	County of Sacramento Department of Health Services Division of Behavioral Health Services Policy and Procedure	Policy Issuer (Unit/Program)	Mental Health Services
		Policy Number	02-12
		Effective Date	04-29-20
		Revision Date	04-29-20
Title: **Corrective Action Plan**		Functional Area: **Contract Administration**	
Approved By: *Signed version available upon request* Ryan Quist, Ph.D. Deputy Director, Behavioral Health Services			

Background/Context:

Sacramento County (County) provides behavioral health services to Sacramento County beneficiaries primarily via contracted Agreements with provider agencies. In order to ensure quality services for Sacramento County Department of Health Services, Division of Behavioral Health (BHS) beneficiaries, BHS provides trainings, technical assistance, regularly monitors and evaluates a contractor's performance as it relates to regulatory requirements and the current executed Agreement for each contractor. When a contractor is not meeting contract requirements or deficiencies persist beyond what BHS determines as a reasonable timeframe for resolution, a Corrective Action Plan (CAP) provides an opportunity for contractors to address performance issues and attain compliance with the Agreement, including compliance with all County policies and relevant regulations. All CAPs will be consistent with all County policies and procedures.

Definitions:

I. **Avatar or Other Electronic Health Record (EHR):** A computer software program that contracted mental health providers and contracted alcohol and drug services providers use to document services, manage billing, and produce data reports.

II. **Good Standing**: When a program has no current CAPs, the program status will be identified as in Good Standing. Good Standing means the program is in compliance with contractual obligations.

III. **Deficient**: Deficient means there has been a problem that has been identified and a clear statement of expectations provided to the contractor by the County. If the Contractor does not address identified concerns within the timeframe requested by the County, the County may administer a CAP.

IV. **Corrective Action Plan:** A written document developed by the contractor in collaboration with, and approved by the County that specifies how the contractor will address each item identified as out-of-compliance. A CAP uses plans that are measurable and objective with clear timelines and deadlines for attaining compliance. While a program is on a CAP, the Contractor is not in compliance with contractual obligations.

Purpose:

To outline a structured and transparent process to evaluate a contractor's compliance performance with Sacramento County BHS and provide a reliable method to identify and support correction of compliance concerns.

Details:

I. Monitoring and Evaluation- Using information obtained through regular monitoring, reviewing, and reporting, the County evaluates programs utilizing reports designed to identify and analyze performance.

A. Areas of performance that may be used to determine if a contractor is in compliance with their contracted Agreement include, but are not limited to:

1. Client health or safety issues

2. A significant and substantiated client grievance

3. Significant underperformance on meeting contractual deliverables around quantity or quality of services

4. Site certification lapses or site certification non-compliance

5. Documentation – Evidence of non-compliance with County policies and/or contractual requirements.

a. Inability to maintain required data elements in Avatar/Electronic Health Record or delays in submitting reports

b. Inability to meet clinical documentation standards for claiming for services provided to beneficiaries

c. Delays in submitting required documentation including contractual documents, invoice documents, programmatic reports, surveys, staffing changes, audited financial statements

d. Delays in Adverse Incident Reporting submissions

e. Other forms of written documentation that are out of compliance

6. Fiscal
   a. Billing and Invoicing issues (e.g. inaccurate, delayed submission)

   b. Failure to maintain financial eligibility and claiming requirements

7. Performance deliverables

   a. Hiring and retention issues that impact service delivery

   b. Service productivity that impacts contract draw down or staff retention

8. Failure to maintain Licensing certifications or regulatory requirements – Federal, State, or County

9. Non-compliance with any other County Policy and Procedures

10. Other concerns identified by BHS

B. The County will communicate and provide technical assistance to contractors regarding regulatory and contractual requirements. Contractors must follow-up with the County if additional technical assistance or consultation is needed to help contractors succeed in implementing requirements.

II. Deficient- If a concern has been identified, the County will bring any deficiencies to the attention of the contractor in writing in a timely manner with the goal of quickly addressing issues through collaborative discussion and technical assistance, when possible.

A. The County will help assess the deficiencies with the following activities, as appropriate:

1. Routine monitoring, evaluation reviews, and quarterly reports

2. Clinical review or fiscal audit(s)

3. Review of Research, Evaluation, and Performance Outcomes data

4. Review of Quality Management data

5. Other assessments activities as indicated

B. The County will address the deficiencies informally whenever possible, and document any informal attempts.

C. The County will notify the contractor in writing if a program has not addressed deficiencies within the timeline identified and a CAP will be initiated. The County Contract Monitor will obtain internal authorization from the Program Manager and Division Manager to place a contractor on a CAP. The Division Manager will inform the BHS Deputy Director about the CAP.

III. Corrective Action Plan- A CAP is intended to address compliance concerns by identifying in writing the compliance findings, a target goal for addressing concerns, and a detailed action plan to meet the target goal.

A. The CAP shall be completed by the contractor using the County Corrective Action Plan (See Attachment A or Attachment B for DMC-ODS contractors in collaboration with the County). A separate CAP form should be used for different areas of performance that need correction to allow for clear monitoring and tracking of compliance.

B. The CAP will include the following information:

1. Details of the areas of performance that need correction as identified by County.

2. The findings that support the need for correction

3. The CAP measurable strategies and steps to address the concerns and meet the target goal, such as specific actions including but not limited to:

a. Improving systems and internal processes

b. Increasing more robust supervision and training

c. Thorough record reviews and audits

d. Revising policies and/or procedures

e. Strategies to address staff morale and creative hiring

4. A target completion date approved by County that is attainable, manageable, and sustainable.

5. CAPs can be identified as urgent, priority, or routine:

    a. Urgent – Concerns related to client health and/or safety that require immediate correction. The provider must submit a follow-up plan to identify how the concerns will be corrected within seven (7) calendar days of the notification.

    b. Priority – Concerns identified with potential impact to the health and safety of the clients, staff, or Contractor. Corrections will substantially correct or eliminate concerns within thirty (30) calendar days.

    c. Routine – Concerns that are identified as ongoing. Corrective actions will substantially correct or eliminate concerns within sixty (60) calendar days.

    d. Annual – Alcohol and Drug Services Contracted Providers are monitored for compliance with laws, regulations, provisions of contracts or grant agreements, and performance measures. Corrective actions will substantially correct or eliminate concerns within thirty (30) calendar days.

C. CAP monitoring and verification shall be documented on the CAP and includes but not limited to:

1. Providing technical support to the contractor to meet target timelines and goals

2. Contractor providing weekly status updates on action steps and providing evidence or references within electronic health record that shows completion of action steps.

3. Monitoring and evaluation by the County to determine if the CAP is being implemented as planned or if additional support is needed along the way.

4. The County will determine if the contractor has corrected the identified findings and completed the CAP actions using observable information or other available data and evidence.

IV. CAP outcomes can include one or more of the following:

A. If the contractor has completed the CAP successfully, the County will issue a Letter of Good Standing (See Attachment B) or a Corrective Action Plan Approval Letter (See Attachment D) to the Contractor.

B. If the contractor has not completed the CAP by the approved timeline, the County will notify the contractor in writing with next steps. Next steps may include, but are not limited to, the following:

   1. Extend the timeline to complete the CAP.

   2. Decrease the contracted capacity and/or the contracted maximum budget amount for the current or next Fiscal Year

   3. Terminate the current year's contracted Agreement.

   4. Not renew a contractor's Agreement the next fiscal year.

   5. Other sanctions as identified by the County.

C. A copy of the CAP will be maintained in the County Contract file and will be sent to signers of the CAP and relevant internal partners, Program Directors and CEOs of the Contractor on a CAP. The BHS Division Manager will inform the BHS Director about the CAP.

References/Attachments:

Attachment A – Corrective Action Plan

Attachment B – Corrective Action Plan (DMC-ODS)

Attachment C – Letter of Good Standing

Attachment D – Corrective Action Plan Approval Letter (DMC-ODS)

Related Policies:

QM 41-01 Division of Behavioral Health Services Compliance Program

ADS 05-14 Annual Contracted Provider Site Reviews

Distribution:

Enter X	DL Name	Enter X	DL Name
X	Behavioral Health Services Staff	**X**	Publish to Intranet
X	Contracted Providers	**X**	Publish to Internet

Contact Information:

Maria Pagador, Human Services Program Planner, BHS
PagadorM@SacCounty.net

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SACRAMENTO COUNTY
DEPARTMENT OF HEALTH SERVICES
Division of Behavioral Health Services

Attachment A

Corrective Action Plan For Enter Agency Enter Program

Fiscal Year:	Enter FY	**1st Date of Relevant Deficiencies:**	Date	**Date of CAP:**	Date	**CAP Completion Date:**	Date
Program Contact:	Click to enter text.	**County Program Coordinator:**	Click to enter text.			**CAP Approvals:**	
Phone & Email	Click to enter text.	**Phone & Email**	Click to enter text.			**PC Initials:**	Date
Program CEO:	Click to enter text.	**County Program Manager:**	Click to enter text.			**PM Initials:**	Date
CEO Email:	Click to enter text.	**Program Manager Email:**	Click to enter text.			**DM Initials:**	Date

Area of Performance Needing Correction	Findings	Measurable Action Steps to Correct	Target Completion Date	County Comments	Priority Level
Choose One	Click to enter text.	Click to enter text.	Date	Click to enter text.	Choose One

Date of 1st Status Update	Measurable Action(s) Taken & Status Update	Evidence Submitted or Reference	Correction Complete?	Date Completed	County Status Determination	Next Step
Date	Click to enter text.	Click to enter text.	Choose	Date	Choose One	Choose One
Contractor Comments:	Click to enter text.				**County Comments:**	Click to enter text.

Date of 2nd Status Update	Measurable Action(s) Taken & Status Update	Evidence Submitted or Reference	Correction Complete?	Date Completed	County Status Determination	Next Step
Date	Click to enter text.	Click to enter text.	Choose	Date	Choose One	Choose One
Contractor Comments:	Click to enter text.				**County Comments:**	Click to enter text.

Date of 3rd Status Update	Measurable Action(s) Taken & Status Update	Evidence Submitted or Reference	Correction Complete?	Date Completed	County Status Determination	Next Step

Date	Click to enter text.	Click to enter text.	Choose	Date	Choose One	Choose One
Contractor Comments:	Click to enter text.				**County Comments:**	Click to enter text.
Date of 4th Status Update	**Measurable Action(s) Taken & Status Update**	**Evidence Submitted or Reference**	**Correction Complete?**	**Date Completed**	**County Status Determination**	**Next Step**
Date	Click to enter text.	Click to enter text.	Choose	Date	Choose One	Choose One
Contractor Comments:	Click to enter text.				**County Comments:**	Click to enter text.
Date of 5th Status Update	**Measurable Action(s) Taken & Status Update**	**Evidence Submitted or Reference**	**Correction Complete?**	**Date Completed**	**County Status Determination**	**Next Step**
Date	Click to enter text.	Click to enter text.	Choose	Date	Choose One	Choose One
Contractor Comments:	Click to enter text.				**County Comments:**	Click to enter text.
Date of 6th Status Update	**Measurable Action(s) Taken & Status Update**	**Evidence Submitted or Reference**	**Correction Complete?**	**Date Completed**	**County Status Determination**	**Next Step**
Date	Click to enter text.	Click to enter text.	Choose	Date	Choose One	Choose One
Contractor Comments:	Click to enter text.				**County Comments:**	Click to enter text.
Date of 7th Status Update	**Measurable Action(s) Taken & Status Update**	**Evidence Submitted or Reference**	**Correction Complete?**	**Date Completed**	**County Status Determination**	**Next Step**
Date	Click to enter text.	Click to enter text.	Choose	Date	Choose One	Choose One
Contractor Comments:	Click to enter text.				**County Comments:**	Click to enter text.

SACRAMENTO COUNTY
DEPARTMENT OF HEALTH SERVICES
Division of Behavioral Health Services

Attachment B

[Contracted Provider Name] Annual Review [Month/Year]

Please submit this completed document and specific evidence to support the current corrective actions (see instructions below). Label all evidence with the applicable question number and highlight the specific portion(s) of the document.
Please send to: Contract Monitor/Program Coordinator Email Address

"Provider Identified Corrective Action(s) Current Status Comments" – Give an update of what is currently being done, please be specific. If a revision or additional intervention is included please indicate (NEW). Updates should be dated and font color changed.
"Date Completed or Planned" – Indicate the specific date it was completed or, if planning to make a revision, the planned date of completion.
"Evidence (Document Name)" – When submitting a document as your evidence, list its name and applicable page/item number in this column. Label all evidence with the corresponding Findings number and highlight the specific section(s) of the document.

Findings Section(s)	Provider Identified Corrective Action(s) Current Status Comments	Date Completed or Planned	Evidence (Document Name & specific location of info in document.)	County BH Comments
Finding(s):	**Provider's Response:**	**Provider's Response:**	**Provider's Response:**	**MHP Response:**

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Attachment C

Department of Health Services
Peter Beilenson, MD, MPH,
Director

Divisions
Behavioral Health Services
Primary Health
Public Health
Departmental Administration

County of Sacramento

County Executive
Navdeep S. Gill

LETTER OF GOOD STANDING

[Date]

[Point of Contact Name]
[Job Title]
[Agency Name]
[Program Name]
[Address]

SUBJECT: Corrective Action Plan with the County of Sacramento, Department of Health Services, Division of Behavioral Health Services

Your agency has fully complied with all applicable requirements relating to the Corrective Action Plan dated [Date] for Fiscal Year [Year]. There are no further actions needed at this time. If you have any questions regarding this process, please contact me at [Phone Number]. Thank you.

_____ _____
County [Division Contact] Signature Date

_____
Printed Name and Title

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Attachment D

Department of Health Services
Peter Beilenson, MD, MPH,
Director

Divisions
Behavioral Health Services
Primary Health
Public Health
Departmental Administration

County of Sacramento

County Executive
Navdeep S. Gill

CORRECTIVE ACTION PLAN APPROVAL LETTER

[Contracted Provider Agency Name]
[Date]
[Point of Contact]

The purpose of this correspondence is to document that this write reviewed the Corrective Action Plan (CAP) that was submitted in response to the annual review report.

[Contracted Provider Agency Name] annual review took place on [Date(s)] and was conducted by this writer. All issues that require your attention were addressed in your CAP.

The Corrective Action Plan has been completed and there are no outstanding or pending items remaining from the [Year} annual review.

Please contact [Program Coordinator Name] if you have any questions.

Thank you,

_____

[Program Coordinator Signature]
Program Coordinator/Contract Monitor