

The logo for the State of Nebraska, featuring the word "NEBRASKA" in a bold, blue, sans-serif font. A yellow swoosh underline starts under the 'N', goes under the 'B', 'R', 'A', and 'S', and then curves upwards under the 'K' and 'A'.

Good Life. Great Mission.

DEPT. OF HEALTH AND HUMAN SERVICES

Division of Behavioral Health Audit Manual

Final – Effective September 1, 2025

TABLE OF CONTENTS

TABLE OF CONTENTS.....	2
PART I: OVERSIGHT FUNCTIONS.....	3
PART II: SCHEDULE OF AUDITS FOR CURRENT FISCAL YEAR.....	7
PART III: CPA AUDIT.....	8
PART IV: GENERAL VERIFICATION/REVIEW PROCEDURES.....	11
PART V: ADDITIONAL CONSIDERATIONS FOR SPECIFIC SERVICES.....	15
PART VI: SERVICES PURCHASED VERIFICATIONS (UNIT/EXPENSE)	16
SERVICES PURCHASED VERIFICATION DECISION FLOWCHART	21
NON-FEE FOR SERVICES VERIFICATION DECISION FLOWCHART	22
PART VII: PROGRAM FIDELITY REVIEWS	23
APPENDIX A: MANDATORY REVIEW COMPONENTS TO BE INCLUDED IN PROGRAM FIDELITY REVIEW OR NATIONAL ACCREDITATION REPORT	25
APPENDIX B: SERVICE SPECIFIC FIDELITY REQUIREMENTS PER Service.....	29
APPENDIX C: DEVELOPING GOALS AND MEASURABLE OBJECTIVES.....	32

PART I: OVERSIGHT FUNCTIONS

The Division of Behavioral Health (DBH) and the Regional Behavioral Health Authority (RBHA) monitor, review, and perform programmatic, administrative, quality improvement, fiscal accountability, and oversight functions on a regular basis with all subcontractors. The roles and responsibilities of DBH and RBHA are set forth in the Nebraska Behavioral Health Services Act, Neb. Rev. Stat. §§ 71-801 to 71-830.

The DBH and RBHA use internal and external measures for oversight of services purchased (unit/expense) through the contracts with their subcontractors.

External measures are performed by entities outside of the Nebraska Behavioral Health System (NBHS), and include the following as appropriate:

1. Independent Annual Financial Audit by a Certified Public Accountant (CPA):
 - a. The purpose of the CPA audit is to assess the accuracy and reliability of provider accounting processes and financial reports.
2. National Accreditation:
 - a. National accreditation refers to the standards set by the Joint Commission, the Commission on Accreditation of Rehabilitation Facilities, the Council on Accreditation, or another nationally recognized accreditation organization approved by the Director of DBH. Each accrediting body has a set of guidelines or program standards that define expected inputs, processes, and outcomes of programs and services. Accreditation bodies assess administrative, organization, and service delivery management of providers. Programs are accredited for conformance to nationally recognized service standards for a general field category that best describes the purpose, intent, and overall focus of a program or service.

Internal measures are performed by entities within Nebraska Behavioral Health System (NBHS), and include the following:

1. Services Purchased (SP) Verifications (unit/expense)
 - a. The SP Verifications (unit/expense) are conducted to verify that services claimed for reimbursement have been delivered to a consumer and that expenses are verified in financial records and are allowable costs. There are two types of services purchased verifications: unit verification for Fee for Service (FFS) services and expense verification for Non-Fee for Service (NFFS) services. These reviews are generally conducted at the same time as the Program Fidelity review but can be completed at separate visits. Unit verifications for fee for services reviews and expense verifications for services considered as non-fee for service or expense based are to be completed no later than September 30 following the fiscal year under review.
 - b. SP Verification of services purchased (unit/expense) includes a review of documentation to verify that the services purchased (unit/expense) were delivered consistent with set requirements. This can include clinical records, progress notes, financial records, and/or other documentation as deemed necessary. SP verifications (unit/expense) shall be conducted on a fiscal year basis for all services billed to RBHA and to DBH under the contract as reflected by Authorization Turn-Around Documents (TADs) or other DBH required supporting documentation.
2. Program Fidelity Reviews (programmatic)
 - a. The purpose of Program Fidelity Review is to review program plans and services delivered to ensure consistency and conformance with service definitions, state regulations, policies and

contract requirements governing mental health and substance abuse programming and specific federal community mental health or substance abuse prevention and treatment block grant program requirements. The Program Fidelity Review is conducted at a minimum of

once every three (3) years for each provider and for each service type. National accreditation may preclude the review of certain surveyed items as determined by the reviewer but does not replace a Program Fidelity Review.

3. Services Purchased and Program Fidelity Reviews may be conducted separately or during the same review as long as all elements of each review is completed. All reviews may be performed in any combination of the following mediums:
 - Conducted in person at the provider location,
 - Via visual telecommunication or accessing electronic health records remotely,
 - By submission of applicable records and files for a desk review.
4. Internal Controls (self-review & monitoring)
 - a. Each subcontractor shall develop and maintain written policies and procedures for internal controls, specifically including cash management, and determination of allowable costs. The goal of these policies and procedures is to create sound business practices to minimize the risk of fraud, or theft of an organization's funds or assets. A common internal control is a "separation of duties" requirement; all business activities are handled by at least two or more different employees, or by contractors outside the organization. Additional information and reference details may be available at the following websites and manuals:
 - i. In compliance with the Committee of Sponsoring Organizations (COSO) documents:
 - a. Standards for Internal Control in Federal Government
 - b. Internal Control Integrated Framework
 - ii. The websites for COSO and the COSO Internal Control documents are:
 - a. <https://www.coso.org/>
 - b. <https://www.coso.org/guidance-on-ic>
 - iii. An organization's Internal Controls must include policies regarding Cash Management and Allowable Costs.
 - a. Council on Financial Assistance Reform: <https://cfo.gov/cofar/>
 - b. National Council of Nonprofits: <https://www.councilofnonprofits.org/>
 - b. It is required to verify that all sub-recipients have written policies for internal controls such as Cash Management and Allowable Costs. The RBHA or DBH must verify that the entity has these written policies but is not required to test the policies.
 - c. Sub-recipient monitoring includes a review and follow-up of any audit findings for that agency. The use of a formal document such as a checklist is required. An example of such a checklist may be available from DBH.
5. Financial Reliability of Sub-recipients
 - a. Federal requirements have strengthened oversight over federal awards to include all pass-through entities. Organizations are required to review the risks of a potential recipient prior to making an award. This risk assessment includes an ongoing review of these sub-recipients. These requirements are outlined in the Federal Regulations at 2 CFR § 200.311. See this link for additional information: <https://www.ecfr.gov/current/title-2/subtitle-A/chapter-II/part-200>
 - i. Pre-award and ongoing
 - a. Required use of a form or checklist for risk assessment
 - b. Sub-recipient required to relate financial data to performance accomplishments of the federal award to ensure expenses are relevant to the service it was charged and supplanting has not occurred.
 - ii. Audit findings – systematic review and follow-up
 - iii. Written policies
 - a. Cash management
 - b. Allowable costs-in accordance with cost principles (2 CFR § 200).
6. Substance Abuse Prevention and Treatment Block Grant (SAPTBG) Program Fidelity and Prevention Review
 - a. SAPTBG Program Fidelity monitors program plans and services delivered to ensure consistency and conformance with SAPTBG requirements (interim services, tuberculosis and

- HIV requirements, subcontractor compliance and charitable choice) for agencies designated as, and providing services for, specified priority consumer populations with substance use disorders (IV drug users, pregnant women, and women with dependent children). This fidelity review is conducted every year for each subcontractor for each service which is funded by SAPTBG funds and may be conducted at the time of the services purchased review.
- b. Prevention Review form ensures activities performed meet SAPTBG definitions of primary prevention and follow one the six SAPTBG identified strategies. Additional items to be reviewed include but are not limited to a review of processes for recording activities in the Nebraska Prevention Information Reporting System (NPIRS) and evaluation of activities for effectiveness. This review is conducted a minimum of once every three years for each subcontractor and may be conducted at the time of other services purchased reviews.

The written procedures outlined in this document provide a systematic approach (across all RBHAs and the DBH) to the oversight of network management, including the monitoring and reviewing of contracted services (unit/expense). Each RBHA is charged with developing Regional written policies and procedures, consistent with the components outlined in this manual, for use in the review of services purchased (unit/expense) from all subcontracted entities. RBHAs shall include, at a minimum, all of the components included in the most recently DBH Audit Manual in their written procedures. Any changes made to the DBH Manual should be reflected in the RBHA's written procedures and shall be submitted to the DBH for review. The RBHA may request DBH to utilize the procedures and review forms used for the RBHA's subcontractors. If this is not requested, DBH will select the forms and procedures to be used to conduct reviews of the RBHA performed services.

Audit elements, policies and procedures discussed in this manual may be revised, including but not limited to changes in behavioral health care best practices, statutory changes, regulatory changes, findings from state or federal audits, or the role of other payers in auditing for quality and/or fidelity. RBHAs will be notified in writing thirty (30) business days prior to the effective date of any change.

Except for RBHA coordination and administration, during the Unit, Fidelity, or Expense Review, all consumers must be assessed for their ability to pay for services received in accordance with the provider policy as approved by the RBHA, and consistent with the DBH Financial Eligibility Policy and resulting fee schedules. .

Not all DBH or RBHA oversight functions may be designated in this manual i.e., DBH audit monitoring activities. The lack of inclusion does not inhibit or preclude additional monitoring or auditing activities as necessary.

PART II: SCHEDULE OF AUDITS FOR CURRENT FISCAL YEAR

A list of the verifications or reviews to be performed is submitted to the DBH by the RBHA for the upcoming fiscal year. As services are added or removed, the RBHA must provide the DBH notification of the change and an updated verification or review list.:

- At least 50% of reviews must be completed within the state fiscal year that payment occurs. The remaining reviews may be delayed until after the end of the fiscal year for a full year for selection and review. All reviews must be completed by September 30 following the state fiscal year being reviewed.
- RP-2a (Services Purchased Verification (unit/expense) & Program Fidelity Review List): this form is submitted with the Regional Budget Plan (RBP) and lists all services within the RBHA to be audited by the RBHA and a projected date of the review.

Notes:

- Services purchased verifications (unit/expense) must be conducted each fiscal year. Each service listed on the form will have a service purchased review (unit/expense) for each fiscal year.
- Program Fidelity Reviews must be conducted at least every three (3) years but may occur more frequently at the discretion of the RBHA or DBH. If a Program Fidelity Review is not scheduled for the upcoming fiscal year, the date of the last review should be noted on the form.
- Units and expense for a service from multiple locations of a single provider may be combined within a review as long as units and expenses from each location are included as part of the selection.
- If there is a service or provider added/deleted/changed, the updated forms must be completed and sent to the DHHS.DBHNetworkOperations@nebraska.gov.

If the RBHA is a service provider, the scheduling of audits is a mutual responsibility between the RBHA and the DBH. The need for the DBH to audit regionally provided services should be reflected on the RP-2a.

For providers under Corrective Action Plans, the DBH or -RBHA will conduct follow-up audits/reviews as prescribed in the Audit findings sent to the Provider and be conducted in the timeline indicated in this manual.

When scheduling audits, the DBH and RBHAs are encouraged to take into consideration the date of the provider's national accreditation review. However, this does not preclude either entity from doing the review in the same fiscal year as the national accreditation review.

PART III: CPA AUDIT

CPA Audits are required of all RBHAs and may be required from any service provider every year. Agencies who hold For Profit status will not be required to submit a CPA audit nor a Single Audit document but may be requested to submit financial statements. CPA audits of the RBHA are due to the DBH within the timeline requirements as specified in the contract. Provider fiscal audits, compilation financial statements (as applicable), or a review of financial statements (as applicable) from subcontracted service providers are due to the RBHA not more than nine (9) months after the end of the service provider's fiscal year, as reflected by the RBHA on the RP-2.

The RBHA shall complete a review of each service provider financial audit by a CPA firm. Documentation of the RBHA's review and comments shall be made available to DBH as part of the compliance review including the provider's financial audit. A coversheet will accompany the CPA audit of the service provider that indicates:

- Date service provider audit was received and reviewed by the RBHA
- A cover sheet signed by RBHA staff demonstrating a review of material weaknesses and identified significant deficiencies, implications for findings, and other activity detailing RBHA oversight.

If material weaknesses or significant deficiencies are found by the CPA firm, a corrective action plan must be requested by RBHA. RBHA should notify the provider and include the following information (may be taken directly from the CPA audit):

- Finding number and name
- Criteria
- Condition/Context
- Cause
- Effect
- Recommendation

The provider's plan of correction should include:

- The condition/context listed
- Recommendation given
- Corrective action to be taken by the provider
- Supporting Documentation that will be submitted to demonstrate action taken:

Example of corrective action for federal finding:

Finding 2016-001: Timeliness of General Ledger Account Reconciliations (Material weakness)

Condition/Context: The agency did not have an adequate control system in place to ensure the general ledger accurately reflects the account balances of the agency on a monthly or annual basis.

Recommendation: The agency should evaluate its internal controls as it relates to the financial close and reporting process to ensure that accounts are properly stated throughout the fiscal year and the audit is completed in a timely basis.

Corrective Action Plan: The agency has hired an experienced full-time accountant in the field of governmental nonprofit healthcare to train and improve the accuracy of the general ledger.

Supporting Documentation included: Vita and letter of hire of new staff.

Note: If this is a repeat finding, the RBHA should expect provider progress towards achieving compliance. For example, if an initial finding was a material weakness, has it been “downgraded” to a significant deficiency.

Audit Parameters

CPA Audits of RBHA must include a two-year comparison of expenditures.

Expenditure Threshold under the Single Audit Act

2 C.F.R. § 200.501 Audit requirements.

(a) Audit required. A non-Federal entity that expends \$1,000,000 or more during the non-Federal entity's fiscal year in Federal awards must have a single or program-specific audit conducted for that year in accordance with the provisions of this part, Audit required.

....

(e) Exemption when Federal awards expended are less than \$1,000,000. A non-Federal entity that expends less than \$1,000,000 during the non-Federal entity's fiscal year in Federal awards is exempt from Federal audit requirements for that year, except as noted in 2 C.F.R. § 200.503, but records must be available for review or audit by appropriate officials of the Federal agency, pass-through entity, and Government Accountability Office (GAO).

§ 200.425 Audit services.

(a) A reasonably proportionate share of the costs of audits required by and performed in accordance with the Single Audit Act Amendments of 1996 (31 U.S.C. 7501-7507), and the requirements of this part are allowable. However, the following audit costs are unallowable:

(1) Any costs when audits required by the Single Audit Act and subpart F of this part have not been conducted, or have been conducted but not in accordance with the requirements; and

(2) Except as provided for in paragraph (c) of this section, any costs of auditing a non-Federal entity that is exempted from having an audit conducted under the Single Audit Act and subpart F of this part because its expenditures under Federal awards are less than \$1,000,000 during its fiscal year.”

(b) The costs of a financial statement audit of a recipient or subrecipient that does not currently have a Federal award may be included in the indirect cost pool for a cost allocation plan or indirect cost proposal.

(c) Pass-through entities may charge Federal awards for the cost of agreed-upon procedures engagements to monitor subrecipients (in accordance with §§ 200.331-333) exempt from having an audit conducted under the Single Audit Act and the requirements of this part. This cost is allowable only if the agreed-upon procedures engagements are:

(1) Conducted in accordance with GAGAS or applicable international attestation standards, as appropriate;

(2) Paid for and arranged by the pass-through entity; and

(3) Limited in scope to one or more of the following types of compliance requirements: activities allowed or unallowed; allowable costs/cost principles; eligibility; and reporting.

NOTE: Federal grant funding always retains its identity as 'federal funds' and all requirements, expectations & restrictions follow those dollars through ALL sub-recipients, regardless of how far removed.

PART IV: GENERAL VERIFICATION/REVIEW PROCEDURES

The following procedures apply to both the Services Purchased (SP) Verification (unit/expense) and the Program Fidelity Review.

Pre-Visit

All network providers should receive reviewer specific policies and procedures, which includes purpose, methods, and process for Program Fidelity Reviews and (SP) Verifications (unit/expense).

The reviewer will work with the provider agency to establish the review date and medium as described in Part 1.4. Agency documents related to contract compliance such as policies, organizational chart, accreditation certificate, and other documents may be requested at any time in preparation for the review date. For onsite or electronic access to consumer files, a list of file names and other information related to consumer files will be sent to the agency no more than two (2) business days prior to the review for program reviews, and ten (10) business days for fiscal reviews. For desk audits that the provider will be sending copies of consumer files to the RBHA or DBH, the list of file names and other consumer information needed may be sent five (5) business days prior to the audit to allow for scanning and sending within the five (5) business day period. For all on site reviews conducted at the provider agency offices, the agency shall have files available for the review team at the appointed time, location, and medium agreed upon for the review.

The reviewer may develop a site visit agenda to be used on each review/verification of providers. If utilized, the agenda will be composed of a schedule of events, including any opening or exit meetings, and any other items of the process. The agenda may be given to the provider agency prior to or at the beginning of the verification/review. If a formal site visit agenda is not created, the reviewer will notify the agency of expectations for staff access for questions, process for any needed communication during or after the review, and availability of an exit summary if requested.

Beginning the Verification/Review

Review team members should arrive on site at the time agreed upon with the organization and locate the Agency/Program Director or designee for introductions. Review team members may meet with management, designated staff members and any other individuals requested by the organization (e.g., Board Members) to attend the opening/orientation meeting. Review team members should introduce themselves and give a brief explanation about the purpose of the audit and the day's agenda/schedule. Program staff are given the opportunity to explain the purpose/mission and key points about program operations, where information will be located, and organization of consumer files. If requested by the agency being reviewed, review team members will sign confidentiality forms indicating their agreement to maintain the confidentiality of information accessed and not share or release the information in any manner not allowable by contract, regulation or law. Even if such form is not used, reviewers must abide by federal and state confidentiality laws and regulations.

A room or work area, including computer access, if necessary, should be made available for the review team members to review confidential records. Clarifications should be made throughout the review process as necessary with agency staff.

Ending the Review/Exit Conference

If requested by the agency or reviewer, an exit conference with management and designated staff may be held to present a summary of preliminary findings and observations, including areas of strength and areas in need of improvement. The feedback given should be focused on compliance with the services purchased verification (unit/expense) and program fidelity review standards and procedures, including any negative findings that may require a Corrective Action Plan (CAP). If an exit conference is not

conducted, the reviewer will communicate to the agency when a final report will be submitted to the agency.

Post Review/Reporting

Following the review, a written report, providing a summary of the audit, will be completed and submitted to the provider agency within forty-five (45) business days of the visit, or by September 30 following the fiscal year under review, whichever is earlier. There may be one report per provider agency, but each service reviewed and type of review will be addressed separately within the report. Copies of the report will be sent into the DBH upon request or as part of the RBHA contract compliance review.

Out of Region Network Providers

RBHA who have letters of agreement (LOA) or a contract with a provider in another regional area, may choose to audit the provider directly, or ask another RBHA to conduct the audit. A Health Insurance Portability and Accountability Act (HIPAA) Business Associate Agreement must be issued between the two RBHAs for the purpose of sharing information to conduct the audit regardless of the number of consumers being added. The requesting RBHA must provide information to the auditing RBHA in a timely manner to minimize disruption of the review process and completion RBHA conducting the audit(s) may include the consumers from both RBHA areas in the random sample selection or conduct a second random sample selection for review. RBHA conducting the review will share the reviews/verifications results as well as the CPA Audit (if one is required) with the other RBHA. Supporting documents related to the audit may be retained by the RBHA conducting the audit.

It is the responsibility of each Region to ensure all contracted providers, including providers serving individuals via LOAs be audited for the services purchased. If another RBHA declines to conduct the audit for a provider in their area, the Region purchasing the service must conduct the review as outlined in this manual.

Corrective Action Plan (CAP)

The reviewer has forty-five (45) business days from the date of the completion of the first audit, or by September 30 following the fiscal year under review, whichever is earlier, (or completion date of expansion, if scheduled on another date) to write a report on the findings of the review to be distributed to provider. The provider is considered to have not met the required compliance threshold in the review and a CAP is required when:

- a. A 95% compliance unit threshold is not reached in the (expanded) five percent (5%) unit sample or more than five percent (5%) of expenses are not verified after expansion or
- b. A trend or critical event is identified in a Fidelity Review. CAP is required.

A CAP is required if a trend is identified during any audit that shows a pattern of failures to complete or perform required activities or requirements. A trend for this purpose is defined as more than three exceptions within a single service or across services being reviewed. Additionally, a CAP is required if a critical event affecting the safety of the person receiving services occurs. A critical event will include but not be limited to failure of the service provider to have required license or credential for the service being performed. The CAP from the provider must be submitted detailing the problem identified, steps the provider will take to correct the problem and the timeline for the correction to be completed. When a CAP is written and covers multiple locations, a process must be in place for each location to correct errors.

The CAP must be submitted to the reviewer within thirty (30) calendar days of the time of receipt of the audit summary utilizing the form available here:

<https://dhhs.ne.gov/Pages/Behavioral-Health-Regulations-Contracts-and-Guidance.aspx>.

The reviewer must approve or deny the CAP within ten (10) business days of receipt. In all instances, service providers will be given a reasonable length of time (30 calendar days), depending on the scope of deficiencies, to make the needed corrections and submit follow-up documentation (if indicated).

If the service provider does not take corrective action or does not submit needed documentation for corrective action by the due date, the reviewer shall withhold payment from the service provider for the identified service(s) until such required documentation is received by the reviewer. The reviewer may also choose to terminate their contract with the provider if the provider shows no effort in taking corrective action.

If similar or additional sanctions are required in successive fiscal year audits and/or financial reviews, or if corrective actions are not made, additional sanctions will be imposed. These sanctions could include, but are not limited to, requiring additional Corrective Action Plans, termination of purchasing the specific service from the provider, or termination of contract with the provider. In any case, payback will be required for any units or expenses not verified.

Re-audit shall occur within no more than 120 calendar days following an approved CAP. Any alteration of this timeline must be explicitly approved by DBH and must be extraordinary circumstances. All normal SP (unit/expense) processes will be followed with the exception of unit/expense selection quantity. The re-audit shall consist of five percent (5%) of units billed or a minimum of five (5) files from the months since the CAP was approved. If a minimum of five (5) files is not available, the reviewer may document this and use all files available. A re-review of expenditures will consist of selecting at least three expenses billed related to the CAP each month since the CAP was approved. Units reviewed during CAP re-review will be excluded from any subsequent normal sample pull during the contract period.

CAPs, copies of the initial review, and follow-up review reports will be sent to the DBH as they are completed.

If a CAP crosses a fiscal year, the review must still occur within 120 days following the approval of the CAP and will use any units billed, expenses billed or services rendered since the review, regardless of contract period. Re-audit of units or fidelity shall consist of five percent (5%) or a minimum of five (5) files for those services in which a CAP was in place. If the provider does not have five (5) files to re-audit the reviewer may document that five (5) files are not available and use all files available. Payback is required for any units or costs not verified on a CAP review regardless of contract period.

Audit report summarizing the Services Purchased Verification (unit/expense) and Program Fidelity Review findings per agency provider shall be given to the reviewers' RBHA governing body every fiscal year.

Service Provider Challenges to Audit Findings

For grievances that are Regulations based, refer to 206 Nebraska Administrative Code (NAC) 2 and 465 NAC 2.

The process for grievances that are contract based is outlined below:

For Service Providers reviewed by RBHA personnel, follow the RBHA's grievance process and timelines.

For Service Providers who undergo the review process by DBH staff:

1. Within ten (10) business days of the SP (unit/expense) and Program Fidelity report, the service provider will make a written request for review to the Director of Behavioral Health.
2. Within five (5) working days, the DBH Director, or designee, will acknowledge, in writing, the Service Provider's request for review.
3. The DBH Director serves as the decision maker for this process and will issue a written decision to the Service Provider within twenty (20) business days following receipt of the Service Provider's written request for review.

Confidentiality

All information concerning the identity of clients must be handled in a confidential manner (as provided in HIPAA, 42 CFR Part 2, 45 CFR Part 160, 45 CFR Part 164, Neb. Rev. Stat. § 68-313, Neb. Rev. Stat. §

68-1209, and 465 NAC 2-003). Providers may request that reviewers sign a confidentiality statement.

Record Retention

All workpapers, documents, reports and correspondence obtained or created during a SP Verification (unit/expense) and any Program Fidelity Review must be retained at a minimum of three (3) years or until no longer needed for a state or federal review, whichever is longer.

PART V: ADDITIONAL CONSIDERATIONS FOR SPECIFIC SERVICES

Supported Employment

Supported Employment as a service has a unique status in the behavioral health system, due to its hybrid billing nature and braided-funding status. As such, it should be reviewed in a manner specific to the unique aspects of the service itself. Supported Employment's unique billing requirements and service delivery expectations dictate an in-depth review of the data entered for each encounter, as well as the timelines that accompany them. The process and standards described herein are requirements **in addition to** those described above. Please reference the Supported Employment Manual for more guidance and for the Supported Employment Audit Tool.

Supported Housing

The allowability of Supported Housing expenditure is dependent upon a variety of factors depending on the type of payment. Review of any expenditures must be based upon an in-depth review of the consumer's file for financial eligibility, lease, diagnosis, functional deficits, and other services. For Landlord Risk payments, supporting documents are required to ensure elements identified the Supported Housing Manual have been met. For each population receiving Supported Housing payments, a minimum of fifteen percent (15%) of expenses billed in the month or a minimum of five (5) consumer files must be reviewed for each month of expenditures selected. If less than five (5) files are available in any given month, the reviewer will document this and use available files in the month for the review. Expenses selected within the fifteen percent (15%) will include all types of documented expenses (e.g., rental payments, household items, etc.). If unallowable costs are found, two additional files for the population affected may be reviewed if available. Payback of all unallowable amounts determined in the review is required.

Professional Partner Program Fidelity

The Professional Partner Program Manual contains a Program Fidelity Audit Tool for review of Professional Partners. This is a different audit tool that is specific to the service requirements and should be used in place of the tools identified in this manual. The selection process for files remains the same as for other services described in this manual (two percent (2%) or minimum of five (5) files, expansion up to five percent (5%) as warranted). Unit audits for Professional Partners follow the guidance in the Audit Manual, with the exception that a diagnosis is required and must be confirmed for a unit to be confirmed.

PART VI: SERVICES PURCHASED VERIFICATIONS (UNIT/EXPENSE)

All services purchased (unit/expense) must be verified on a fiscal year basis regardless of whether they are paid via FFS determined rate or as NFFS expense reimbursement.

Services billed to the RBHA or DBH on a rate will be verified using the FFS process. Services billed to the RBHA or DBH by expense reimbursement will use the verification of expense methodology.

SP Verifications (unit/expense) may be conducted together or separately. At least 50% of reviews must be completed prior to the end of the fiscal year (June 30). The deadline for completion of all SP Verifications (unit/expense) is September 30 following the fiscal year being reviewed in order to allow a more thorough review of June services (unit/expense). All reports regardless of when the review was completed must be completed within forty-five (45) business days, or by September 30 following the fiscal year under review, whichever is earlier.

FFS Services Purchased Verification (Unit Verification)

Pre-Visit:

The unit sample of services purchased is selected from the provider Turn-Around Document (TAD), or other DBH required documentation for authorized or registered encounter units submitted with provider billings of the current fiscal year.

A TAD is available in the Centralized Data System (CDS) at the end of a billable month. A provider accesses the DBH required documentation menu on-line and a document indicating, by service and by client and by months of service, authorized service units for the billable month. The provider enters encounter data (the number of units of service provided to the consumer for the month). This report is printable or can be exported for use.

At a minimum, the verification must review a random selection of two percent (2%) of the total number of services purchased during the fiscal year for all mental health and substance abuse services, with a minimum of five (5) files total. Source documentation for establishing the two percent (2%) sample size is the provider's current contract at the time of the audit. Audits of providers with low initial monthly utilization may be scheduled at later dates. All files within that service will be reviewed if less than the 5-file minimum is available.

For a single service with multiple service units available (e.g., Community Support one month (three hours) and fifteen-minute units), all units should be calculated using the smallest denomination. In doing this, the larger number will be converted to the smaller unit equivalents to pull the sample amount. For example, one month of Community Support equals twelve fifteen-minute units. If a provider has budgeted for 175 monthly units, this would equal 2,100 units (175 x 12 fifteen-minute units). The sample size would be two percent (2%) for this amount, 42 units or minimum of five (5) files, whichever is appropriate. When names are selected, if the consumer has a monthly encounter billed, this will account for twelve (12) units or three (3) hours to be audited in that file for the month.

Outpatient may include individual, family, and group units. If units are not budgeted separately, sample size must be determined based on equivalent individual units budgeted.

The two percent (2%) or five percent (5%) random selection of consumer files for each services purchased verification must be from at least two (2) non-consecutive months within the same fiscal year the services were purchased and must include services purchased from all service locations and Medical or Therapeutic leave units billed as allowed per Continuum of Care Manual. It may be necessary to pull additional months/units as needed to obtain the minimum five (5) files or required units. If a provider has more than one location for the same service, consumer files from all locations may be pooled prior to

determining the two percent (2%) or five percent (5%) sample size. It is not required for the reviewer to ensure files from each location are audited.

All Prior Fiscal Year (PFY) units paid within the contract at the time of the review must be reviewed for verification and to ensure compliance of timely filing as allowed in the Financial Eligibility and billing guidance in the contract. PFY units may not be included within the two percent (2%) or five percent (5%) sample.

Process:

The number of units verified shall be designated on the reviewer's work papers. A percentage of verified units must be calculated by dividing the total units verified by the total units reviewed. A ninety-five percent (95%) compliance is the minimum acceptable threshold for services purchased unit verifications.

At a minimum, the following items must be reviewed and meet requirements for the service billed to verify a unit:

- a. Consumer financial eligibility for services, including any Medicaid or insurance coverage as appropriate
- b. Type of service billed, (e.g., individual, group), date of service and length of service
- c. Unit reported correctly in CDS for month, service name and unit designation
- d. Consumer residency/citizen attestation
- e. Signed Consent for Treatment
- f. As appropriate, clinical license of practitioner
- g. As appropriate, diagnosis.

When auditing a file of a consumer who became covered by Medicaid, the reviewer must review when billing to the RBHA or DBH was stopped compared to the date of Medicaid eligibility. Additionally, the reviewer must determine if any retroactive billing for Medicaid occurred and any corresponding refund for DBH necessary due to the Medicaid billing that has occurred.

When auditing a file of a consumer with insurance and the claim was denied and billed to RBHA or DBH, the reviewer must ensure billing followed timelines established by contract (see financial eligibility and manuals incorporated). Also see therapeutic and medical leave in fidelity section.

Payback will be sought for:

- a. Services provided are not verifiable in the agency's consumer/program records.
- b. Services provided do not agree with the reimbursement claim with respect to date, type, and length of service.
- c. Consumer is ineligible according to the DBH Financial Eligibility, including Citizen Attestation, and Fee Schedule or when there was no current Financial Eligibility determination on file at the time of the service provision (Current is defined as within the 11 months prior to the month of the service).
- d. Service provision is found to have been provided by an individual without the appropriate licensure, credentials, or requirements as defined by state or DBH approved RBHA service definition;
- e. Services denied by insurance due to provider error, or not filed or billed within designated timeline.
- f. Services billed to both DBH and Medicaid that have not been repaid.
- g. All (100%) non-verified units. All unit paybacks must be corrected in CDS and submitted on a provider billing document.
- h. All units following patterns of improper billing practices identified during review.

If a unit of service was verified but found to be recorded incorrectly in the data system, a correction of the unit in the CDS is required. This will result in the incorrect unit being refunded, and the correct unit being billed. The payment refunded and subsequently received will be based on the rate in effect for the units designated. If the service is paid as expense, data corrections must still be completed, even though no funds will be subsequently refunded or paid.

If a provider is found to have staff person(s) performing service(s) without a valid license, certification or credentialing as required by the service definition, DBH or the RBHA may require payback of all units performed by the staff person in the contract period. Additionally, the provider must be placed on a CAP.

Post Review and Reporting

Post review and reporting shall follow the guidelines indicated in Part IV. Components of the review report shall include:

- Name of agency and service(s) audited
- Date of review and mode of review (e.g., onsite, remote access, desk audit, etc.)
- For each service reviewed
 - Contracted units for the service based upon fiscal year unit totals
 - 2% or 5% sample of contracted FY units as determined at the time of the audit
 - Number of files audited
 - Months that were audited
 - Number of units verified
 - Percent of units verified.
 - Need for a CAP

NFFS Services Purchased Verification (Expense Verification)

All services purchased on an expense reimbursement basis must be verified annually. This may be conducted in conjunction with a unit and/or program fidelity review or as a separate verification. At least 50% of the expense verifications for services considered as NFFS must be completed before June 30. The remaining reviews of expense verifications may be completed after June 30 but must be completed no later than September 30 following the fiscal year being reviewed.

Pre-Visit:

The reviewer's Finance Director or designee will determine the months to verify and notify the agency at least ten (10) business days in advance of the visit. At a minimum, two non-consecutive months of documentation must be reviewed for each service for each contract year. The provider will be notified of the months to be reviewed and the documentation that will be needed by the reviewer. This includes, but is not limited to:

1. General Ledger (GL) for service(s) being reviewed
2. Payroll, time sheets, time studies, and payroll allocations
3. Receipts, invoices, mileage reimbursement, and any other expense verification documents
4. Canceled checks, bank statements, or other warrants used for payment of expenses claimed
5. Internal worksheets that were used to create expense reimbursement to the reviewer
6. Cost allocation charts or basis
7. Requested policies
8. Client files as necessary for the service(s) being reviewed (e.g., housing, financial eligibility, flex funds).

Procedures for Each Service Being Reviewed:

1. Select a sample of five (5) client files from the service being verified. The reviewer will need to determine client financial eligibility was established and units submitted align with the agency's records. This may be completed in conjunction with or as part of a Program Fidelity Review or unit verification. Client financial eligibility file reviews may be waived for a service if participation in the service requires enrollment in another DBH service where financial eligibility is determined (i.e., Housing Assistance). An affirmative statement to any waiver of client file review must be made either in the Pre-visit correspondence or in the Post Review report.

2. Verify that total expenses reflected in the GL can be traced to the billing amount submitted to the reviewer. This will include verifying that any revenue received/generated by the service provider was deducted from the total expense and the adjusted expense amount was billed to the reviewer.
3. Verifying payroll expenses and documentation. If employee salary, wages or fringe benefits are split between multiple services or sources of funding, determine how the compensation was allocated to the service being reviewed for reasonableness and accuracy. If time sheets with direct coding of time to different funding sources or activities are not used, a time study is required. Review methodology and results to determine applicability and reasonableness. If any variation from the time study results have been made, documentation and justification for the change must be provided and reviewed. Unsubstantiated variance from a time study may be disallowed.
4. Randomly select at a minimum two (2) non-employee expenses and two (2) employee related expenses, if available, (e.g., mileage reimbursement) for each service. Additional expenses may be selected. Verify that receipts and documentation of payments exist and are reflected in the correct expense account. Expenses being selected include a large or non-recurring expense as well as recurring costs. If appropriate documentation cannot be located for an expense, document the missing items, and select an additional expense to verify.
5. If the expense being reviewed is part of a larger bill, determine how the amount was allocated to the service and if this is reasonable and allowable within applicable regulations and contract, including documents and regulations incorporated by reference into the contract. Review the basis for any allocation method being used if costs are being shared across multiple cost centers, services, or sources of funding.
6. Verify that payments received from the RBHA, State or other payers were credited to the services as billed.
7. During the review, note any trends or areas of needed improvement identified. If the identified areas could pose a financial risk to the agency under review or the reviewer (e.g., lack of or poor supporting documentation, missing required approvals), a CAP may be required to minimize the risk. (see Corrective Action Plan)

If less than five percent (5%) of each service' expenses in the month cannot be verified or are unallowable for the months reviewed, no audit expansion is required. Payback is determined based on the amounts determined to be unallowable or unverified.

If a unit of service was verified but found to be recorded incorrectly in the data system, a correction of the unit in the CDS is required. Data corrections must still be completed, even though no funds will be subsequently refunded or paid.

If more than five percent (5%) of the expenses for one or both of the months in the service cannot be verified or is deemed to be unallowable, the sample must be expanded to include a third (3rd) month of expenditures for that service. The additional month of expenditures will be reviewed as outlined in steps 2 through 5 listed above. If the expenses can be verified in the third month, any expenses determined to be unverified or unallowable in the first two months will be required to be repaid and a Corrective Action Plan will be required.

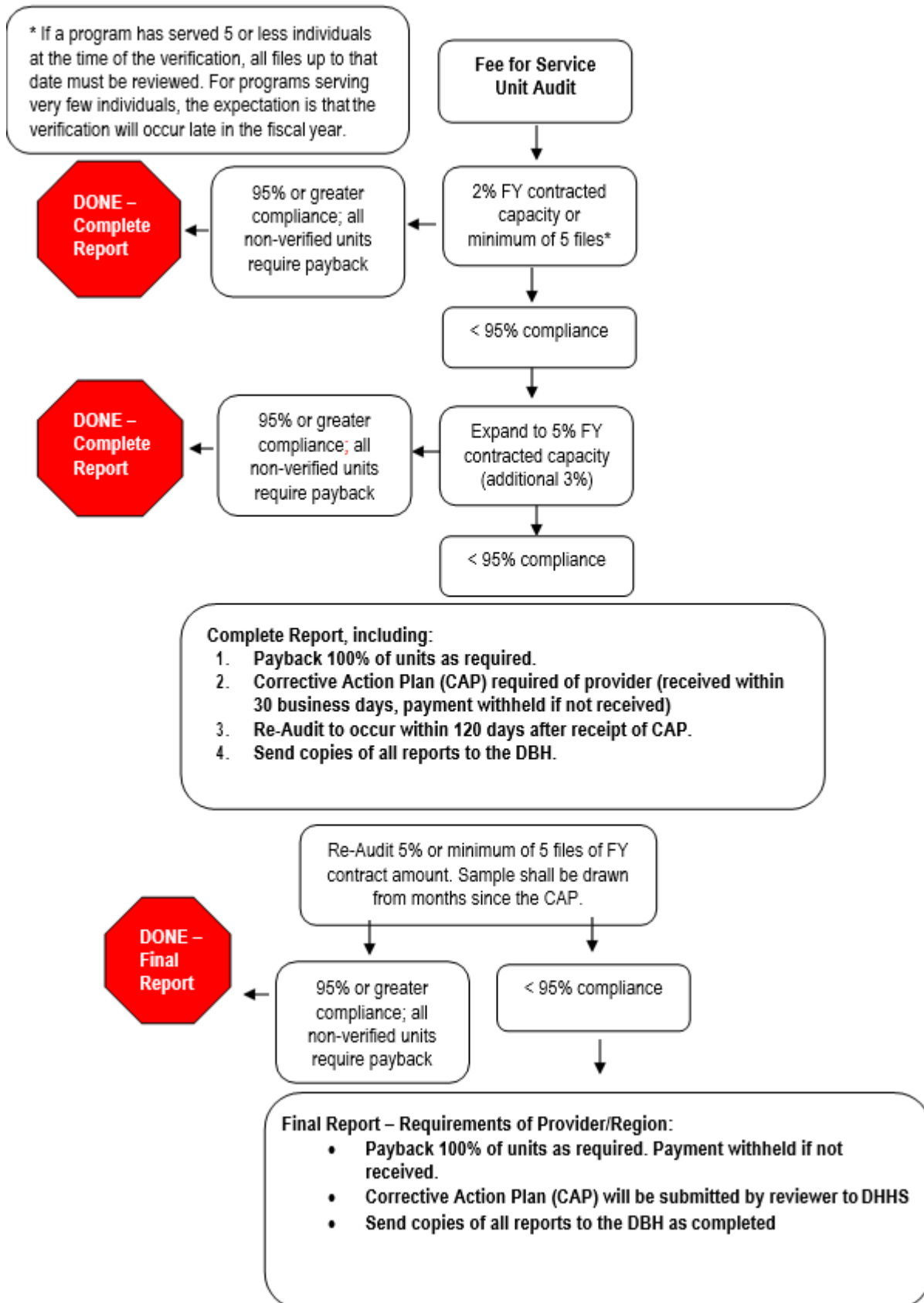
If more than five percent (5%) of the expenses cannot be verified for the third month reviewed, the sample must be expanded to include all months paid for the service during the fiscal year. Payback will be determined based upon the total unverified or unallowable expenditures for all months reviewed. A corrective action plan must be required in this situation.

Post Review and Reporting:

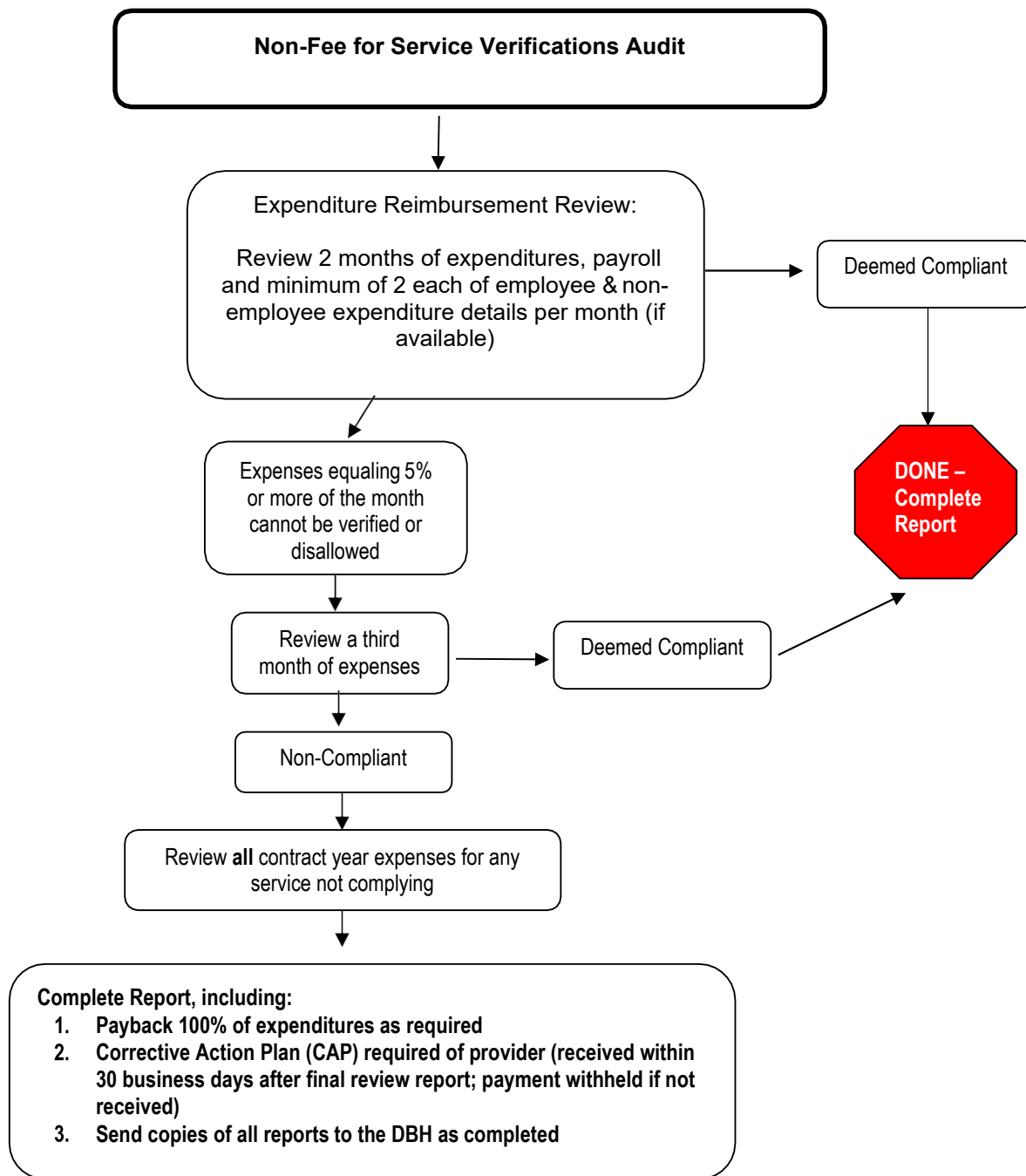
Post review and reporting shall follow the guidelines indicated in Part IV. Components of the review report shall include:

- Name of agency,
- Date of review and mode of review (e.g., onsite, remote access, desk audit.)
- Listing of documents that were reviewed,
- Listing of expenses and months that were reviewed,
- Narrative of findings,
- Corrective actions required, if applicable,
- General comments and observations,

SERVICES PURCHASED VERIFICATION DECISION FLOWCHART



NON-FEE FOR SERVICES VERIFICATION DECISION FLOWCHART



PART VII: PROGRAM FIDELITY REVIEWS

Program Fidelity Review Process

Program Fidelity Reviews shall be conducted on each provider and service a minimum of once every three years (3) and can be conducted at the same time as the services purchased verification. The reviews determine compliance with applicable state statutes, state and federal rules and regulations, state or DBH approved RBHA service definitions, contract provisions (i.e., services are culturally sensitive) and other mandatory guidelines for service provision. Appendix A contains a list of required items in the file to be reviewed. Additional items may need to be reviewed to ensure compliance.

Pre-Visit

Program Fidelity Reviews shall include of a minimum of three (3) files per service, per provider. The deadline for completion of Program Fidelity Reviews is September 30 following the fiscal year being reviewed in order to allow a more thorough review of June service units. Reviewers can choose from files being examined as part of the Services Purchased Verification, or can use the TADs, or other DBH approved documentation as applicable to choose three separate consumer files for review.

The Program Fidelity Review shall also evaluate other documentation including programmatic plans and clinical details of the service that are sufficient to verify that the services provided comply with state regulations and service definition components.

Process

Reviewer examines the three (3) client files, program documents and service outcomes to ensure compliance with service definitions, rules and regulations, and other mandatory guidelines. When errors are encountered in the initial sample, the auditor may expand the sample size by 2 files (5 files total) to determine if a CAP is necessary or assign a CAP based on the initial three files. Expansion must be completed if errors are found but these do not meet the threshold for a CAP in the first three files (See Corrective Action Plan section of this manual)

Discharge

If reviewing the file of an individual who has been discharged, the reviewer must check CDS to ensure the person has been fully discharged in the system.

Special note regarding Therapeutic and Medical leave and Informed Choice.

Auditing for Medical or Therapeutic Leave

Medical Leave: Documentation of the need for stabilization is reflected in the consumer's treatment plan and file. The program will be reimbursed at the full program rate per day. This reimbursement is only available if the treatment placement is not used by another consumer.

Therapeutic Leave: The therapeutic rationale and leave period must be indicated in the treatment plan. Documentation of the outcome of the therapeutic leave and the need for continued residential level of care must be indicated in the consumer's record. The DBH will reimburse at the full program rate per day as long as the placement is not used by another consumer.

Auditing for Informed Choice

During a Fidelity Review, the reviewer(s) will monitor that consumers' informed choice is reflected in treatment, support, employment, and housing service and discharge plans, including in annual updates or addendums. If the frequency of treatment plan review/updates are specified in the service definition, consumer involvement in the planning and direction of their treatment must be clearly reviewed and indicated in the update per service definition timeline. If the frequency of treatment plan review/update timeline is not specified in the service definition, consumer involvement in the planning and direction of their treatment must be reviewed per the timeline for such updates in the agency program plan or policy as long as such update occurs, with the exception of Medication Management, at a minimum of every six (6) months of the persons continued stay within the service.

Consumer involvement in planning and direction of their treatment for Medication Management may be indicated by a consent to treat document signed prior to the appointment.

For individuals under the legal age of consent or who cannot legally provide consent, informed choice from the parent or guardian should be reflected in the plan and subsequent updates.

Post-Visit:

The reviewer shall complete a report detailing the results of the review and distribute it to the provider within forty-five (45) business days of the visit, or by September 30th following the end of the fiscal year, whichever is earlier. If necessary, the report shall require the provider to complete a CAP detailing how they intend to correct the components not meeting compliance. The reviewer may provide technical assistance to the provider at any time once the audit has been initiated. CAP will be submitted to reviewer within thirty (30) business days of the notification that the provider did not meet compliance standards in the review.

Components of the Program Fidelity Review report shall include:

- Name of agency and service audited
- Date of review and mode of review (e.g., onsite, remote access, or desk audit)
- Program Fidelity (PF)
 - Number of files reviewed
 - Identify whether PF was met
- Number of exceptions
- Program Review observations
- Suggestions / Recommendations
- Corrective actions required, including a CAP if applicable
- If applicable, Services Purchase report elements

Copies of the initial review, the CAP, and subsequent follow-up review reports are to be sent to the DBH as completed.

APPENDIX A: MANDATORY REVIEW COMPONENTS TO BE INCLUDED IN PROGRAM FIDELITY REVIEW OR NATIONAL ACCREDITATION REPORT.

Applicability of the documentation requirements below is dictated by the service definition of the service being reviewed and other contract requirements. Sections F through H below are directly from *Appendices: Documentation Requirements* from the *Nebraska Continuum of Care Manual for Mental Health and Substance Use Disorders*. Items in Section A through E below are from the *Documentation Requirements* from the *Nebraska Continuum of Care Manual for Mental Health and Substance Use Disorders*, required elements for data reporting, or best practice for comprehensive care.

In addition to the documentation within consumer or participant files, additional items that may be useful to obtain while conducting the audit include:

- A listing of agency personnel first/last name including, credential the person holds, their, typed name, signature, and initials and specific program the staff persons work in
- Documentation the program is available 24 hours per day, 7 days per week if admission is required 24 hours per day
- Documentation of required staffing per service definition
- Program plan for the service being audited, as appropriate
- Agency policies, as appropriate

A. Administrative Paperwork
Copy of completed admission form in participant file
Admission dates in CDS complies with dates in file
Signed documentation by consumer and/or guardian that gave informed consent to treatment, rehabilitation and/or recovery services, medication usage and services to be provided, as appropriate.
Documentation consumer is made aware of how they can access their records <u>(Excludes Crisis Response)</u>
Signed documentation consumer and/or guardian is aware of agency grievance policy and process. <u>(Excludes Crisis Response)</u>
Documentation consumer meets financial eligibility criteria (includes family income, number of dependents) at time of service in any month <u>(Excludes Crisis Response)</u>
Documentation of completed re-verification process every year to ensure continuing eligibility <u>(Excludes Crisis Response)</u>
Signed copy of citizen attestation. <u>(Excludes: Emergency Protective Custody hold, Acute Inpatient Services, Subacute Inpatient Services, Withdrawal Management ASAM Level 3.2 or 3.7, Crisis Stabilization, Emergency Psychiatric Observation, Crisis Response Teams and 24-hour Crisis Line Services)</u>
Emergency Contact (name, relationship & contact information)
Documentation that orientation was completed <u>(Excludes Crisis Response)</u>
Documentation that information on Nebraska Voter Registration was provided <u>(Excludes Crisis Response)</u>
Documentation of review of Consumer Rights with the individual; <u>(Excludes Crisis Response)</u>
Clearly defined participant expectations <u>(Excludes Crisis Response)</u>
Right to refuse treatment <u>(Excludes Crisis Response)</u>
Documentation that risks and benefits of every service for which consent is sought, and right to refuse service, are explained to the consumer at a level that is educationally appropriate to the individual.
Copy of completed payment or no cost agreement, including appropriate personnel, participant, and/or parent/guardian signature(s), as applicable <u>(Excludes Crisis Response)</u>
As applicable, Proper Release of Information (ROI) form(s) completed in its entirety, including:
1. Signature of professional, participant, and/or parent/guardian signature
2. Should not exceed one (1) year scope
Copy of EPC certificate <u>(EPC only)</u>

Board of mental health commitments, reasons and dates of commitment (<u>Acute and Sub-acute Hospital Services Only</u>)
B. Personal information and Demographics in CDS (Corresponds to required data entry into CDS Fields, may be collected via intake paperwork or clinical assessment)
Consumer legal name, preferred name
Date of Birth, Social Security or equivalent number
Demographics, including age, race, ethnicity, address, telephone, gender, marital status
Mental Health Board Date, Commitment Date (if applicable)
Living Arrangements, dependents, household income
Employment Status, Education Level, Military Status
Health status (Last PCP visit, suicide attempts in the last 30 days, last dental visit)
Trauma history
Diagnostic Information (date, SMI/SPMI criteria, diagnosis code, functional deficits)
Substance use information if applicable (prior treatment, substance used, age of first use, frequency at admission and discharge, volume and route)
C. Clinical Assessments:
Assessment and Evaluations (See below for services)
○ SUD Assessment / SUD Addendum in accordance with the SUD Assessment Service Definition (<u>SUD Services, excluding Social Detox and Medically Monitored IP Withdrawal Mgmt.</u>)
○ Mental Health Assessment / Mental Health Assessment Addendum in accordance with Mental Health Assessment Service Definition (<u>Treatment Services – Outpatient (excluding Medication Management and Therapeutic Consultation), Rehabilitation Services (excluding Supported Employment), Emergency Psychiatric Observation, and Crisis Stabilization</u>)
○ 24-Hour Crisis Line, Crisis Response, Emergency Community Support, Hospital Diversion, Mental Health Respite, Therapeutic Consultation, Supported Employment, Social Detox, and Medically Monitored IP Withdrawal should meet the documentation requirements of their respective service definitions.
○ <u>Medication management service only:</u> The record must contain a medication use profile. This profile must include: ▪ A listing of all medications and dosages currently prescribed by the psychiatric prescriber (MD, APRN, or PA); ▪ A listing of all medications and dosages currently prescribed by any other prescriber; ▪ A listing of all over-the-counter medications, herbal preparations, or other alternative treatment being used by the individual; ▪ Documentation from the program's medical provider (MD, APRN, PA, LPN, RN), including, upon discontinuation, the date and reason each drug is discontinued;(only applicable if a medical provider is directly involved in the service) ▪ Documentation of the individual's response to the teaching and medications prescribed (e.g., adverse effects, therapeutic effects, adherence issues)(only applicable if a medical provider is directly involved in the service)
D. Clinical Record Contents
Presence of required documentation specific to each service as outlined in Appendix B
Other appropriate assessments required by service definition. (i.e., functional deficits, clinical screeners)
Presence of an Individual's Treatment, Rehabilitation, and Recovery Plan and updates to plans;
A chronological record of all services provided to the individual. • Each entry must include the staff member who performed the service received. • Each entry includes the date the service was performed, the duration of the service as applicable, the place of the service, and the staff member's identity and legible signature, name, and title.

All record entries must be dated, legible and indelibly verified. In the case of electronic records, signatures may be replaced by an approved, uniquely identifiable electronic equivalent.
Documentation of the individual's participation in the service and involvement of family and significant others is present;
Documentation of treatment, rehabilitation, and recovery services and discharge planning is present;
A listing of medications prescribed for the individual;
Documentation of coordination with other services and treatment providers, including medical providers. Documentation of telephone calls, collateral contacts or other outreach activities that demonstrate continuing treatment/rehabilitation responsibility are considered services and require a progress note. Providers of multiple services must indicate how significant individual issues are shared between providers;
Discharge summaries from previous levels of care, if applicable;
Discharge summary per service (when appropriate); and
History of courts or CPS involvement (if applicable)
Social supports utilized by consumer (previous and current)
Housing (ability to maintain housing, type of current housing, need for assistance)
Recreational activities (consumer's preferences)
HIV screening: yes/no (Required for Substance Abuse Block Grant (SABG) Services Only)
TB screening: yes/no (Required for SABG Services Only)
Pregnancy screening: yes/no (Required for SABG Services Only)
IV drug use screening: yes/no (Required for SABG Services Only)
Hepatitis B screening: yes/no (Required for SABG Services Only)
E. Individualized Treatment, Rehabilitation, and Recovery Plan: For treatment and rehabilitation services, a plan must be developed with the person served. Each record must contain a recovery- oriented individualized treatment, rehabilitation, and recovery plan for all services provided based on the individualized and person-centered assessment of the individual and the Behavioral Health Service Definitions. This plan must:
Incorporate and be consistent with best practices;
Include the individual's individualized goals and expected outcomes in their own words if possible;
Contain prioritized objectives that are measurable and time-limited;
Describe therapeutic interventions that are recovery-oriented, trauma-informed, person-centered, and strength-based;
Identify staff responsible for implementing the therapeutic interventions;
Specify the planned amount, frequency, and duration of each therapeutic intervention;
Delineate the specific criteria to be met for discharge or transition to a lower level of care;
Include a component to avoid crises or admission to a higher level of care using principles of recovery and wellness;
Include the signature of the individual and/or guardian to indicate agreement with the plan;
Document that the individual treatment, rehabilitation, and recovery plan is completed within the time frame specified in policies and Behavioral Health Service Definitions;
Document that the plan has been developed, reviewed, updated, and revised with the direct and active involvement of the individual. If documentation shows that the individual is not achieving his/her goals, timely revision of the plan must be documented;
Be approved and signed by the licensed clinician (as appropriate)
F. Progress Notes: Each record must contain progress notes that document implementation of the individual's treatment, rehabilitation, and recovery plan. Progress notes must be completed within the timeframe specified in the program's policies and procedures and document the unit(s) provided to the individual. Progress notes must document:
All services provided;
How services provided relate specifically to goals and priorities identified in the individual's treatment, rehabilitation, and recovery plan;
Individual's participation in the service and revision of goals and treatment activities as needed;
Individual's opinion of progress being made (in individual's own words, if possible).

G. Discharge Plan: Discharge planning is an ongoing process that occurs through the duration of service and across documentation. The discharge plan must be strengths-based, recovery-oriented, trauma-informed and include participation by the individual and family/legal guardian as appropriate. The discharge plan must be documented in the individual's record. The discharge plan must:
Begin on admission and be updated on an ongoing basis with the direct and active participation of the individual and family/legal guardian, as appropriate and with the individual's consent;
Be a component of the Individualized Treatment, Rehabilitation, and Recovery plan and be consistent with the goals and objectives identified with the direct and active participation of the individual, family/ guardian as appropriate;
H. Discharge Summary: A discharge summary must be documented in the individual's record and contain the signature of the licensed clinician and date of signature. For individuals committed to a program by a mental health board, the provider must notify the commitment board of the discharge. The discharge summary must:
Be provided within the time frame specified in the program's policies and procedures which considers the prompt transfer of clinical records and information to ensure continuity of care;
Provide a summary of service provided;
Document the individual's progress in relation to the individual's treatment/rehabilitation/recovery plan, addressing recovery-oriented goals identified by the individual and how strengths have been utilized;
• Address the individual's need for ongoing services to promote recovery. A crisis/safety/relapse prevention plan must be in place and address triggers, helpful intervention strategies, and contact information for resources useful in a crisis;
• Describe the reason(s) for discharge;
• Describe referral information; and
Include recommendations and referrals including, but not limited to:
1. Any ongoing treatment and rehabilitative service needs;
2. Accessing and using medication;
3. Accessing physical health care;
4. Employment;
5. Transportation;
6. Social connectedness – formal and informal support systems;
7. Financial resources.

APPENDIX B: SERVICE SPECIFIC FIDELITY REQUIREMENTS

Applicability of the documentation requirements below is dictated by the service definition of the service being reviewed and other contract requirements. Items listed do not encompass all requirements expected in each service definition. The outlined requirements are expected to be reported on individually within each fidelity audit.

24-Hour Crisis Line
Copy of an as needed agreement with a mental health professional.
Accessibility of service includes multiple languages available.
Crisis Response
Documentation that a Brown-Stanley safety plan is developed.
Documentation of required trainings for on-site responders.
Crisis Stabilization
Mental health assessment and/ or substance use assessment completed within 24 hours of admission.
Crisis stabilization plan is developed within 24 hours of admission.
Emergency Community Support
Completion of a finalized service plan within 14 days of admission.
Documentation of needed contact hours depending on transition source.
Emergency Psychiatric Observation
Documentation of substance use disorder screening and health screening by a registered nurse.
Discharge plan includes community based follow up services.
Hospital Diversion
Documentation of a Wellness and Recovery Service Plan tailored to the individual.
Follow up calls made available to consumer within 24 hours of discharge.
Mental Health Respite
Listing of additional behavioral services made available.
Referrals made to community services as needed.
Acute Inpatient Hospitalization
Plan of care is reviewed at team meetings at least daily.
Face to face service with physician or APRN at least 6 out of 7 days.
Subacute Inpatient Hospitalization
At least 35 hours of active treatment is made available weekly, seven days per week.
Face to face service with psychiatrist or APRN three times weekly.
Client Assistance Program
No more than 5 sessions have taken place.
An appropriate referral is made for clients who have reached their maximum sessions.
Day Treatment
Treatment or recovery plan is developed within 72 hours of admission.
Treatment or recovery plan is reviewed with client at least twice monthly.
Intensive Community Services
Assessment will be reviewed within 10 days of admission and official treatment/recovery plan will be developed within 30 days of admission.
At least 6 face to face contacts per month or 6 total ours of contact per month.
Medication Management
Education on medication documented.
Documentation that provider attempted to coordinate with other appropriate medical professionals as needed.

Mental Health Assessment
Assessment includes a trauma screening and specific follow-up as applicable.
Assessment includes appropriate clinician signature(s).
Outpatient Psychotherapy
Includes a mental health/ substance use assessment indicating this level of care is appropriate.
Peer Support
Peer is currently credentialed.
Consultation with the peer occurs with a licensed provider at least every 90 days.
Documentation of at least 1 in person contact per month. If in person delivery is unavailable, documentation on barriers needed.
Therapeutic Consultation
Consultation with the client's support team is available at least two times per episode of care.
Community Support
Programmatic assessment and treatment/rehabilitation/recovery plan is developed with in the first 30 days of admission.
Day Rehabilitation
Programmatic assessment identifies current skill inventory.
Treatment plan outlines client's needs and supports in order to integrate into the community.
Day Support
Treatment plan outlines client's needs and supports in order to integrate into the community.
Itinerary of daily schedule of individual skill building activities is available, and client's attendance is recorded.
Psychiatric Residential Rehabilitation
The initial treatment plan is created with 72 hours of admission.
At least 25 hours a week of treatment services are available, and an additional 20 hours a week of off-site activities are available.
Recovery Support
At least 1 face to face contact per month.
Treatment plan is reviewed with the client at least every 120 days.
Secure Residential
Mental health and nursing assessment completed within 24 hours of admission.
42 hours of active treatment is available per week.
Substance Use Disorder Assessment
Includes the use of an accepted screening instrument.
Includes collateral contacts.
Intensive Outpatient
At least 9 hours of treatment is provided over 3-5 sessions per week.
Treatment/recovery plan is reviewed with the client at least every 2 weeks.
Halfway House
At least 8 hours of treatment is offered per week.
Treatment/recovery plan is developed within 14 days of admission.
Social Detox
Daily documentation of the client's progress.
Therapeutic Community
At least 30 hours of treatment and recovery services are offered weekly.
An initial treatment/recovery plan is developed within 24 hours of admission, and the comprehensive plan developed within 7 days of admission.
Intermediate Residential
At least 30 hours of treatment and recovery services are offered weekly.
An initial treatment/recovery plan is developed within 24 hours of admission, and the comprehensive plan developed within 7 days of admission.
Short Term residential
At least 42 hours of treatment and recovery services are offered weekly.
An initial treatment/recovery plan is developed within 24 hours of admission, and the comprehensive plan developed within 7 days of admission.
Dual Disorder Residential

At least 42 hours of treatment and recovery services are offered weekly.
An initial treatment/recovery plan is developed within 24 hours of admission, and the comprehensive plan developed within 7 days of admission.
Medically Monitored Inpatient Withdrawal Management
A biophysical screening is conducted within 4 hours of admission.
Documentation of daily assessment of client's progress.

APPENDIX C: DEVELOPING GOALS AND MEASURABLE OBJECTIVES

(From SAMHSA)

To be able to effectively evaluate your project, it is critical that you develop realistic goals and measurable objectives. This appendix provides information on developing goals and objectives. It also provides examples of well-written goals and measurable objectives.

GOALS

Definition – a goal is a broad statement about the long-term expectation of what should happen because of your program (the desired result). It serves as the foundation for developing your program objectives. Goals should align with the statement of need that is described. Goals should only be one sentence.

The characteristics of effective goals include:

- Goals address outcomes, not how outcomes will be achieved.
- Goals describe the behavior or condition in the community expected to change.
- Goals describe who will be affected by the project.
- Goals lead clearly to one or more measurable results.
- Goals are concise.

Examples

Unclear Goal	Critique	Improved Goal
Increase the substance use and HIV/AIDS prevention capacity of the local school district	This goal could be improved by <i>specifying an expected program effect in reducing a health problem</i>	Increase the capacity of the local school district to reduce high-risk behaviors of students that may contribute to substance use and/or HIV/AIDS
Decrease the prevalence of marijuana, alcohol, and prescription drug use among youth in the community by increasing the number of schools that implement effective policies, environmental change, intensive training of teachers, and educational approaches to address high-risk behaviors, peer pressure, and tobacco use.	This goal is not concise	Decrease youth substance use in the community by implementing evidence-based programs within the school district that address behaviors that may lead to the initiation of use.

OBJECTIVES

Definition – Objectives describe the results to be achieved and the manner in which they will be achieved. Multiple objectives are generally needed to address a single goal. Well-written objectives help set program priorities and targets for progress and accountability. It is recommended that you avoid verbs that may have vague meanings to describe the intended outcomes, like “understand” or “know” because it may prove difficult to measure them. Instead, use verbs that document action, such as: “By the end of 2020, 75% of program participants will be *placed* in permanent housing. To be effective, objectives should be clear and leave no room for interpretation.

SMART is a helpful acronym for developing objectives that are ***specific, measurable, achievable, realistic, and time-bound***:

Specific –

Includes the “who” and “what” of program activities. Use only one action verb to avoid issues with measuring success. For example, “Outreach workers will administer the HIV risk assessment tool to at least 100 injection drug users in the population of focus” is a more specific objective than “Outreach workers will use their skills to reach out to drug users on the street.”

Measurable –

How much change is expected. It must be possible to count or otherwise quantify an activity or its results. It also means that the source of and mechanism for collecting measurement data can be identified and that collection of the data is feasible for your program. A baseline measurement is required to document change (e.g., to measure the percentage of increase or decrease). If you plan to use a specific measurement instrument, it is recommended that you incorporate its use into the objective. Example: By 9/20 increase by 10% the number of 8th, 9th, and 10th grade students who disapprove of marijuana use as measured by the annual school youth survey.

Achievable –

Objectives should be attainable within a given time frame and with available program resources. For example, “The new part-time nutritionist will meet with seven teenage mothers each week to design a complete dietary plan” is a more achievable objective than “Teenage mothers will learn about proper nutrition.”

Realistic –

Objectives should be within the scope of the project and propose reasonable programmatic steps that can be implemented within a specific time frame. For example, “Two ex-gang members will make one school presentation each week for two months to raise community awareness about the presence of gangs” is a more realistic objective than “Gang-related violence in the community will be eliminated.”

Time-bound –

Provide a time frame indicating when the objective will be measured or a time by when the objective will be met. For example, “Five new peer educators will be recruited by the second quarter of the first funding year” is a better objective than “New peer educators will be hired.”

Examples:

Non-SMART Objective	Critique	SMART Objective
Teachers will be trained on the selected evidence-based substance use prevention curriculum.	The objective is not SMART because it is not <i>specific</i> , <i>measurable</i> , or <i>time bound</i> . It can be made SMART by <i>specifically</i> indicating who is responsible for training the teachers, how many will be trained, who they are, and by when the trainings will be conducted.	<i>By June 1, 2020, LEA supervisory staff</i> will have trained <i>75% of health education teachers in the local school district</i> on the selected, evidence-based substance use prevention curriculum.
90% of youth will participate in classes on assertive communication skills.	This objective is not SMART because it is not <i>specific</i> or <i>time bound</i> . It can be made SMART by indicating <i>who</i> will conduct the activity, <i>by when</i> , and <i>who</i> will participate in the lessons on assertive communication skills.	By the <i>end of the 2020 school year, district health educators</i> will have conducted classes on assertive communication skills for 90% of youth <i>in the middle school</i> receiving the <i>substance use and HIV prevention curriculum</i> .
Train individuals in the community on the prevention of prescription drug/opioid overdose-related deaths.	This objective is not SMART as it is not <i>specific</i> , <i>measurable</i> or <i>time bound</i> . It can be made SMART by specifically indicating <i>who</i> is responsible for the training, <i>how many</i> people will be trained, <i>who</i> they are, and by <i>when</i> the training will be conducted.	<i>By the end of year two of the project, the Health Department</i> will have trained <i>75% of EMS staff in the County Government</i> on the selected curriculum addressing the prevention of prescription drug/opioid overdose-related deaths.