practitioner 2 Service Duration: 30

Practitioner 2 Doc and Travel: 0

Practitioner 2 Total Duration: 30

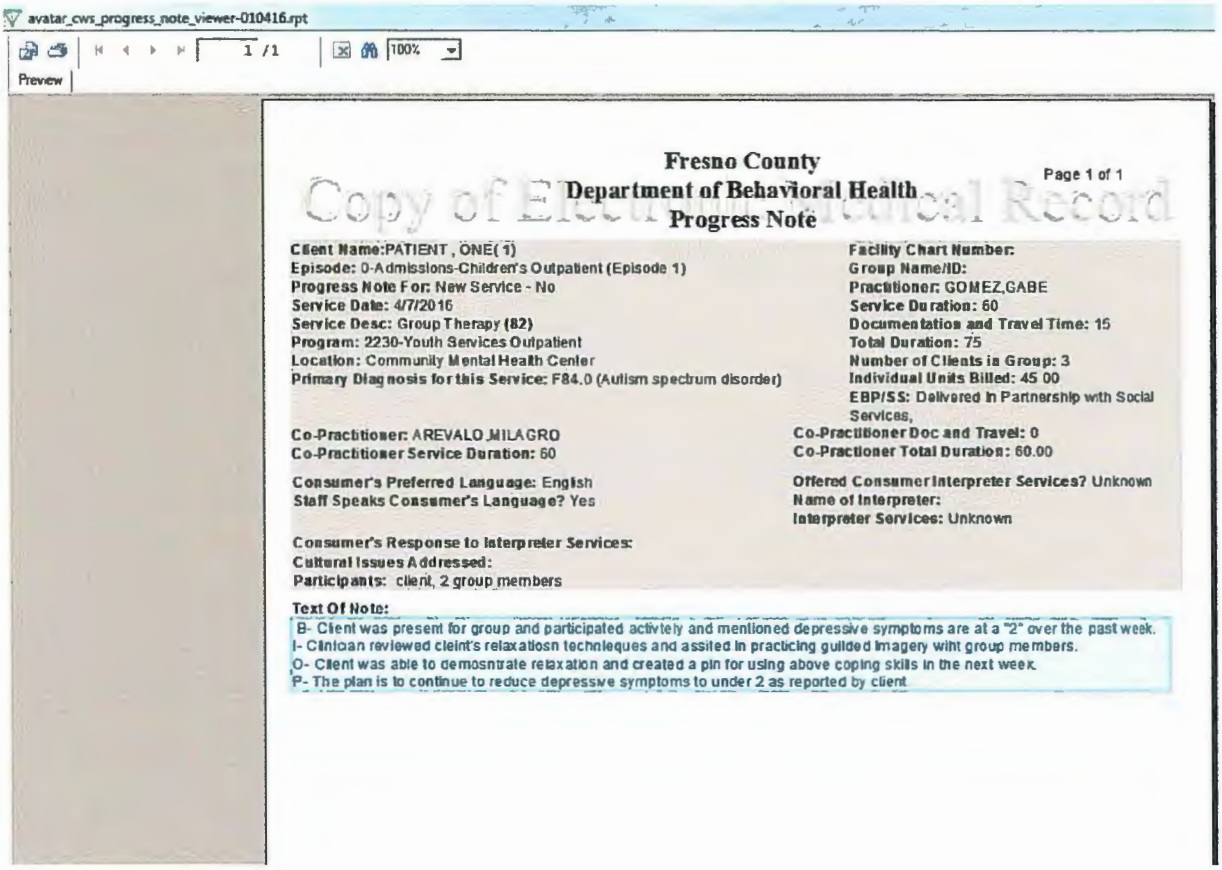
Person to Individualize this Group Note: Cynthia Hager, LCSW

Evidence-Based Practices / Service Strategies (CSI):
- [x] Age-Specific Service Strategy
- [ ] Assertive Community Treatment
- [ ] Delivered in Partnership with Health Care
- [ ] Delivered in Partnership with Law Enforcement
- [ ] Delivered in Partnership with Social Services
- [ ] Delivered in Partnership with Substance Abuse Services
- [ ] Ethnic-Specific Service Strategy

Note:

Demontration only

Sample Group Progress Note



avatar_cws_progress_note_viewer-010416.rpt

1 /1 100%

Preview

Fresno County

Department of Behavioral Health

Progress Note

Client Name: PATIENT , ONE(1)
Episode: 0-Admissions-Children's Outpatient (Episode 1)
Progress Note For: New Service - No
Service Date: 4/7/2016
Service Desc: Group Therapy **(82)**
Program: 2230-Youth Services Outpatient
Location: Community Mental Health Center
Primary Diagnosis for this Service: F84.0 (Autism spectrum disorder)

Facility Chart Number:
Group Name/ID:
Practitioner: GOMEZ,GABE
Service Duration: 60
Documentation and Travel Time: 15
Total Duration: 75
Number of Clients in Group: 3
Individual Units Billed: 45 00
EBP/SS: Delivered in Partnership with Social Services,

Co-Practitioner: AREVALO,MILAGRO
Co-Practitioner Service Duration: 60

Co-Practitioner Doc and Travel: 0
Co-Practioner Total Duration: 60.00

Consumer's Preferred Language: English
Staff Speaks Consumer's Language? Yes

Offered Consumer Interpreter Services? Unknown
Name of Interpreter:
Interpreter Services: Unknown

Consumer's Response to Interpreter Services:
Cultural Issues Addressed:
Participants: client, 2 group members

Text Of Note:

B- Client was present for group and participated activtely and mentioned depressive symptoms are at a "2" over the past week.
I- Clinicain reviewed cleint's relaxatiosn technieques and assited in practicing guilded imagery wiht group members.
O- Client was able to demosntrate relaxation and created a pin for using above coping skills in the next week.
P- The plan is to continue to reduce depressive symptoms to under 2 as reported by client

Attachment T
MHP Protocol Invoice Claims Review for Children's Placement

Inter Office Memo

DATE: April 5, 2016

TO: Katherine Rexroat, Clinical Supervisor
Managed Care Office

FROM: Marlene Saghdejian, Staff Analyst
Mental Health Contracts

SUBJECT: Invoice process for Children's Master Placement Agreeement - RCL 12-14 providers for specialized residential mental health services (Agt.# 14-313).

Current method used by Mental Health Contracts Division in processing invoices received from Children's Placement Provider:

- Analyst receives invoice from Provider
  - Checks to make sure the invoice clearly identifies the service month.
  - Checks invoiced rate(s) for services against approved contract rates and ensures that the rate calculation adds up to the amount invoiced.
  - Checks to make sure the billing detail is included for services rendered.
  - Checks to make sure Claim Certification is included, signed and is filled out in accordance to the units of service, the month of service and the amount invoiced.
  - Analyst then attaches a cover sheet to the invoice packet identifying the date the packet is being sent to the Children's Placement Team for review, the number of pages included, Invoice number, provider name, and a signature line for the Children's Placement Team to sign off on upon review and approval of the invoice supporting documentation.

- Analyst contacts Children's Placement Team, Clinical Supervisor via e-mail to let her know we are in receipt of an invoice packet for her review and that they are going to be dropped off with the Children's Services Secretary for her to pick up and review. Analyst encloses supporting documents (Invoice packet which includes: Invoice, billing detail documentation, Claim Certification, Progress notes, Program Schedule of Activity and any other supporting documentations) within an envelope and routs to Children's Placement Team, Clinical Supervisor via dropping the envelope with Children's Services Secretary.

- Children's Placement Team, Clinical Supervisor picks the envelope up from Children's Services Secretary, reviews progress notes/supporting

documentation and returns to Analyst via dropping packet back off with Children's Services Secretary upon review. If there is any missing documentation and or questions per clinical review the Children's Placement Team lets Contracts Analyst know upon identifying question or concern on the cover sheet, Analyst then follows up with provider to request missing information.

- If no questions/problems with the supporting documents, Contracts Analyst processes the invoices upon receipt of the reviewed supporting documents form Children's Placement Team, Clinical Supervisor for payment.

If you have any questions or concerns, please contact Marlene Saghdejian at 600-5239.

Thank you.

cc: Joseph Rangel, Division Manager
Preet Sanghera, Principal Staff Analyst

Inter Office Memo

DATE: April 5, 2016

TO: Katherine Rexroat, Clinical Supervisor
Managed Care Office

FROM: Marlene Saghdejian, Staff Analyst
Mental Health Contracts

SUBJECT: Invoice process for Children's Master Placement Agreeement - RCL 12-14 providers for specialized residential mental health services (Agt.# 14-313).

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  - Checks to make sure the billing detail is included for services rendered.
  - Checks to make sure Claim Certification is included, signed and is filled out in accordance to the units of service, the month of service and the amount invoiced.
  - Analyst then attaches a cover sheet to the invoice packet identifying the date the packet is being sent to the Children's Placement Team for review, the number of pages included, Invoice number, provider name, and a signature line for the Children's Placement Team to sign off on upon review and approval of the invoice supporting documentation.

- Analyst contacts Children's Placement Team, Clinical Supervisor via e-mail to let her know we are in receipt of an invoice packet for her review and that they are going to be dropped off with the Children's Services Secretary for her to pick up and review. Analyst encloses supporting documents (Invoice packet which includes: Invoice, billing detail documentation, Claim Certification, Progress notes, Program Schedule of Activity and any other supporting documentations) within an envelope and routs to Children's Placement Team, Clinical Supervisor via dropping the envelope with Children's Services Secretary.

- Children's Placement Team, Clinical Supervisor picks the envelope up from Children's Services Secretary, reviews progress notes/supporting

documentation and returns to Analyst via dropping packet back off with Children's Services Secretary upon review. If there is any missing documentation and or questions per clinical review the Children's Placement Team lets Contracts Analyst know upon identifying question or concern on the cover sheet, Analyst then follows up with provider to request missing information.

- If no questions/problems with the supporting documents, Contracts Analyst processes the invoices upon receipt of the reviewed supporting documents form Children's Placement Team, Clinical Supervisor for payment.

If you have any questions or concerns, please contact Marlene Saghdejian at 600-5239.

Thank you.

cc: Joseph Rangel, Division Manager
Preet Sanghera, Principal Staff Analyst

DOCUMENTATION STANDARDS FOR CLIENT RECORDS

The documentation standards are described below under key topics related to client care. All standards must be addressed in the client record; however, there is no requirement that the records have a specific document or section addressing these topics.

A. Assessments

1. The following areas will be included as appropriate as a part of a comprehensive client record.
   - Relevant physical health conditions reported by the client will be prominently identified and updated as appropriate.
   - Presenting problems and relevant conditions affecting the client's physical health and mental health status will be documented, for example: living situation, daily activities, and social support.
   - Documentation will describe client's strengths in achieving client plan goals.
   - Special status situations that present a risk to clients or others will be prominently documented and updated as appropriate.
   - Documentations will include medications that have been described by mental health plan physicians, dosage of each medication, dates of initial prescriptions and refills, and documentations of informed consent for medications.
   - Client self-report of allergies and adverse reactions to medications, or lack of known allergies/sensitivities will be clearly documented.
   - A mental health history will be documented, including: previous treatment dates, providers, therapeutic interventions and responses, sources of clinical data, relevant family information and relevant results of relevant lab tests and consultations reports.
   - For children and adolescents, pre-natal and perinatal events and complete developmental history will be documented.
   - Documentations will include past and present use of tobacco, alcohol, and caffeine, as well as illicit, prescribed and over-the-counter drugs.
   - A relevant mental status examination will be documented.
   - A five axis diagnosis from the most current DSM, or a diagnosis from the most current ICD, will be documented, consistent with the presenting problems, history mental status evaluation and/or other assessment data.

2. Timeliness/Frequency Standard for Assessment
   - An assessment will be completed at intake and updated as needed to document changes in the client's condition.
   - Client conditions will be assessed at least annually and, in most cases, at more frequent intervals.

B. Client Plans

1. Client plans will:
   - Have specific observable and/or specific quantifiable goals
   - Identify the proposed type(s) of intervention
   - Have a proposed duration of intervention(s)
   - Be signed (or electronic equivalent) by:

  - The person providing the service(s), or
  - A person representing a team or program providing services, or
  - A person representing the MHP providing services
  - When the client plan is used to establish that the services are provided under the direction of an approved category of staff, and if the below staff are not the approved category,
  - A physician
  - A licensed/ "waivered" psychologist
  - A licensed/ "associate" social worker
  - A licensed/ registered/marriage and family therapist or
  - A registered nurse
- In addition,
  - Client plans will be consistent with the diagnosis, and the focus of intervention will be consistent with the client plan goals, and there will be documentation of the client's participation in and agreement with the plan. Examples of the documentation include, but are not limited to, reference to the client's participation and agreement in the body of the plan, client signature on the plan, or a description of the client's participation and agreement in progress notes.
  - Client signature on the plan will be used as the means by which the CONTRACTOR(S) documents the participation of the client.
  - When the client's signature is required on the client plan and the client refuses or is unavailable for signature, the client plan will include a written explanation of the refusal or unavailability.
- The CONTRACTOR(S) will give a copy of the client plan to the client on request.

2. Timeliness/Frequency of Client Plan:
  - Will be updated at least annually
  - The CONTRACTOR(S) will establish standards for timeliness and frequency for the individual elements of the client plan described in item 1.

C. Progress Notes

1. Items that must be contained in the client record related to the client's progress in treatment include:
  - The client record will provide timely documentation of relevant aspects of client care
  - Mental health staff/practitioners will use client records to document client encounters, including relevant clinical decisions and interventions
  - All entries in the client record will include the signature of the person providing the service (or electronic equivalent); the person's professional degree, licensure or job title; and the relevant identification number, if applicable
  - All entries will include the date services were provided
  - The record will be legible
  - The client record will document follow-up care, or as appropriate, a discharge summary

2. Timeliness/Frequency of Progress Notes:
Progress notes shall be documented at the frequency by type of service indicated below:

A. Every Service Contact
- Mental Health Services
- Medication Support Services
- Crisis Intervention

B. Daily
- Day Treatment Intensive

C. Weekly
- Day Treatment Intensive: A clinical summary reviewed and signed by a physician, a licensed/waivered/registered psychologist, clinical social worker, or marriage and family therapist; or a registered nurse who is either staff to the day treatment intensive program or the person providing the service
- Day Rehabilitation

D. Other
- Targeted Case Management-every service contact, daily, or weekly summary.

REASONS FOR RECOUPMENT

All medical records and documentation are subject to review to determine if medical necessity criteria were met. This review includes all claims associated with the beneficiary's care during placement.

The following occurrences will be considered out of compliance:

Assessment
1. No assessment has been completed.
2. The assessment or other documents in the medical record do not contain the required elements.
3. Medication consent requirements not met.
4. Documentation that is illegible.

Client Plan
1. Requirements not met.
2. Client plan was not completed.
3. Client plan was not updated at least annually and when there were significant changes in the beneficiary's condition.
4. Client plan was not signed by staff as indicated in 3d.
5. No evidence that the contractor offered a copy of the client plan to the beneficiary.
6. No evidence of the beneficiary agreeing or participating in the client plan.
7. Client plan was not signed by the beneficiary when required.
8. No written explanation when the beneficiary refuses to sign or is unavailable.
9. No written definition of what constitutes a long-term care beneficiary.
10. Documentation that is illegible.

Progress Notes

1. Progress notes do not describe how services provided reduced impairment, restored functioning, or prevented significant deterioration in an important area of life functioning outlined in the client plan.
2. Progress notes that do not indicate the date of service, the amount of time and beneficiary encounters.
3. Documentation that is illegible.
4. Services not documented timely.
5. No signature of person providing the services.
6. Evidence that beneficiaries are not receiving services that were claimed.

CHART REVIEW PROTOCOL

SECTION K ***CHART REVIEW—NON-HOSPITAL SERVICES***

	CRITERIA	IN COMPLIANCE Y	N	*INSTRUCTIONS TO REVIEWERS* COMMENTS
RE: ASSESSMENT				
2.	Regarding the Assessment, are the following conditions met:			• Review the MHP's written documentation standards guidelines. • Review assessment(s), evaluation(s), and/or other documentation to support 1a, 1b, and 1c. • Review the prior and current assessment for timeliness and frequency. **NOTE:** The MHP shall establish written standards for timeliness and frequency for the required assessment elements identified in 2c. (Refer to the MHP Contract, Exhibit A, Attachment I)
2a.	Has the Assessment been completed in accordance with regulatory and contractual requirements?			
2b.	Has the Assessment been completed in accordance with the MHP's established written documentation standards for timeliness and frequency?			

SECTION K CHART REVIEW—NON-HOSPITAL SERVICES

	CRITERIA	IN COMPLIANCE Y	N	*INSTRUCTIONS TO REVIEWERS* COMMENTS
2c.	Does the Assessment include the areas specified in the MHP Contract with the Department? 1) Presenting Problem. The beneficiary's chief complaint, history of presenting problem(s), including current level of functioning, relevant family history and current family information; 2) Relevant conditions and psychosocial factors affecting the beneficiary's physical health and mental health; including, as applicable, living situation, daily activities, social support, cultural and linguistic factors and history of trauma or exposure to trauma; 3) Mental Health History. Previous treatment, including providers, therapeutic modality (e.g., medications, psychosocial treatments) and response, and inpatient admissions. If possible, include information from other sources of clinical data, such as previous mental health records, and relevant psychological testing or consultation reports; 4) Medical History. Relevant physical health conditions reported by the beneficiary or a significant support person. Include name and address of current source of medical treatment. For children and adolescents, the history must include prenatal and perinatal events and relevant/significant developmental history. If possible, include other medical information from medical records or relevant consultation reports;			• Review for the required appropriate elements. These elements may include but not limited to the following: a) Presenting Problem b) Relevant conditions and psychosocial factors c) Mental Health History d) Medical History

SECTION K CHART REVIEW—NON-HOSPITAL SERVICES

	CRITERIA	IN COMPLIANCE Y	N	*INSTRUCTIONS TO REVIEWERS* COMMENTS
	5) Medications. Information about medications the beneficiary has received, or is receiving, to treat mental health and medical conditions, including duration of medical treatment. The assessment shall include documentation of the absence or presence of allergies or adverse reactions to medications, and documentation of an informed consent for medications; 6) Substance Exposure/Substance Use. Past and present use of tobacco, alcohol, caffeine, CAM (complementary and alternative medications) and over-the-counter drugs, and illicit drugs; 7) Client Strengths. Documentation of the beneficiary's strengths in achieving client plan goals related to the beneficiary's mental health needs and functional impairments as a result of the mental health diagnosis; 8) Risks. Situations that present a risk to the beneficiary and/or others, including past or current trauma; 9) A mental status examination; 10) A complete five-axis diagnosis from the most current DSM, or a diagnosis from the most current ICD-code shall be documented, consistent with the presenting problems, history, mental status examination and/or other clinical data; and, 11) Additional clarifying formulation information, as needed.			• Review for the required appropriate elements. These elements may include but not limited to the following (continued): e) Medications f) Substance Exposure/Substance Use g) Client Strengths h) Risks i) A mental status examination j) A complete five-axis diagnosis k) Additional clarifying formulation information, as needed

SECTION K CHART REVIEW—NON-HOSPITAL SERVICES

	CRITERIA	IN COMPLIANCE Y	N	*INSTRUCTIONS TO REVIEWERS* COMMENTS
2d.	Did the provider obtain and retain a written medication consent form signed by the beneficiary agreeing to the administration of psychiatric medication?			• Review the medication orders and medication consents.
2e.	Did the documentation include, but not limited to: 1) The reasons for taking such medications; 2) Reasonable alternative treatments available, if any; 3) The type, range of frequency and amount, methods (oral or injection), and duration of taking the medication; probable side effects; possible additional side effects which may occur to beneficiaries taking such medication beyond three (3) months; and 4) That the consent, once given, may be withdrawn at any time by the beneficiary.			
2f.	Is the documentation legible?			

• *CCR, title 9, chapter 11, section 1810.204* • *CCR, title 9, chapter 11, section 1840.112(b)(1-4)* • *CCR, title 9, chapter 11, section 1840.314(d)(e)* • *CCR, title 9, chapter 4, section 851- Lanterman-Petris Act* • *MHP Contract, Exhibit A, Attachment I*	OUT OF COMPLIANCE: • No assessment has been completed. • The assessment or other documents in the medical record do not contain the required elements. • Medication consent requirements not met. • Documentation that is illegible.

Documentation: List documents reviewed that demonstrate compliance and provides specific explanation of reason(s) for in compliance or out of compliance.

SECTION K CHART REVIEW—NON-HOSPITAL SERVICES

	CRITERIA	IN COMPLIANCE Y	N	*INSTRUCTIONS TO REVIEWERS* COMMENTS
RE: CLIENT PLAN				
3.	Regarding the client plan, are the following conditions met:			NOTE: Coordinate findings with the System Review process. • Review the MHP's written documentation standards guidelines.
3a.	Has the client plan been completed in accordance with regulatory and contractual requirements?			
3b.	Has the client plan been updated at least annually, or when there are significant changes in the beneficiary's condition?			• Review the prior and current client plans for timeliness and frequency.
3c.	Does the client plan include the items specified in the MHP Contract with the Department? 1) Specific, observable, and/or specific quantifiable goals/treatment objectives related to the beneficiary's mental health needs and functional impairments as a result of the mental health diagnosis.			NOTE: Coordinate findings with the System Review process. • Review the objectives and interventions of the client plan for compliance as indicated in 3c (1-6).
	2) The proposed type(s) of intervention/modality including a detailed description of the intervention to be provided.			
	3) The proposed frequency and duration of intervention(s).			
	4) Interventions that focus and address the identified functional impairments as a result of the mental disorder.			
	5) Interventions that are consistent with client plan goal(s)/treatment objective(s).			
	6) Be consistent with the qualifying diagnoses.			

SECTION K CHART REVIEW—NON-HOSPITAL SERVICES

	CRITERIA	IN COMPLIANCE Y	N	INSTRUCTIONS TO REVIEWERS COMMENTS
3d.	Is the client plan signed (or electronic equivalent) by 1) The person providing the service(s) or, 2) A person representing a team or program providing the service(s) or, 3) A person representing the MHP providing service(s) or, 4) By one of the following as a co-signer, if the client plan is used to establish that services are provided under the direction of an approved category of staff, and if the signing staff is not of the approved categories, one (1) of the following must sign: A. A Physician B. A Licensed/Waivered Psychologist C. A Licensed/Registered/Waivered Social Worker D. A Licensed/Registered/Waivered Marriage and Family Therapist E. A registered nurse, including but not limited to nurse practitioners, and clinical nurse specialists			• MHP shall provide a list of staff, staff signatures (or electronic equivalent), professional degree, licensure or job title, and relevant identification number, if applicable. • Review for the staff signature requirements as indicated in 3d. NOTE: CCR, title 9, chapter 11, section 1810.254: "Waivered/Registered Professional" means an individual who has a waiver of psychologist licensure issued by the Department or has registered with the corresponding state licensing authority for psychologists, marriage and family therapists or clinical social workers to obtain supervised clinical hours for psychologist, marriage and family therapist or clinical social worker licensure.

SECTION K CHART REVIEW—NON-HOSPITAL SERVICES

	CRITERIA	IN COMPLIANCE Y	N	*INSTRUCTIONS TO REVIEWERS* COMMENTS
3e.	Is there documentation of the beneficiary's degree of participation and agreement with the client plan as evidenced by, but not limited to: 1) Reference to the beneficiary's participation in and agreement in the body of the client plan; or 2) The beneficiary signature on the client plan; or 3) A description of the beneficiary's participation and agreement in the medical record. The beneficiary's signature or the signature of the beneficiary's legal representative is required on the client plan when: 1) The beneficiary is expected to be in long-term treatment, as determined by the MHP, and, 2) The client plan provides that the beneficiary will be receiving more than one (1) type of SMHS. When the beneficiary's signature or the signature of the beneficiary's legal representative is required on the client plan and the beneficiary refuses or is unavailable for signature, the client plan shall include a written explanation of the refusal or unavailability.			• Review for the beneficiary's degree of participation and agreement with the plan as follows: A. Reference the beneficiary's participation and agreement in the body of the client plan, the beneficiary's signature on the client plan or, a description of the beneficiary's participation and agreement in the medical record. B. Whether or not the beneficiary signature is required: • Is the beneficiary expected to be in long-term treatment as determined by the MHP? • Will the beneficiary be receiving more than one type of Specialty Mental Health Services? • Is the beneficiary required to sign the client plan per the MHP's documentation standards guidelines? C. When the beneficiary's signature is required on the client plan and the beneficiary refuses or is unavailable for signature, is there a written explanation of the refusal or unavailability?
3f.	Does the MHP have a written definition of what constitutes a long-term care beneficiary?			• Review the MHP's written definition of a long-term care beneficiary.
3g.	Is there documentation that the contractor offered a copy of the client plan to the beneficiary?			• Review the medical record for documentation.

SECTION K CHART REVIEW—NON-HOSPITAL SERVICES

	CRITERIA	IN COMPLIANCE Y	N	*INSTRUCTIONS TO REVIEWERS* COMMENTS
3h.	Is the documentation legible?			
	• *CCR, title 9, chapter 11, section 1810.205.2* • *CCR, title 9, chapter 11, section 1810.254* • *CCR, title 9, chapter 11, section 1810.440(c)(1)(2)* • *CCR, title 9, chapter 11, section 1840.112(b)(2-5)* • *CCR, title 9, chapter 11, section 1840.314(d)(e)* • *DMH Letter 02-01, Enclosure A* • *W&IC, section 5751.2* • *MHP Contract, Exhibit A, Attachment I*			OUT OF COMPLIANCE: • Requirements not met in 3a-3c. • Client plan was not completed. • Client plan was not updated at least annually and when there were significant changes in the beneficiary's condition. • Client plan was not signed by staff as indicated in 3d. • No evidence that the contractor offered a copy of the client plan to the beneficiary. • No evidence of the beneficiary agreeing or participating in the client plan. • Client plan was not signed by the beneficiary when required. • No written explanation when the beneficiary refuses to sign or is unavailable. • No written definition of what constitutes a long-term care beneficiary. • Documentation that is illegible.
	Documentation: List documents reviewed that demonstrate compliance and provides specific explanation of reason(s) for in compliance or out of compliance.			

SECTION K ***CHART REVIEW—NON-HOSPITAL SERVICES***

		IN COMPLIANCE		*INSTRUCTIONS TO REVIEWERS*
	CRITERIA	Y	N	COMMENTS
RE: PROGRESS NOTES				
4. 4a.	Do the progress notes describe how services provided reduced impairment, restored functioning, or prevented significant deterioration in an important area of life functioning outlined in the client plan?			• Review the MHP's documentation standards guidelines. • Review the progress notes for: A. How services provided reduced impairment, restored functioning, or prevented significant deterioration in an important area of life functioning outlined in the client plan. B. Timely documentation C. Medical necessity D. Beneficiary encounters and relevant clinical decisions E. Interventions applied, beneficiary's response to the interventions and the location of the interventions; F. The date the services were provided G. Documentation of referrals to community resources and other agencies, when appropriate; H. Documentation of follow-up care, or as appropriate, a discharge summary; I. Amount of time taken to provide services J. Signature of the person providing the service; the person's type of professional degree, licensure or job title; and the relevant identification number, if applicable. K. The date the service was documented in the medical record by the person providing the service.
4b.	Do the progress notes document the following? 1) Timely documentation of relevant aspects of client care, including documentation of medical necessity; 2) Documentation of beneficiary encounters, including relevant clinical decisions, when decisions are made, alternative approaches for future interventions; 3) Interventions applied, beneficiary's response to the interventions and the location of the interventions; 4) The date the services were provided; 5) Documentation of referrals to community resources and other agencies, when appropriate; 6) Documentation of follow-up care, or as appropriate, a discharge summary; and 7) The amount of time taken to provide services; 8) The signature of the person providing the service (or electronic equivalent); the person's type of professional degree, licensure or job title; and the relevant identification number, if applicable; and 9) The date the service was documented in the medical record by the person providing the service.			

SECTION K CHART REVIEW—NON-HOSPITAL SERVICES

	CRITERIA	IN COMPLIANCE Y	N	INSTRUCTIONS TO REVIEWERS COMMENTS
4c.	Timeliness/frequency as follows: 1) Every service contact for: A. Mental health services B. Medication support services C. Crisis intervention D. Targeted Case Management 2) Daily for: A. Crisis residential B. Crisis stabilization (one per 23/hour period) C. Day treatment intensive 3) Weekly for: A. Day treatment intensive (clinical summary) B. Day rehabilitation C. Adult residential			NOTE: Effective September 1, 2003, the day treatment intensive weekly clinical summary note must be reviewed and signed by one of the following: - Physician - Licensed/Waivered Psychologist - Licensed/Registered/Waivered Social Worker - Licensed/Registered/Waivered Marriage and Family Therapist - Registered Nurse NOTE: Documentation must support the program requirements, the type of service, date of service and units of time claimed.
4d.	Is the documentation legible?			

- *CCR, title 9, chapter 11, section 1810.254*
- *CCR, title 9, chapter 11, section 1810.440(c)*
- *CCR, title 9, chapter 11, section 1840.112(b)(2-6)*
- *CCR, title 9, chapter 11, section 1840.314*
- *CCR, title 9, chapter 11, sections 1840.316 - 1840.322*
- *CCR, title 22, chapter 3, section 51458.1*
- *CCR, title 22, chapter 3, section 51470*
- *MHP Contract, Exhibit A, Attachment I*
- *DMH Letter No. 03-03*

OUT OF COMPLIANCE:

- Progress notes do not describe how services provided reduced impairment, restored functioning, or prevented significant deterioration in an important area of life functioning outlined in the client plan.
- Progress notes that do not indicate the date of service, the amount of time and beneficiary encounters as specified in 4a - 4c.
- Documentation that is illegible.
- Services not documented timely.
- No signature of person providing the services as specified in 4b (8).
- Evidence that beneficiaries are not receiving services that were claimed.

Documentation: List documents reviewed that demonstrate compliance and provides specific explanation of reasons for in compliance or out of compliance.

Attachment U
Written Program Description for DTI from 10DP

BAYFRONT YOUTH AND FAMILY SERVICES

Day Treatment Intensive (DTI)

Program Description

The Bayfront Youth and Family Services (Bayfront YFS) DTI Program is a 40 bed residential facility (RCL 14) located at 4151 Fountain Street Long Beach CA 90804. The facility is an intensely structured, unlocked group home that meets the requirements of Community Care Licensing. Bayfront Youth & Family Services (Bayfront YFS) serves children and adolescents in the Service Planning Area 8 (SPA 8) of Los Angeles County.

Bayfront YFS was established in the City of Long Beach as a 501(c)(3) organization in 1999 by a group of Clinicians (Board of Directors). The program purpose was to provide an intensively structured program for those adolescents aged 11 to 18 who had not been able to be treated in existing community care residential facilities within Los Angeles County, as well as counties outside of Los Angeles.

Bayfront YFS supports a family-centered, strength-based, and needs-driven planning process. Service delivery objectives are to assist clients in returning home and successfully remaining home; preventing future disruption or placements, symptom reduction as well as overall improvement of family functioning and preventing psychiatric hospitalization or the need for re-entry to acute levels of care. Family voice, choice and ownership of strategies to return or maintain clients in their community with normalized and inclusive community options, activities and opportunities are the focus.

All clients referred for Residential Services at Bayfront YFS are expected to receive an individually-prescribed array of DTI services. The exact nature of these services will be identified during the course of the intake process at Bayfront YFS' RCL 14 group home. Upon admission to the group home the intake process will be coordinated by the client's primary therapist and may include, in addition to DTI, medication support, and TBS. All clients referred to the Bayfront YFS have unmet needs for stability, continuity, emotional support, nurturing and permanence. They need intervention and advocacy for behavioral improvement and emotional and educational stability. These needs are evidenced by residents' substantial difficulty functioning successfully in the family, school, and community.

All residents at Bayfront YFS are expected to participate in all individual therapeutic activities and groups offered and admission is contingent upon their consent to do so. (There will be no waiting period as all residential services clients qualify and will be automatically enrolled in the DTI program at their time of intake to the residential facility). At this time, each client will be introduced to his/her Primary Therapist who will be involved in developing and/or refining the client's individualized care plan that specifies the strengths and needs of each DTI participant. The primary therapist will also initiate strategy development in preparation for the client's discharge from the residential setting to the community living setting. Utilization of discharge groups will enable each member an opportunity to begin establishing community connections to resources such as community-based self-help and family support groups, health/medical/emergency services, benefits establishment, independent living skills enhancement, legal, housing and living, vocational options, cultural/spiritual and mental health linkages just to name a few. In most cases after specific needs have been identified and initial goals have been created, the client and their Primary Therapist (or that person's designee) will begin

traveling together into the community to introduce (or in some case re-introduce) the client with their future residential surroundings. The client will begin to get a feel for healthy independence and self-empowerment as their primary Therapist will work side-by-side with each client to encourage assertiveness and facilitate making community connections.

Types of Services

1. **Therapeutic Milieu:** The therapeutic milieu includes therapeutic programs that are structured by well-defined service components with specific activities being performed by identified staff. It
   a. Takes place for the continuous scheduled hours of operation,
   b. Creates a supportive and nurturing interpersonal environment that teaches, models, and reinforces constructive interaction,
   c. Supports peer/staff feedback to clients on strategies for symptom reduction, increasing adaptive behaviors, and reducing subjective distress,
   d. Empowers clients through involvement in the overall program and the opportunity for risk taking in a supportive environment, and
   e. Supports behavior management interventions that focus on teaching self-management skills that children, youth, adults, and older adults may use to control their own lives, to deal effectively with present and future problems, and to function well with minimal or no additional therapeutic intervention.

   Group services are provided to two or more individuals focusing on mental health needs in a group setting. Clients in the DTI program participate in multiple groups per week that focus on improving social skills, addressing intra-psychic conflicts that interfere with achievement of individual goals, and provide opportunities for the practice of social behaviors that will prepare the clients for successful functioning in their school/home/community environments.

2. **Therapeutic Milieu Service Components:** The following menu of services are available during the course of the therapeutic milieu for at least an average of three hours per day:
   a. **Skill Building Groups:** Staff help clients to identify barriers/obstacles related to their psychiatric/psychological experiences and, through the course of group interaction, become better able to identify skills that address symptoms and behaviors and to increase adaptive behaviors.
   b. **Adjunctive Therapies:** Staff and clients participate in non-traditional therapy that utilizes self-expression (art, recreation, dance, music, etc.) as the therapeutic interventions. Participants do not need to have any level of skill in the area of self-expression, but rather be able to utilize the modality to develop or enhance skills directed towards client plan goals.
   c. **Psychotherapy:** Psychotherapy means the use of psychosocial methods within a professional relationship to assist the person or persons to achieve a better psychosocial adaptation, to acquire greater human realization of psychosocial potential and adaptation, to modify internal and external conditions that affect individuals, groups, or communities in respect to behavior, emotions, and thinking, in respect to heir intrapersonal and interpersonal processes. Psychotherapy is provided by licensed, registered, or waivered staff practicing within their scope of practice. It does not include physiological interventions, including medication intervention. All clients participate in individual psychotherapy sessions a minimum of two times per week with their primary therapist. To the extent permitted by the client's individual circumstances, every effort is made to include parents, caregivers, and significant adult relatives in the psychotherapy process, making them aware of the client's

progress in the program, and assuring that interventions in the Day Treatment Program are related or meaningful to the caregivers to whom the clients will be returning.

d. **Process Groups:** Staff facilitate these groups to help clients develop the skills necessary to deal with their individual problems/issues by using the group process to provide peer interaction and feedback in developing problem-solving strategies and to assist one another in resolving behavioral and emotional problems.

3. **Community Meeting:** All clients in DTI the program participate in daily Community Groups that focus on orienting clients to the here-and-now, reviewing progress toward the achievement of individual goals, and anticipating social and/or emotional challenges that will be faced (or were faced) during the day. Community meetings address issues pertinent to the continuity and effectiveness of the therapeutic milieu. Group Services may be delivered in the context of field trips in the community that focus on practicing and demonstrating appropriate community behaviors. Additional Group interventions may include the opportunity for parents or caregivers to participate in Parent support Groups that will address planning for (or reviewing) issues that could come up (or did come up) during home visits/passes.

4. **Individual Rehabilitation:** Individual rehabilitation services include assistance with maintaining or restoring the client's daily living skills, medication education and compliance, independent and transitional living skills, leisure and community activities necessary to support and meet treatment goals, and individual/family counseling re: these services and outcomes.

5. **Contact with Significant Support Persons/Collateral Services:** Clients have at least one contact per month with a family member, caregiver, or significant support person and/or legally responsible adult as applicable. The contacts and involvement focus on the role of the significant support person in supporting the client's community reintegration. Collateral services include, but are not limited to, individual contacts with parents or caregivers, parenting classes, phone contacts with community stakeholders, and consultations school personnel.

6. **Plan Development:** Development and approval of treatment/service plans and monitoring the ongoing progress of treatment.

7. **Case Management:** Case management services will consist of activities that are provided by program staff to access medical, educational, social, or other needed community services for children and their families.

8. **Crisis Response:** The DTI program has an established protocol for responding to clients experiencing a mental health crisis. For more information, please see subsections Crisis Planning and Crisis Intervention Services immediately below, and the "Crisis Intervention Services" on page 5.
   a. **Crisis Planning:** Crisis planning will begin at the time of intake and will include solution-focused, problem solving strategies that support prevention, management, and stabilization of a crisis with the objective of successfully maintaining the client in the least restrictive environment and mainstream school setting. The crisis plan addresses both family and school situations with the objectives of de-escalation and problem-solving.
   b. **Crisis Intervention Services:** Crisis intervention services' objective is to prevent hospitalization and disruption of placement. Preventative, strategic planning enable clients

and families to employ coping skills to avoid crisis from occurring while in their home or any other community setting. Crisis intervention services include stabilization of the presenting emergency and include, but are not limited to, assessment, evaluation, and collateral linkage and services, as well as therapy and medication compliance. Implementation of a crisis plan during the transition group, along with trained parent/caregivers and staff will aid in de-escalation of a situation to avoid placement disruption and/or hospitalization.

9. **Schedule:** Program schedules are made available to clients and their families, caregivers, or significant support persons. Schedules identify when and where the service components of program will be provided and by whom. The schedule also specifies the program staff, their qualifications, and the scope of their responsibilities. Along with the schedules, the program includes the detailed group activity descriptions for each activity listed on the schedule.

10. **Staffing Ratios:** Staffing ratios are consistent with requirements in Title 9, CCR, Sections 1840.350 and 1840.352 and include at least one staff whose scope of practice includes psychotherapy. Please refer to page 6 "Staffing Profile" for more detailed information.

11. **Outcomes Measurement:** Bayfront YFS currently tracks outcome measures through the agency's Continuous Quality Improvement (CQI) monthly report. CQI tracks the following data:
    - Client GAF from admission to discharge
    - Client satisfaction survey
    - Positive discharge to a lower level of care (this includes discharge to a level 12 or lower, reunification with family/caregiver, and independent living)
    - Client incident reports (these incidents include client containments, client to client assaults, client to staff assaults, AWOL's, 5585's, self-injurious behaviors, and use PRN's).

Bayfront YFS also implements three types of measurements: Youth Outcome Measures Self Report (Y-OQ SR), Beck Depression Inventory II (BDI-II), and Beck Anxiety Inventory (BAI). These measurements allow for a more streamlined treatment and are administered on intake, quarterly, and at discharge.

Medication Support

Medication support services include prescribing and monitoring of psychiatric medication necessary to alleviate the symptoms of mental illness, decrease psychiatric hospitalizations, decrease placement disruption, decrease transition into higher levels of care, and stabilize clients at the lowest leve., least restrictive environment. A psychiatrist oversees medication support services. All DTI clients have an initial assessment meeting with one of the consulting psychiatrists within 7-14 days of admission, and regular monthly follow-up visits if they have been prescribed medication. Since the consulting psychiatrists participate in regular team meetings, more frequent contacts can be arranged if necessary.

Service Linkage

The client that is admitted to the DTI program will have been linked to resources that were identified when the client was residing at the group home and entered the discharge group. When the client leaves the group home, to the extent permitted by program resources, personnel will be available to assist with transporting the client to his or her home should the client request. The Primary Therapist will be available to work collaboratively with all of the client's support services and be ready to assist

the client with making connections with new resources should new needs unfold. Discharge from the program will be dependent on whether or not the client has met his or her goals and all needed linkages are in place. For Probation-referred clients, the purpose of the DTI Program is to provide coordinated, integrated, and intensive psychotherapy and rehabilitation interventions to clients whose past and current behavior demonstrates that they need to participate in, and will benefit from, a structured, multimodal treatment program that is offered at least six days per week.

Crisis Intervention Services

Crisis Intervention services are available as part of the DTI package of services. Crisis intervention services outside of the hours of the normal DTI program are provided by the residential services personnel, with back-up available the PMRT 911 as necessary. Once the client has begun a transition to their home from living at the group home, they will have become familiar with how to access services in case of an emergency or a crisis situation. During this period, each client is aware that they can contact their program resources and a licensed/waivered clinician will offer assistance immediately until the crisis is resolved and further interventions can continue on a regular basis. If the referral cannot be resolved by the on-call therapist, a referral to 911, PMRT, and if needed, the local hospitals, etc. will be made. If the crisis is medication related, a treatment team representative can assist with linkage to emergency medication services if the client's current psychiatrist is unavailable. Support and follow up will continue until the client and the family's informal support systems are secure with the process.

Crisis intervention services' objective is to prevent hospitalization and disruption of placement. Preventative, strategic planning enable client and families to employ coping skills to avoid crisis from occurring while in their home or any other community setting. Crisis intervention services include stabilization of the presenting emergency and include but are not limited to assessment, evaluation, and collateral linkage and services, as well as therapy and medication compliance. Implementation of a crisis plan during early engagement, along with trained parent/caregivers and staff will aid in de-escalation of a situation to avoid placement disruption and/or hospitalization. Bayfront YFS DTI Program personnel have the resources to link and/or provide emergency respite for clients should they be unable to de-escalate or remain safe. Safety is the priority and appropriate referrals will be explored. For clients on home visits, clients and families are provided with contact numbers for the Psychiatric Mobile Response Team (PMRT) in their county of residence. As needed, program personnel will participate in the transitional planning and support if the client is hospitalized and discharging back home.

Staff Training

On-going trainings are conducted and topics covered include specific training on cultural diversity to help staff increase awareness of cultural and ethnic differences and sensitivities as well as increase skills in order to respond to and interact appropriately to the different cultural background of clients. These trainings are conducted through in-service, webinar, and videos within the company and also by employing outside professional speakers. Procedural orientation covers topics in confidentiality, child abuse reporting, field safety, HIPAA, sexual and workplace harassment, company policies and procedures, Pro-Act and Non-Violent/Verbal De-escalation and Crisis Management, neglect, abuse, and misappropriation issues, child/adolescent development, attachment issues, boundaries, active listening, stress management, client and family empowerment, crisis intervention, behavioral and therapeutic interventions and behavioral modification techniques, mental health, family relations,

developmental disabilities, referral processes, substance abuse, cultural diversity, employee training handbook (which includes fire & disaster procedures, accident, illness & injury prevention), rights of persons served, Title 22 and State regulations, to name a few. Once the employee completes the company orientation and training, they are trained by their specific department head. The Head of Services and the various department heads including the company staff developer covers training specific to each department. All program policies & procedures, crisis response intervention & management, psychotropic medication and DSM-IV TR disorders and diagnosis, and documentation requirements are presented. Day Treatment-specific material is introduced as well. Such material includes a regular review of the dynamics of team functioning as well as an overview of "assessment, and time frames for completion of assessments for Family Safety, need for crisis support, development of Family Safety and Crisis Plans, and Family strengths, use of services that are directly linked to Child and Family preferences, choices, values and culture, examining extended Family systems to identify Family supports and services that can be obtained or purchased from within the family structure, specific methods for helping children and families build the skills needed to meet their specific needs and result in greater self-sufficiency, and provision monitoring, timely consultation, and ongoing coaching to promote skill acquisition and enhancement by experienced supervisors/program managers or subject matter experts."

Staffing Profile

Bayfront's staffing profile is as follows: 9 MA-level, Licensed/Waivered clinicians, 8 BA-BA Level Rehabilitation Counselors which meets and exceeds the DTI program client staffing ratio of 1:8. Each client will have a primary clinician who is responsible for ensuring that all the strengths and needs are identified; that all the identified services are provided in a timely and appropriate manner; is the contact point for children, families, service providers, and the community; and to ensure that the county representative(s) has adequate opportunities for input and access to the client and family and planning process. The Primary Therapist provides targeted interventions with family, and client and collaborates with community and county agencies as well as, interacts with school personnel. Staffing will be sufficient to assure that the required 1:8 ratio will be met 6-days per week.

The Director of Clinical Services is a licensed Marriage & Family Therapist with 4 years post licensure and supervisory experience. The Director of Clinical Services is responsible for client coordination and mental health services provided by Bayfront YFS and will oversee implementation of all needs and services plans. The Director of Clinical Services collaborates with the Administrator in the coordination of clinical and administrative functions.

Overall Mission and Vision

The goals of the program are to ensure that all clients have access to an individually prescribed array of coordinated interventions that are designed to promote and demonstrate the clients' readiness for successful community living. It is also a goal of the program that, upon discharge from the group home, all clients will be linked to community-based services and resources so as to promote stable and safety for community living, as well as safely reduce future reliance on out-of-home care. These clients will be linked and secured with an array of comprehensive services specific to each individual's needs.

Bayfront Youth & Family Services
"Changing lives is what we do!"

MEMO

Date: September 24, 2015

Re: Termination of Residential RCL 14 Program & Associated Agreements

To: All Contracted County Agencies & MHP's

Due to recent circumstances outside of our control it is with our deepest regret to inform you of our intent to close the residential care RCL 14 program and facility located at 4151 Fountain Street, Long Beach, California 90804. Closure will be effective as of October 31, 2015. A hardcopy letter with official notification will be submitted to all contracted agencies, as per instructions given under "Notice" language within each agreement.

Please make arrangements for the transportation of the adolescents from our facility prior to the closure date. Our utmost concern is for the care and safety of the clients in our care and, therefore, we will do all we can to ensure a smooth transition.

We appreciate your understanding. If you have any questions, please feel free to reach out to me at 562.719.9250 ext. 252 or at Maryam@BayfrontYFS.org.

Sincerely,

Maryam Ribadu Jenkins
President/CEO

MRJ/sps

State of California – Health and Human Services Agency | Department of Health Care Services

MEDI-CAL CERTIFICATION AND TRANSMITTAL

PART A COUNTY INFORMATION

COUNTY SUBMITTING FORM: Fresno PROVIDER #: 10DP NPI#: 1619233707

PART B TYPE OF TRANSACTION (Check all that apply)

- ☐ Medi-Cal Activation — Activation date: _____
- ☑ Medi-Cal Termination — Termination date: 11/1/15
- ☐ Medi-Cal Recertification — Recertification date: _____
- ☐ Address Change — Effective date: _____
- ☐ Name Change — Effective date: _____

- ☐ New Provider
- ☑ All Services
- ☐ Mode/Service Function
- ☐ Mode/Service Function

Re-certification required. Complete parts A-G.
Please complete parts C and G only.

PART C PROVIDER INFORMATION

Provider Name: Bayfront Youth and Family Services-Residential Treatment Program

Address: 4151 Fountain Street City: Long Beach Zip Code: 90804-3023

PART D MEDI-CAL ACTIVATION DATE

Per the MHP contract, the Medi-Cal activation date cannot be earlier than the latest of the following dates:

1). Date the provider requested certification: _____ 2). Date the site was operational: _____

3). Date of the fire clearance **(must be within 1 year of the onsite review):** _____

4). Date of the onsite review **(The onsite review must be completed within 6 months of the activation date.):** _____

5). Is this an out-of-county certification or re-certification? ☐ Yes ☐ No

If the answer to question 5 is yes, enter the name of the host county that conducted the onsite review? _____

PART E RESIDENTIAL SERVICES

☐ Adult Residential H0019 (05/65) ☐ Crisis Residential H0018 (05/40) ☐ Non-Hospital PHF H2013 (05/20)

Number of Beds **(maximum of 16):** [ ]

Note: All residential certifications & recertifications require submission of the residential license and MUST be 16 beds or less.

PART F OUTPATIENT SERVICES

Mode (Check ONLY one) ☐ **(12) Hospital Outpatient** ☐ **(18) Non-Hospital Outpatient**

☐ Case Manage/Brokerage	T1017 (15/01)	☐ Crisis Stabilization ER	S9484 (10/20)
- Intensive Care Coordination (ICC)	T1017 (15/07)	☐ Crisis Stabilization UC	S9484 (10/25)
☐ Mental Health Services	H2015 (15/30)	☐ Day TX Intensive Half Day	H2012 (10/81)
- Intensive Home Based Services (IHBS)	H2015 (15/57)	☐ Day TX Intensive Full Day	H2012 (10/85)
☐ Therapeutic Behavioral Services (TBS)	H2019 (15/58)	☐ Day Rehab, Half Day	H2012 (10/91)
☐ Medication Support	H2010(15/60)	☐ Day Rehab, Full Day	H2012 (10/95)
☐ Crisis Intervention	H2011 (15/70)		

PART G AUTHORIZED SIGNATURE (S)

The above named provider is certified by this agency to participate in the Short-Doyle/Medi-Cal program. I attest that the above named provider site complies with requirements of the CCR, Title 9, Sections 1810.435-436 and the terms of the contract between the MHP and the Department.

Laura Olivas — County Email: laolivas@co.fresno.ca.us
Print name of person completing form

Dotty Brown — Phone: (559) 600-4652 Date: 3/25/16
Authorized Signature Signed by: ☑ County Mental Health Director or Designee ☐ DHCS Compliance Section

E-MAIL OR FAX signed and completed form to: EMAIL: *DMHCertification@dhcs.ca.gov* or by FAX: (916) 440-5497

PART H DHCS COMPLIANCE SECTION APPROVAL TO TRANSMIT DATA TO DHCS

DHCS Compliance Section: Vicky Ulong Date: 3/30/16

DHCS 1735 (Rev. 09/2014)

RECEIVED 3/29/16

Attachment V
Bayfront Children and Family Services
Closure Letter and Termination Transmittal

MEMO

Date: September 24, 2015

Re: Termination of Residential RCL 14 Program & Associated Agreements

To: All Contracted County Agencies & MHP's

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Sincerely,

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☐ Medi-Cal Recertification	Recertification date:		
☐ Address Change	Effective date:	Re-certification required. Complete parts A-G.	
☐ Name Change	Effective date:	Please complete parts C and G only.	

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Laura Olivas County Email: laolivas@co.fresno.ca.us

Print name of person completing form

Betty Brown Phone: (559) 600-4652 Date: 3/25/16

Authorized Signature Signed by: ☑ County Mental Health Director or Designee ☐ DHCS Compliance Section

E-MAIL OR FAX signed and completed form to: EMAIL: *DMHCertification@dhcs.ca.gov* or by FAX: *(916) 440-5497*

PART H DHCS COMPLIANCE SECTION APPROVAL TO TRANSMIT DATA TO DHCS

DHCS Compliance Section: Vicky Wong Date: 3/30/16

DHCS 1735 (Rev. 09/2014)

RECEIVED 3/29/16