**Logo with names of organizations "Champaign County Developmental Disabilities Board/Champaign County Mental Health Board"
**

# **CCDDB/CCMHB Site Visit Protocol and Report**

To assure an appropriate level of accountability and full compliance with the terms and conditions of service contracts, the Champaign County Mental Health Board (CCMHB) and the Champaign County Developmental Disabilities Board (CCDDB) require quarterly reporting specific to each contract and an annual Performance Outcomes Report in compliance with specifications defined in the contract. Biannual or more frequent site visits are conducted at the discretion of the Associate Directors using the following protocol and attached report forms and checklists.

# **Prior to the Site Visit**

1. *Scheduling –* CCDDB/CCMHB staff will schedule a meeting with the appropriate agency staff person (e.g., program supervisor) to complete the review. This may be done by phone or email, with a minimum of 5 working days’ notice. Date and time scheduled will be at the mutual convenience of Board and Agency staff. A list of requested documents will be shared with the agency. The meeting may be conducted through a virtual platform such as Microsoft Teams, Zoom, WebEx, or other, provided both parties agree.

*For Fee for Service contracts only* – arrange the meeting with a minimum of 7 working days’ notice and include Financial Manager in planning and preparation. Select cases from the cumulative list of unduplicated clients for the current program year. Identify claims associated with the selected case records. Share this list with the agency program representative 24 hours in advance of the scheduled record review appointment. Because the goal is to review at least 5% of total claims or claims on behalf of 5 clients, whichever is greater, be sure to select enough claims/clients in case some cannot be reviewed.

1. *Agency preparation –* The provider will gather the requested documents and make them available to CCDDB/CCMHB staff at the start of the site visit. A standardized report form and checklist are used to guide the review of documents.

*For Fee for Service contracts only –* The provider will pull the identified client claims/billings for review and make them available at the start of the record review appointment.

1. *Reviewer preparation –* CCDDB/CCMHB staff will review:

* Program Plan (for utilization targets and outcome measures)
* Quarterly Reports and year to date reported activity (to verify)
* Special Provisions section of the contract
* Most recent site visit report (for concerns which may persist)
* Most recent completed Annual Performance Outcome Report

CCDDB/CCMHB staff will develop discussion topics of emerging issues or concerns identified in the above review or by other staff, particularly the Cultural and Linguistic Competence Coordinator and Operations and Compliance Coordinator, who may also participate in the meeting.

*For Fee for Service contracts only* – in addition to the above, identify claims for review (see “Scheduling” above.)

# **During the Site Visit**

1. *View documentation or other evidence*, whether on site or through a virtual platform, to verify:

* State Licensure current and client notices (posted in agency lobby or shown during the meeting);
* Relevant credentials of agency staff responsible for contracted services;
* Most recent survey/audit/review by accreditor, or
* For agencies without accreditation, review SOPS such as bylaws, personnel policies, and financial policies.
* Assurances included in contract, e.g drug free workplace, EEO/non-discrimination statement.
* Site(s) where services are delivered;
* Site(s) where client/service records are maintained;
* Services reported during most recent quarter.

1. *Discussion* with agency representative of program and performance:

* Are the most recent utilization numbers over or under targets?
* *For grant contracts -* review of three (or more) TPC case files
  1. First examine unopened case file information to scrupulously avoid any possible breaches of client confidentiality.
  2. Complete the Treatment Plan Client case file checklist (Appendix A for CCDDB and Appendix B for CCMHB), confirming client Champaign County residency, completed screening or assessment, treatment plan present, service contacts documented including through case notes, releases of information, evaluations, etc.
  3. If NTPC case files are being reviewed, check client Champaign County residency, intake/program enrollment form, service contacts documented, releases of information, evaluations, etc.
* Emerging issues – new developments, e.g. state policy; shifts in client population; challenges/opportunities; board status.
* Review contract requirements, including program plan, reporting process and forms, new utilization targets or services, and CLC plan. (The CLC Coordinator may also complete a site visit review.)
* *For Fee for Service contracts* – review 5% of total program claims or claims related to 5 cases, whichever is greater, as above. As above, exclude any files with familiar names and verify residency, assessment/eligbility, payor source, treatment plan, and service contacts. Compare claims with documentation of service and dates indicated. If errors are found, the process may be repeated.

1. *Exit interview –* summarize results/findings. If deficiencies have been identified, explain the requirement for corrective action within a reasonable timeframe.

# **Subsequent to the Site Visit**

1. *Summarize observations* in the report form (Appendix C), with copies to the Agency, the CCDDB/CCMHB contract file (through the Operations and Compliance Coordinator) and Executive Director.
2. *Outcome of the Site Visit* may be:

* “Documentation Met Expectations” – the activity which had been reported is well documented, and client records are complete;
* “Documentation Sufficient to Verify Activity” – reported activity met minimal expectations for documentation, with deficiencies, e.g., records were present but required effort to verify eligibility and services; or
* “Finding of Significant Abnormalities” – absence of documentation of client eligibility and/or participation in service, triggering written notice of findings and requiring an agency response on corrective action (such notice is very rare – emphasis on significant). A follow-up site visit may be required within 90 days, or issues may be addressed at next site visit, depending on significance of findings.
* *For Fee for Service Contracts –* if errors are found, indicate whether clarification is required and whether claims and billings are to be adjusted.

**Appendix A**

# **CCDDB Treatment Plan Client Case File Review Checklist**

Intake: ☐ Date: \_\_\_\_\_\_\_\_\_

Residency: ☐ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gender: \_\_\_\_\_\_ Age: \_\_\_\_\_\_ Race: \_\_\_\_\_\_ Hispanic: \_\_\_\_\_\_ Referral Source: \_\_\_\_\_\_

Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Proof of CCDDB eligibility (PUNS enrollment): ☐ Y ☐ N Date: \_\_\_\_\_\_\_\_\_

Psychological Assessment: ☐ Y ☐ N Date: \_\_\_\_\_\_\_\_\_

Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Person-Centered Plan: ☐ Date: \_\_\_\_\_\_\_\_\_ Signatures: ☐ Y ☐ N

Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Case Notes: ☐ Current: ☐ Y ☐ N Provider Signature: ☐ Y ☐ N

ROIs: ☐ Signatures: ☐ Y ☐ N \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ICAP: ☐ Date: \_\_\_\_\_\_\_\_\_ Current: ☐ Y ☐ N

Medical Info: ☐\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Correspondence: ☐. Other Documents (Describe):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Notes on Case File Records:

**Appendix B**

# **CCMHB Treatment Plan Client Case File Review Checklist**

Intake: ☐ Date: \_\_\_\_\_\_\_\_\_

Residency: ☐ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gender: \_\_\_\_\_\_ Age: \_\_\_\_\_\_ Race: \_\_\_\_\_\_ Hispanic: \_\_\_\_\_\_ Referral Source: \_\_\_\_\_\_

Comments:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Proof of CCMHB eligibility: ☐ Y ☐ N Type: ­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_

Assessment: ☐ Y ☐ N Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_

Current: ☐ Y ☐ N

Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Comments:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Service/Treatment Plan: ☐ Date: \_\_\_\_\_\_\_\_\_ Signatures: ☐ Y ☐ N

Comments:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Case Notes: ☐ Current: ☐ Y ☐ N Provider Signature: ☐ Y ☐ N

Medical Info: ☐\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Correspondence: ☐. Other Documents (Describe):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Notes on Case File Records:

**Appendix C**

**Logo with names of organizations "Champaign County Developmental Disabilities Board/Champaign County Mental Health Board"
**

# **CCDDB/CCMHB Site Visit Form**

**AGENCY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PROGRAM: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ # Records Requested: \_\_\_\_\_\_\_, # Records Examined: \_\_\_\_\_\_\_**

**PARTICIPANTS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

(Copies of documentation viewed at this meeting *may* be requested for contract file.)

# **ACCREDITATION:**

Evidence of current accreditation or State Licensure?

Y N

Other posted client notices?

Y N

Do the agency staff responsible for contracted services have relevant credentials?

Y N

Copies of most recent survey/audit/review by accreditor?

Y N

*OR* if not accredited, copies of bylaws, personnel policies, and financial policies?

Y N

Evidence of assurances included in contract, such as drug free workplace, EEO/non-discrimination statement?

Y N

# **SERVICE DELIVERY:**

Confirmed site(s) where services are delivered?

Y N

Confirmed site(s) where client/service records are maintained?

Y N

Verification of services reported during the most recent quarter?

Y N

# **UTILIZATION:**

Are the most recently reported utilization numbers over or under targets?

Concerns from most recent Annual Performance Outcome Report?

# **ELIGIBILITY AND SERVICES CLAIMED:**

Review of three (or more) client case files, attached. Deficiencies?

For Fee for Service contracts, are the selected claims/billings verified by documented service contacts? Describe deficiencies.

# **DISCUSSION:**

Emerging issues:

Review of contract requirements:

# **CONCLUSION:**

Outcome of Site Visit (check one):

Documentation Met Expectations

Documentation Sufficient to Verify Activity

Finding of Significant Abnormalities

Comments:

If corrective action is indicated, provide detail and timeline for corrective action plan and other follow up:

Signed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Cc: Agency Representative, CCDDB/CCMHB Operations and Compliance Coordinator for contract file, CCDDB/CCMHB Executive Director*