SBHO Administrative Review Results: Chart Items Report

Agency Name

Date of Administrative Review

1. Evidence of agency purchasing services if not able to provide medically necessary behavioral health services.	
2. Ensure MH Intake packet or SUD assessment process includes current version of outpatient rights.	
3. Medicaid only - Evidence of client notified of primary clinician terminated/no longer employed at agency) within 15 days of separation.	
4. Evidence in chart how advance directive information was made available/distributed/tracked.	
5. Evidence that request for second opinion appointments occur within 30 days,when requested.	
6. Evidence of choice or change of provider is effected when requested.	
7. Review process for agency securing "restricted access" or unauthorized access clinical charts.	
8. Clients have access and right to review clinical file and be told cost for copying.	
9. Review ROI and ROI process in client file; request a staff member to describe agency process.	
10. Review charts for evidence of PIPs and new program development	

SBHO Administrative Review Results: HIPAA and 42CFR

Agency Name

Date of Administrative Review

1. Provide policies and procedures that show the agency aligns with federal regulations and SBHO policies.

2. Demonstrate that a HIPAA log exists and that it is up-to-date.

3. Provide documentation and describe process which demonstrates how Breach vs Violation is determined.

4. Review agency ROI(s) for adherence to HIPAA (and 42 CFR Part 2, if SUD).

5. Provide information regarding methods which would be used for any breach notification.

6. Provide agency policy which identifies permitted uses and disclosures of client records or client information.

7. Provide agency policies which clearly define and identify authorized disclosures.

8. Evidence of Agency log of Medical Record disclosures. Measure - Review of Agency log (date and content)

9. Ensure agency has a policy which reflects that only necessary minimum information will be disclosed.

10. Review policy and procedure that demonstrates the patient's right to access their records.

11. Review policy and procedure that demonstrates a patient's right to amend their record.

12. Review policy and procedure that demonstrates the patient's right to receive an accounting of disclosures regarding their records.

13. Provide policy and procedure which demonstrates the patient's right to restrict access to their records.

14. Provide policy and procedure which demonstrates patient's right to recieve agency's notice of privacy practices.

15. Provide visual verification that interview rooms are secure and private.

16. Provide visual verification that the front reception area has reminders that there is limited or no privacy in that area.

17. Provide visual verification that computer screen and monitors are maintained as secure, including the use of privacy settings.

18. Provide visual verfication of secure and privacy log-in access, including password management and that staff can report clear understanding of need and use of this practice.

18. Review agency risk assessment and discuss with administration to ensure it is up-to-date and has identified high, medium, and low risks.

19. Review agency log to ensure provision of effective risk training (this can be part of Compliance training).

20. Observe files to ensure patient content is in locked container - either locked files and/or locked shred bin.

21. Observe office doors are locked or office does not have patient content available to unauthorized persons.

SBHO Administratvie Review Results : Information Systems

Agency Name

Date of Administrative Review

1. Provide evidence that the provider's Disaster Plan is up to date. ☐

2. Provide evidence that a copy of provider's Disaster Plan is stored off-site. ☐

3. Demonstrate Disaster Plan has been tested. ☐

4. Provide evidence that the provider's Disaster Plan contains agency's mission or scope. ☐

5. Provide evidence that that there is an appointed disaster recovery team. ☐

6. Provide evidence that provider's Disaster Plan has provisions for back-up of key personnel. ☐

7. Provide evidence that provider's Disaster Plan includes identification of emergency procedures. ☐

8. Provide evidence that provider's Disaster Plan contains procedures for allowing effective communication. ☐

9. Provide evidence that provider's Disaster Plan contains visibly listed emergency telephone numbers. ☐

10. Provide evidence that provider's Disaster Plan contains application inventory, e.g. Office software. ☐

11. Provide evidence that provider's Disaster Plan contains prioritization for business recovery. ☐

12. Provide evidence that provider's Disaster Plan contains hardware and software vendor list. ☐

13. Provide evidence that provider's Disaster Recovery Plan contains confirmation of updated system and operations documentation. ☐

14. Provide evidence that provider's Disaster Plan contains process for frequent backup of systems and data. ☐

15. Provide evidence that provider's Disaster Plan contains offsite storage of system and data backup files. ☐

16. Provide evidence that provider's Disaster Recovery Plan contains designated recovery options that may include use of a hot or cold site. ☐

Agency Name

Date of Administrative Review

17. Provide evidence that provider's Disaster Recovery Plan contains evidence that disaster recovery tests have been performed.

18. Data stored on local stations hard disks have restricted access to authorized users, requiring unique user IDs and hardened passwords.

19. Data stored have restricted access using control lists using unique user ID and hardened password.

20. Data on disks mounted to servers are located in area accessible only to authorized personnel, access by key, card key, combination lock or comparable.

21. Paper documents stored in secured area only accessible to authorized persons, storedd in locked container.

22. Evidence that data stored on optical disks will not be transported out of secured area and must be kept in secure storage.

23. Evidence that access to State data controlled by DSHS staff who issue authentication credentials. Notice to DSHS immediately when staff leaves employ or no longer needs access.

24. Data storage on portable media/devices transported outside secured area - encrypt data and devices to 128 bits.

25. Data storage on portable media/devices transported outside secured area - access control with password or stronger authentication.

26. Data storage on portable media/devices transported outside secured area - manual locking devices whenever left unattended; auto lock after < 20 minutes.

27. Data storage on portable media/devices transported outside secured area - physical protect portable devices/media - kept in locked storage, using check-in, frequent inventories.

28. Evidence that devices/media with DSHS data must be in physical control of authorized agency staff.

29. Evidence that DSHS data not stored on any portable devices or media unless specifically authorized.

30. Evidence that DSHS data may be stored on portable media as part of contractor's existing documnted bakc process for business continuity/disaster recovery. If back up media retired while contining DSHS information, media will be destroyed.

31. Evidence that DSHS data may be stored on non-portable media as part of contractor's existing documented bakup processes for business continutity or disaster recovery. If backup media retired while containing DSHS information media will be destroyed.

32. Evidence that DSHS data is segregated/distinguishable from non-DSHS data. Includes procedures for data storage on media, in logical container, within shared database, and paper documents.

33. Evidence that media stored on server or workstation hard disks or removable media is disposed using wipe utiltiy, degaussing, and/or physical destruction.

34. Evidence that paper documents with sensitive or confential information is disposed by recycling through a contracting firm or onsite shredding, pubping or incineration.

35. Evidence that optical discs are disposed by incineration, shredding, or defacing readable surface with a coarse abrasive.

36. Evidence that magnetic tape is disposed by degaussing, incinerating, orcrosscut shredding.

37. Provider sends timely certifications that attest, based on best knowledge, information and belief, to the accuracy, completeness and truthfulness of the information and/or data.

SBHO Administrative Review Results: Personnel Records Checklist

Agency Name

Date of Administrative Review

Agency Staff Name: Hire Date:

Position:

Cultural Diverstiy Training provided twice a year	☐
Medicaid Fraud Abuse Training	☐
HIPPA training within first 30 days of hire?	☐
Signed HIPPA statement	☐
Evidence that personnel file contain signed attestation to abide by Code of Conduct	☐
WSP or other background check	☐
Board Certification, state licesnure, or agency affiliated	☐
School training certificate/Specialists Training log	☐
Current Training Plan	☐
Current Evaluation Plan	☐
Attended annual safety and violence prevention training	☐
Evidence of date deputized	☐
SUD - TB Test on file	☐
SUD - Blood Born Pathogen Training	☐
SUD - Control of disease	☐
OIG Check documented done at time of hire	☐

Agency Name

Date of Administrative Review

Evidence of signed job description ☐

Evidence of Agency Orientation ☐

Evidence of annual Enrollee Rights training ☐

SBHO Administrative Review Results: Personnel Report

Agency Name

Date of Administrative Review

1. Ensure number of qualified agency personnel, age appropriate, sufficent number, and access/travel standards. Measure - Review caseload numbers, availability to specialists, and travel standards.

2. Verify primary source verification for education and credentials (state slicensure can substitute primary source documents). Measure - Reandom review of 10% of personnel files of recently hired staff for primary source verification check. (See Personnel checklist).

3. Random sample review of agency employee files for training and evaluation plans. Measure - Random review of 10% of recently hired staff (See Personnel Records Checklist).

4. Signed statements are maintained on file acknowledging understanding and agreement to abide by HIPAA requirements. Measure - Random review of 10% of recently hired staff (see Personnel Records Checklist).

5. Agency staff have received annual HIPAA training. New staff receive training within 30 days of start date. Measure - Random review of 10% of recently hired staff (see Personnel Records Checklist).

6. Verify Medicaid fraud and abuse training. Measure - Random review of 10% of recently hired staff (see Personnel Records Checklist).

7. Verify Safety and Violence Prevention training occurs annually. Measure - Random review of 10% of recently hired staff DMHPs (see Personnel Records Checklist).

8. DMHPs only: Evidence of deputized date for recently hired (previous 12 months) DMHPs. Measure - 100% review of all recently hired DMHPs (see Personnel Records Checklist).

9. Verify no Physician Incentive Plan(s). Measure - Random Review

10. Random sample of Exit Interviews from recently departed staff (within the past 12 months). Measure - Random review Exit Interviews for trends.

11. Verify Agency provides Cultural Diversity training twice a year to staff. Measure - Random review of 10% of recently hired staff (see Personnel Records Checklist).

12. Verify Agency Orientation training includes: training on grievance and appeal system, duty to warn, staff ethical standards and conduct, including reporting of unprofessional conduct to appropriate authorities, and Agency Policy and Procedure review. Measure - Random Review.

13. Evidence that Agency conducts background check before start date and annually thereafter

SBHO Administrative Review Results: Program Integrity Report

Agency Name

Date of Administrative Review

1. Provide evidence that provider has current Medicaid Fraud Abuse (MFA) Plan. Comply with SBHO Medicaid Fraud and Abuse Plan. Measure - Review agency plan for updates, such as SBHO Compliance Committee participation, risk assessment, method of reviewing subcontractors. ☐

2. Demonstrate policy and procedures that providers follow for reports of allegations of Medicaid Fraud or Abuse from agency/staff in the past 12 months in log. ☐

3. Review policy and procedure, as well as observe evidence that ensure Federal Exclusion website searches are conducted upon hire, continue every month following (including view ongoing files which can be paper or electronic). ☐

4. Ensure monthly Federal Exclusion attestations are submitted in a timely manner. ☐

5. Evidence provided that provider has maintained a current list of management staff that includes name, DOB, and SS number. ☐

6. Provider has mechanism that if an employee or subcontractor is found to have a conviction or sanction or found to be under investigation for criminal offense related to healthcare are to be removed from direct responsibility for, or involvement with the Salish BHO/PIHP funded services. ☐

7. Provide evidence of provider's Compliance Committee meetings and available trainings to staff. Measure - Review of agency Compliance Committee meeting notes and training logs. ☐

8. Review of agency cultural diversity goals and how the goals are assessed. ☐

9. Provide evidence of provider's participation in SBHO Compliance Committee. ☐

10. Provide evidence of Compliance training, e.g. listed in training log. Training must occur at least annually. ☐

11. Provide evidence of Agency Code of Conduct. Ensure content adheres to SBHO Code of Conduct content. ☐

12. Ensure agency has an identifed Compliance Officer. ☐

13. Provide evidence that provider has adequate retention policy, in line with SBHO policy and contract. ☐

14. Observe and verify accurate method of exclusion check. ☐

15. Ensure agency administration is familiar with CLAS (HHS website) expectations. ☐

16. Provide evidence that ensures staff is aware of types of disasters/emergencies and what agency protocols are in the event of such. ☐

Agency Name

Date of Administrative Review

17. Ensure emergency exit routes are posted. ☐

18. Provider is able to demonstrate agency alternative communication methods for persons with visual or hearing impairment or limitation. ☐

19. Provider is able to demonstrate/describe plan to evacuate all persons, including person with mobility impairment and children if child care offered. ☐

20. Provide evidence of policy to ensure emergency phone access when power outage and/or phone service is out. ☐

21. Overall review of policies and procedures shows compliance with all applicable state and federal laws. ☐

22. Provide evidence that provider is in compliance with non-discrimination policies (such as Title IV or the Civil Rights Act of 1964, Age Discrimination Act of 1965, Rehabilitation Act of 1973, Title II and II of American with Disabilities Act) and DSHS Administrative policies. ☐

23. Agency has been responsive to SBHO CAP requests - e.g. Admin Rev, chart reviews, UMC, Fiscal audit, QUIC. ☐

24. Provide evidence of policy which ensures enrollee is notified of changes in state law related to direct services. ☐

25. Agency is able demonstrate how they identify/confirm payer at time of service. ☐

26. Provide evidence that agency policies, procedures, and form demonstrate an effort to ensure sliding fee scale payments. ☐

27. Provide evidence that policy and procedure regarding all non-Medicaid individuals seeking services are assisted with accessing Medicaid to determine if they qualify for that program. ☐

28. Medicaid clients only: Provide evidence of policy that client receives notification (within 15 days) that primary clinician is no longer working there, e.g. terminated. ☐

29. Medicaid client only: Ensure there is policy procedure that allows agency clinician to advocate for Medicaid clients so that they are not denied, limited, or discontinued medically necessary behavioral health services. ☐

30. Demonstrate agency has effective Critical Incident Policy. ☐

31. Review Critical Incident Log for adequate content and process. ☐

32. Ensure there is a designated person(s) to process/log all critical incidents. ☐

33. Review smoking Policy - in light with WAC 388-877-0420(16) 388-877-020(12). ☐

Agency Name

Date of Administrative Review

34. Identify all, if any, civil monetary penalties and assessments of vendors, providers, or subcontractors.

35. Review provider safety policy and ensure it includes adequate safety, e.g. Marty Smith safety outreach protocols.

36. After review of broad spectrum of policies and procedures - clear evidence is present off current practice/acronyms and review dates in policies.

37. Medicaid clients - Review Policy to ensure second opinions occur within 30 days, when requested. Non-Medicaid - as resources available.

38. Provide evidence that policy and procedure ensures client choice and change of providers is done, when requested.

39. Provide evidence that agency policy/procedure includes securing "restricted access" of clinical charts.

40. Provide evidence of provider policy regarding client right to have access and review their clinical file.

41. Review ROI Policy to ensure appropriate procedure how disclosure is processed.

42. Provide evidence of policy reflecting compliance with SBHO Seclusion and Restraint policy; Also, evidence in incident reports.

43. Agency discloses 5% or more ownership information for agency and any subcontractors.

44. Provide evidence that provider ensures formal Tribal Coordination Plans with each local Tribe or evidence of efforts to establish a plan. Measure - review of formal and informal efforts to improve Tribal collaboration and communication.

SBHO Administrative Review Results : Quality Assurance Report

Agency Name

Date of Administrative Review

1. Provide evidence of an existing Quality Management Plan. ☐

2. Provide evidence that the provider is actively implementing their Quality Managaement Plan. ☐

3. Ensure evidence that provider participates in the SBHO Quality Improvement Committee. ☐

4. Provide evidence that services are offered/provided to improve the treatment of consumers regarding the quality of intake evaluations. ☐

5. Provide evidence that services are offered/provided to improve treatment of consumers regarding effectiveness of prescription medications. ☐

6. Review of policy/procedure which reflects - training plans, who funds trainings, required trainings, and frequency. ☐

7. Provide agency policy/procedure which reflects adequate clinical supervision (at least annually. ☐

8. Provide policy/procedure which reflects credential requirments and prohibits staff from providing clinical services if not adequately credentialed. ☐

9. Demonstrate that the agency collects, maintains, and uses information to correct deficiencies and improve services, including sentinel events. ☐

10. Provide evidence that agency has and uses a clear definition of grievance which aligns with the WAC grievance definition. ☐

11. Provide clearly written policy showing enrollee rights which align with WAC enrollee rights. ☐

12. Provide evidence that clients are informed of Ombuds services, including contact information given to client. ☐

13. Provide evidence of agency policy/procedure which reflects who and when a grievance may be filed with agency or SBHO. ☐

14. Provide evidence of agency policy/procedure which reflects the enrollee's rights during the grievance process. ☐

Agency Name

Date of Administrative Review

15. Provide evidence of agency policy showing what is applicable content in written notices involved in the grievance process. ☐

16. Provide evidence of agency policy which reflects that record retention of grievances is 10 years. ☐

17. Evidence that Grievance documents are stored separate from Clinical Records. Measure - Review of storage location. ☐

18. Provide evidence of agency policy/procedure which outlines the appeal process and timelines. ☐

19. Provide evidence of agency policy/procedure which outlines requirements and process of Adverse Benefit Determinations. ☐

20. Provide evidence of adequate policy/procedure regarding rights and process for administrative hearings. ☐

21. Provide evidence of accurate and substantive policy/procedure which outlines process for grievance reporting. Include who, what, when, where. ☐

22. Provide evidence of ongoing data collection by the agency. Data is actively used to discern objective measures aimed at examining clinical services. ☐

23. Provide evidence that the agency has valid method to identify areas warranting improvement. ☐

24. Provide evidence of that agency is implementing plans to improve areas identified as warranting improvement. ☐

25. Provide evidence that agency culture includes consumer choice and participation in Quality Management. ☐

26. Provide evidence that family and other natural supports identified by enrollee are a part of the enrollee's evaluation and treatment process. ☐

27. Provide evidence of timely access to care for emergency and non-emergency services. ☐

28. Provide evidence of agency's up-to-date EBP, Promising Practices, and fidelity, including trainings and certifications by accredited institution(s). ☐

29. Provide evidence of the agency providing quality crisis services. ☐

30. Provide evidence of local efforts to provide services that are integrated and coordinated with other formal/informal service delivery systems. ☐

31. Provide evidence of agency's internal tracking system to monitor advance directives, e.g. are they readily available when client needs implementation of advance directive. ☐

SBHO Administrative Review Results: Walk-Through Report

Agency Name

Date of Administrative Review

1. Evidence of Ombuds brochures/flyer in reception/main lobby, treatment rooms, satellite sites. ☐

2. Evidence of Point to your Language sign in lobby/reception. ☐

3. Evidence of Posted Advance Directives in reception/lobby - brochure. ☐

4. Evidence of posted enrollee rights in all prevalent languages in public areas. ☐

5. Evidence of information on how to file a grievance posted in public areas. ☐

6. Evidence of SBHO Member handbook or agency comparable information sheet explaining all benefits for enrollee. ☐

7. Evidence of DSHS Benefits Booklet available in conspicuous areas of agency. ☐

8. Agency staff can explain process when an individual requests to review their own medical record. ☐

9. Confirm by observing - agency has all necessary licnses, cerfications and/or permits as required by law. ☐

10. Observe Medicaid Fraud Control Unit Hotline Reporting Flyer in common Staff area. ☐

11. In ET - Observe posted client rights. ☐

Agency Name

Date of Administrative Review

12. In ET - Observe HIPAA privacy practices - private interview rooms, privacy screens, locked files/doors. ☐

13. In ET - Observe Ombuds brochures/flyers in client areas. ☐

14. In ET - Observe inpatient policy regarding security and safety. ☐

15. Observe agency call logs which contains date and type of call (e.g. grievance, information,requesting services) and date of attempted resolution. ☐

16. Evidence of log for use of interpreters. ☐

17. Observe layout to determine ADA accessibility; consider ADA checklist completed by agency. ☐

18. www.ada.gov/racheck.pdf - Ensure ADA assessment is done. ☐