Colorado Medicaid
Community Mental Health Services Program

FY 07–08 Site Review Report

for

Behavioral HealthCare, Inc.

June 2008

This report was produced by Health Services Advisory Group, Inc. for the Colorado Department of Health Care Policy & Financing.

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Overview of FY 07–08 Compliance Monitoring Activities

The Balanced Budget Act of 1997, Public Law 105-33 (BBA), requires that states conduct an annual evaluation of their managed care organizations and prepaid inpatient health plans (PIHPs) to determine compliance with regulations, contractual requirements and the state's quality strategy. The Department of Health Care Policy & Financing (the Department) has elected to complete this requirement for the Colorado behavioral health organizations (BHOs) by contracting with an external quality review organization (EQRO), Health Services Advisory Group, Inc. (HSAG).

This is the fourth year that HSAG has performed compliance monitoring reviews of the BHOs. For the fiscal year (FY) 07–08 site review process the Department requested a focused review of five areas of performance. HSAG developed a review strategy consisting of five components for review, which corresponded with the five areas identified by the Department. These are: Access to Care (Component 1), Coordination of Care (Component 2), Oversight and Monitoring of Providers (Component 3), Member Information (Component 4), and Review of Corrective Action Plans and Supporting Documentation (Component 5). Compliance with federal regulations and contract requirements was evaluated through review of the five components. This report documents results of the FY 07–08 site review activities. Details of the site review methodology and summaries of the findings, strengths, opportunities for improvement, and required actions for each component are contained within the section of the report that addresses each component. Template data collection tools for Components 1, 3, and 4, as well as completed documents for Components 2 and 5, are found in the appendices.

In developing the data collection tools and in reviewing the five components, HSAG used the BHOs' contract requirements and regulations specified by the BBA with revisions that were issued on June 14, 2002, and effective on August 13, 2002. The site review processes were consistent with the February 11, 2003, Centers for Medicare & Medicaid Services final protocol *Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs)* (see Appendix H).

Objective of the Site Review

The objective of the site review was to provide meaningful information to the Department and the BHOs regarding:

- The BHO's compliance with federal regulations and contract requirements in the five areas of review.
- The quality, timeliness, and access to mental health care furnished by the BHO, as assessed by the specific areas reviewed.
- Possible interventions to improve the quality of the area reviewed.
- Activities to sustain and enhance performance processes.

To accomplish these tasks, HSAG:

- Collaborated with the Department to determine the review and scoring methodologies for each component of the review, data collection methods, the schedule, the agenda, and other issues as needed.
- Collected and reviewed documents before and during the on-site portion of the review.
- Analyzed the data and information collected.
- Prepared a report of findings (2007–2008 Site Review Report) for each BHO.

Throughout the review process, HSAG worked closely with the Department and the BHOs to ensure a coordinated and supportive approach to completing the site review activities.

Summary of Results

Each component of the review was assigned an overall score of *In Compliance*, *In Partial Compliance*, or *Not In Compliance* based on conclusions drawn from the review activities. Required actions were assigned to any component receiving a score of *In Partial Compliance* or *Not In Compliance.* As appropriate, opportunities for improvement were also identified for some components regardless of the score. While recommendations for enhancement of BHO processes were provided based on these identified opportunities for improvement, these recommendations (as differentiated from required actions) do not represent noncompliance with contract or BBA regulations at this time.

Table 1-1 presents the score for **Behavioral HealthCare, Inc.** (**BHI**) for each of the components. Details of the findings for each component follow in subsequent sections of this report.

Table 1-1—Results

Component	Overall Score
Component 1—Access to Care	☒ *In Compliance* ☐ *In Partial Compliance* ☐ *Not In Compliance*
Component 2—Coordination of Care	☒ *In Compliance* ☐ *In Partial Compliance* ☐ *Not In Compliance*
Component 3—Oversight and Monitoring of Providers	☒ *In Compliance* ☐ *In Partial Compliance* ☐ *Not In Compliance*
Component 4—Member Information	☒ *In Compliance* ☐ *In Partial Compliance* ☐ *Not In Compliance*
Component 5—Review of FY 06–07 CAPs	☒ *In Compliance* ☐ *In Partial Compliance* ☐ *Not In Compliance*

Methodology

HSAG conducted member interviews and telephone assessments of **BHI**'s access processes and compared the results with the BHO's policies and published practices and with information obtained from interviews with key BHO staff members.

HSAG reviewed for compliance with the following contract requirements:

- *Exhibit C.1:* "The Contractor shall assess the need for services."
- *II.F.1.a.5*: "The Contractor shall meet the standards for timeliness of service for routine, urgent, and emergency care."
- *II.F.1.f:* "The Contractor shall allow, to the extent possible and appropriate, each Member to choose his or her health professional."

Member Interviews

The Department provided HSAG with a sample of 10 Medicaid members (with an oversample of 58 Medicaid members) who received or attempted to receive services between the dates of January 1, 2007 and December 31, 2007. The intended sample mix for each BHO was as follows: three Medicaid members who received only an intake visit during the review period, three Medicaid members who received an intake and subsequent services during the review period, and four Medicaid members who were identified by various stakeholder groups.[2-1] HSAG interviewed four adult Medicaid members, three of whom received services following the intake assessment, and six individuals whose children were Medicaid members who had received an intake assessment with four receiving subsequent services. There were no Medicaid members identified by the stakeholder groups who met the selection criteria for the sample (members who experienced an issue accessing services between July 1, 2006, and December 31, 2007, and had not had the matter investigated by either the Medicaid ombudsman or the Department). HSAG developed a short questionnaire that was conducted via telephone. Members were asked to describe their experience of obtaining an individual, confidential assessment for entry into services. Interview questions were designed to obtain members' perceptions related to the ease of gaining access to services provided by the BHO and information provided to them during initial and subsequent contact with the BHO.

[2-1] Stakeholder groups are the Mental Health Planning and Advisory Council, the Mental Health Advisory Committee, and the Office of the Ombudsman for Medicaid Managed Care.

Telephone Assessment of BHO Access Processes

HSAG conducted five calls per BHO to assess the processes and practices at each BHO for providing access or intake services to Medicaid members in the BHO's service area. The HSAG caller identified him/herself as an HSAG representative calling on behalf of the Department. The caller then asked a series of situational and standard questions about policies and processes for providing access to services. Answers were recorded by each caller and are summarized in the findings section below. The caller worksheets (see Appendix B) included scripts with a set of situations to present to the BHO intake worker. The situations presented to the BHO intake worker were different for each of the four calls. The caller worksheets also included a set of policy or process questions, which were standard questions to be asked during each call. Each scripted call was made to each BHO simultaneously. That is, Call Script 1 was made to each BHO on Tuesday, January 8, 2008, at 2 p.m.; Call Script 2 was made to each BHO on Saturday, January 12, 2008, at 3 p.m. and repeated on Monday, January 28, 2008, at 12:30 p.m.; Call Script 3 was made to each BHO on Wednesday, January 23, 2008, at 9:30 a.m.; and Call Script 4 to each BHO on Tuesday, January 29, 2008 at 4 p.m.

Summary of Findings

The **BHI** Intake Assessment Training Outline included the requirement to assess each member to determine which services are needed. Training was completed at each of the **BHI** network CMHCs in December 2007 and January 2008, as evidenced by completed sign-in rosters. The Consumer Request for Contracted Provider policy described the process used for scheduling an assessment for members who do not wish to receive services from one of the CMHCs. The **BHI** intake packet included assessment forms for both emergency and routine intake services. During the on-site interview, **BHI** management staff members reported that each of the centers used a peer review process to review completeness of member records (including the presence of an intake assessment) and brought difficult cases to the Risk and Resource meetings for peer discussions regarding appropriateness of services. Each of the CMHC peer review forms included a section for the reviewer to evaluate the member assessment. During each call that HSAG made to **BHI** or its network CMHCs, the intake staff members indicated that the Medicaid member described in the call scenario would be scheduled for an intake assessment, or in the case of the emergency scenario, may be urged to go to the nearest emergency room for an evaluation. Each of the **BHI** and CMHC intake staff members were aware of **BHI** specialty programs such as **BHI**'s Developmental Disabilities/Mental Illness (DDMI) center of excellence and the nursing home treatment team, and indicated that although the specialty programs were at a particular CMHC, members from any part of the **BHI** service area were offered the programs.

The Access and Availability policy included the standards for timely access to services. The **BHI** Intake Assessment Training Outline indicated that the Access and Availability policy was reviewed during the trainings completed in December 2007 and January 2008. **BHI** reported quality improvement information to **BHI** board members, provider advisory council members, and consumer advisory board members through quarterly **BHI** Quality Improvement Report Cards. **BHI**'s Quality Improvement Report Cards indicated that early in calendar year 2007 **BHI** was 97 percent compliant with the requirement to provide face-to-face emergency services within one hour. **BHI** required the submission of a corrective action plan by, and implemented monthly monitoring

of, the CMHC that was out of compliance. The **BHI** Quality Improvement Report Card for October through December 2007 demonstrated that **BHI** was 100 percent compliant with the timeliness standard for emergency services, following the corrective actions. The Quality Improvement Report Cards indicated that **BHI** remained at 100 percent compliance for provision of timely urgent and routine services throughout the review period.

BHI's Access and Availability policy stated that members may call any of the contracted community mental health centers (CMHCs) or independent providers to obtain services, or may ask that a provider be added to the network. The Consumer Request for Contract Provider policy described the process for allowing consumers to choose a provider from the network or continue services with a nonnetwork provider. The **BHI** list of single-case agreements indicated that, at the time of the site review, **BHI** had single-case agreements with approximately 40 providers in addition to the contracted providers in the **BHI** network. The **BHI** member handbook included a specific discussion regarding choosing a provider that emphasized member choice. A provider directory was included in the mailing with the member handbook. One of the eight CMHC/**BHI** intake staff members who HSAG spoke to was unsure if Medicaid members could request providers outside of the CMHCs; however, the staff member readily indicated that she would refer the caller to **BHI** for assistance.

During HSAG's telephone assessment calls to the **BHI** and CMHC intake numbers, there were issues with Aurora Mental Health Center's phones disconnecting the calls. During the on-site interviews, **BHI** management staff members reported that they had been aware of Aurora Mental Health Center's difficulties with the phone lines during that time period, and that they were aware that the mental health center resolved those issues.

During two of the telephone assessment calls, HSAG callers placed the calls to **BHI** rather than the CMHCs. During those calls, HSAG staff spoke with the utilization management (UM) staff at **BHI**. During the on-site interview, **BHI** management staff clarified that it was **BHI**'s process that when calls requesting services came directly to **BHI**, they were referred to the UM staff and that **BHI** did not hire intake workers in addition to the UM staff. **BHI** management staff also reported that calls placed directly to the CMHCs were handled by the CMHCs.

Summary of Strengths and Opportunities for Improvement

BHI had processes in place to ensure that members are assessed during the intake process and that the intake appointment was within the required time frames. These processes included monitoring, training, the use of corrective action plans, and repeated training and monitoring. **BHI** used a peer review process within each CMHC and among CMHCs during the Risk and Resource meetings to reassess the appropriateness of services provided to members, particularly to members with difficult or complex issues.

BHI's intake process was to schedule individuals for an orientation session during which members were seen in small groups and given information about Medicaid benefits and services. Immediately following the group orientation, members were seen briefly in a private session by a clinician who assessed the member's needs and assigned the member to a therapist with the appropriate expertise. Ten of 10 members interviewed expressed satisfaction with the first appointment. During HSAG's

calls, one scenario had to do with receiving an urgent appointment to obtain medications. The process described was: (1) gather information over the telephone to determine urgency, (2) schedule the member for an orientation session during which the member would be scheduled for an appointment with a therapist, (3) have the therapist assess the urgency of the medication need during the first scheduled appointment, and (4) following that assessment, have the therapist schedule an appointment with a prescriber. During the on-site interview, **BHI** management staff members acknowledged that this process appeared cumbersome and indicated that depending on urgency, members could move through the steps rather quickly. While **BHI** staff members indicated that it was the responsibility of the primary therapist to assist the member in navigating the process, the multiple steps involved could possibly create delays or present a barrier to timely access for members needing medication assessments or presenting with an urgent need. **BHI** may want to reassess the steps and procedures required during an intake to determine if the member's needs are appropriately prioritized and attended to in a timely fashion when an urgent visit or medication assessment is warranted.

Since **BHI** relied heavily on its CMHCs to provide access and intake services to Medicaid members, **BHI** trained each of the CMHCs regarding its access policies and requirement for timely access. During the intake assessment telephone calls, the next available appointments were within the required time frames for the situation presented. The results of the telephone assessment calls and the member interviews conducted by HSAG demonstrated that CMHC and **BHI** staff members were compliant with **BHI**'s requirements. **BHI** informed providers of access requirements through a variety of formats (online, in-person training, videotaped training, and through the provider manual). **BHI** also assessed the efficacy of CMHC staff training with a test following training and used results of those tests to design further training.

Summary of Required Actions

There are no corrective actions required at this time as **BHI** was found to be in compliance with this component.

Methodology

Care coordination (as defined in the FY 07–08 BHO contract) means the process of identifying, screening, and assessing members' needs; identification of and referral to appropriate services; and coordinating and monitoring an individualized treatment plan. This treatment plan should also include a strategy to ensure that all members and/or authorized family members or guardians are involved in treatment planning and consent to the medical treatment. The focus of the FY 07–08 Coordination of Care record review was to use the clinical record to identify and assess the BHO's and providers' practices related to care coordination with primary care physicians and parents or guardians of children receiving services, specifically with respect to medication management. The Department provided HSAG with a sample of 10 Medicaid members (with an oversample of 5) who were children (0–17 years of age) and who received a medication management visit between January 2007 and September 2007. A reference period of 45 days prior to, and 45 days following, the medication management encounter date was used for review of each record. The purpose of the record review was to identify instances of care coordination between mental health provider(s) and the family (parent or guardian) and between mental health provider(s) and the primary care physician (PCP) related to medication management. Mental health providers may include the prescriber or the therapist.

HSAG reviewed for compliance with the following contract requirements:

- *II.F.1.g.3:* "The Contractor shall coordinate with the Member's medical health providers to facilitate the delivery of health services, as appropriate."
- *II.G.1.c:* "The Member has the right to participate in decisions regarding his or her health care."
- *II.G.5:* "The Contractor shall encourage involvement of the Member, family members, and advocates in service planning."

Summary of Findings

The **BHI** Coordination of Care policy described the process for coordinating members' care with medical providers, family, and other agencies. The Early and Preventive Screening, Diagnosis, and Treatment (EPSDT) screening/primary care physician (PCP) letter template included sections to provide information about treatment planning and medications prescribed, as well as a section to request, if applicable, an EPSDT screening by the PCP. The PCP Notification policy indicated that this letter is sent to the PCP following an intake assessment. PCP notification reports from the CMHCs indicated that **BHI** tracked the CMHCs' compliance with this policy. The **BHI** delegation agreements with the CMHCs and annual delegation oversight audits demonstrated that **BHI** required the CMHCs to assign each member a care coordinator. **BHI**'s list of integrated projects included descriptions of projects designed to enhance members' coordination of care. Integrated projects included a peer specialist position at the Colorado Mental Health Institute at Fort Logan and the colocation of therapists at North Metro Community Services, numerous school-based health clinics, pediatrician offices, and federally-qualified health clinics (FQHCs). In addition, during the

on-site interview, **BHI** management staff stated that the **BHI** medical director offered consultation to PCPs in the community as needed.

Member newsletters, drop-in center meeting minutes, and **BHI** quarterly utilization management (UM) and Office of Consumer and Family Affairs (OCFA) Report Cards described **BHI**'s initiatives to enhance coordination of care and support members' participation in recovery. **BHI**'s care coordination and recovery initiatives included programs such as the Bipolar Education and Skills Training (BEST) program, nursing home and alternative care facility (ACF) outreach programs, the DDMI center of excellence, the Medical Home program, the Peer Specialist program, the Consumer Advisory Board, vocational training programs, the Parent Empowerment program, and a variety of wellness programs.

The coordination-of-care record review included 10 records of children who received a medication management visit within the review period. Record 8 was removed from the sample and replaced with Record 11 from the oversample due to Medicaid/**BHI** being a secondary payor and not having directly provided services. Ten records included documentation that the therapist communicated with family members either by phone or in person during therapy sessions. In eight of those records there was documentation that the therapist specifically discussed medications or the child's response to medications. Four records included documentation that the primary therapist communicated directly with the prescriber either by telephone or by attending the medication management session with the family. Four records included documentation of communication with other agencies such as schools, social services, or probation. One record included documentation of communication with the PCP.

Summary of Strengths and Opportunities for Improvement

BHI had a variety of creative methods to enhance the quality of care coordination. **BHI**'s integrated projects included colocation of mental health center staff at FQHCs, schools, and pediatrician offices. **BHI** used peer specialist positions and consumer-run programs to empower members to participate in care. Specialty programs such as the BEST program and the DDMI center of excellence used peer support and therapist expertise to enhance coordination of care. **BHI** conducted focus groups with members who were enrolled in the BEST program to revise and enhance the BEST treatment modules.

BHI had policies and required forms for coordination of care with PCPs and required CMHC reporting related to coordination or communication with PCPs. However, the requirement was that this communication would occur following an intake assessment. There was no direction regarding ongoing communication with PCPs. While it was evident that **BHI**'s providers documented numerous coordination-of-care activities with family members and other service agencies, **BHI** may want to consider developing additional criteria or guidelines to ensure that coordination and communication with PCPs occur at other appropriate times during the member's treatment.

Summary of Required Actions

There are no corrective actions required at this time as **BHI** was found to be in compliance with this component.

Methodology

HSAG conducted a desk review of policies and an on-site review of documentation with an interview of key BHO personnel. This component of the compliance monitoring review was designed to examine the BHO's processes for directly monitoring independently contracted providers, and to examine the BHO's processes for monitoring the community mental health centers (CMHCs) regarding supervising and training of their providers. Specific attention was paid to the BHO's practices related to identifying and responding to issues during its monitoring of the CMHCs. The review period for this component of the review was January 1 through December 31, 2007.

HSAG reviewed for compliance with the following contract requirements:

- *II.F:* "The Contractor shall ensure that required and alternative services are provided through a well-organized service delivery system. The service delivery system shall include mechanisms for ensuring access to quality, specialized care from a comprehensive provider network."
- *II.G.4.h.3:* "Additional Member rights include the right to have an independent advocate, request that a provider be considered for inclusion in the network, and receive culturally appropriate and competent services from participating providers."
- *II.H.10.a.1:* "The Contractor shall be responsible for all work performed under this Contract, but may enter into Provider agreements for the performance of work required under this Contract. No provider agreements, which the Contractor enters into with respect to performance under the Contract, shall in any way relieve the Contractor of any responsibility for the performance of duties required under this Contract."
- *II.H.10.a.3:* "The Contractor shall monitor Covered Services rendered by provider agreements for quality, appropriateness, and patient outcomes. In addition, the Contractor shall monitor for compliance with requirements for Medical Records, data reporting and other applicable provisions of this Contract."

Summary of Findings

BHI policies and procedures for monitoring the performance of providers included the following policies: Clinical Quality of Care Concerns, Clinical Practice Guidelines, Subcontractual Relationships and Delegation, Service Quality Measurement, Provider Credentialing and Recredentialing, and Culturally Appropriate and Competent Services. **BHI** quarterly network adequacy reports, quarterly UM and OCFA Report Cards, and the CMHC reports of alternative service encounters demonstrated that **BHI** monitored services and the service delivery system by monitoring enrollment, penetration rates, adherence to access standards, and a variety of utilization management measures, including hospital recidivism and over- and underutilization. The quarterly Quality Improvement Report Cards demonstrated that **BHI** monitored consumer outcomes through focus groups with members who received services through the BEST program. The quarterly

Quality Improvement Report Cards also demonstrated that **BHI** monitored for the presence of documentation indicating communication with PCPs.

BHI's intake and access training PowerPoint presentation included results of **BHI**'s own secret shopper project that assessed the CMHCs' intake processes and timeliness of appointments offered. During the on-site interview, **BHI** management staff members confirmed that **BHI** had conducted secret shopper projects during fiscal years 06–07 and 07–08. **BHI**'s annual Delegation Oversight report included provider monitoring as well as monitoring delegated functions performed by the CMHCs. Provider topics monitored included the posting of rights and ombudsman posters, staff member completion of required training, and the review of results of the CMHCs' most recent Division of Mental Health survey report. Minutes of the Risk and Resource and the Provider Advisory Council meetings demonstrated that member complaints, quality-of-care concerns, sentinel events, and utilization data trends were reviewed by these committees. The membership of both committees consisted of management staff from each of the CMHCs as well as the **BHI** medical director and **BHI** management staff.

During the on-site interview, **BHI** management staff reported that **BHI** management staff members reviewed reports and other documentation submitted by network CMHCs. This included the CMHCs' utilization management (UM) and quality improvement (QI) program descriptions, corporate compliance plans, utilization review criteria, Alternative Services Encounter Reports, practice guidelines, and completed peer reviews. Policies and procedures submitted by the CMHCs and reviewed by **BHI** included policies regarding emergency services, care coordination, clinical supervision, denials, notices of actions, grievances, consumer rights, access to interpreter services, access to care, utilization management, and advance directives. In addition, **BHI** provided training for topics related to Medicaid contract compliance (actions and appeals, intake access, grievances, and the DDMI practice guidelines) as evidenced by training outlines, PowerPoint presentations, and training rosters. **BHI** provided evidence that it conducted a standardized consumer satisfaction survey (the Mental Health Corporation of America consumer satisfaction survey) in addition to the Department-administered Mental Health Statistical Improvement Project (MHSIP) and the Youth Services Survey for Families (YSS-F).

On-site review of minutes from the Provider Advisory Council and Risk and Resource meetings demonstrated that a peer review process was used to review cases and monitor for quality and appropriateness of services delivered, as well as to monitor utilization patterns, quality-of-care concerns and grievances, and that **BHI** required corrective actions from the CMHCs as indicated. **BHI**'s report on the statistically valid sample of encounter records demonstrated that **BHI** monitored for the accuracy and completeness of encounter data as well as the presence of supporting documentation in the medical records.

The member handbook included the list of member rights, including the right to request that a provider be included in the network. **BHI**-developed training included a description of the member's right to request that a provider be included in the network as well as a discussion of the external provider network and the process for offering single-case agreements. Review of the provider directory and on-site interviews with **BHI** management staff indicated that **BHI** used the electronic version of the provider directory to search for organizational and independently contracted providers by license, specialty, location, and language spoken.

Summary of Strengths and Opportunities for Improvement

BHI's approach to training CMHC staff regarding policies and procedures related to Medicaid contract compliance was the development and/or presentation of the training by **BHI** staff. Training occurred in various formats to accommodate different learning styles. **BHI** administered tests to staff members who had received training related to the content of that training and used the test results to redesign future training. Also, **BHI** used member satisfaction surveys in addition to the MHSIP and YSS-F to monitor member outcomes. The delegation oversight process included monitoring CMHC providers related to performance of selected Medicaid contract requirements for the provision of services as well as for the performance of delegated activities. **BHI** used a variety of monitoring processes, including review of reports and policies, audits, and peer review discussions.

Summary of Required Actions

There are no corrective actions required at this time as **BHI** was found to be in compliance with this component.

Methodology

HSAG compared results of the member interviews and the telephone assessments to BHO policies and to documentation provided to members in writing. This component assessed the accuracy of information provided verbally during the intake process at the BHO and at facilities designated by the BHO to perform the intake function on behalf of the BHO.

HSAG reviewed for compliance with the following contract requirements:

- *II.G.4.b:* "The Contractor shall have in place a mechanism to help Members and potential Members understand the requirements and benefits of the plan."
- *II.G.1.d:* "The Contractor shall establish and maintain written policies and procedures for treating all Members in a manner that is consistent with the right to receive information on available treatment options and alternatives, presented in a manner appropriate to the Member's condition and ability to understand."

Summary of Findings

The member handbook described mandatory and alternative services offered and how to access those services. The Enrollee Information, Consumer Rights, Written Enrollee Materials, and Alternative Formats policies described the processes for ensuring that Medicaid members were informed of their rights and were treated in a manner consistent with those rights, including the right to receive information on available treatment options.

BHI conducted quarterly open houses for new members, which included clinicians on-site to conduct brief assessments/intake sessions as needed. Copies of e-mail communication demonstrated that **BHI** staff attended Love and Logic and Parent Empowerment meetings held by the local school district. During these meetings, **BHI** explained services and distributed member handbooks. Each member newsletter highlighted certain services available through **BHI**. **BHI** had an ACF outreach program during which **BHI** staff spoke with ACF directors, then Medicaid members individually, who wished to learn more about **BHI** and the services offered. The nursing home outreach program used peer outreach specialists working with members in the nursing home to explain **BHI** services and connect individuals with services requested. Drop-in center agendas indicated that one member right was highlighted and discussed each week, and that services offered by BHI were discussed, as well. During the on-site interview, **BHI** management staff members reported that **BHI** staff also worked with the county social services staff and Children's Hospital staff to help those organizations understand **BHI**'s services. **BHI** staff members also reported that there was a peer specialist staff member located at the Mental Health Institute at Fort Logan to assist members with transition to outpatient services through **BHI**.

During the member interviews, six members remembered receiving written material about **BHI**. Four members remembered something about the content of the material they received. Four

members stated that they were aware of a complaint process, with one member indicating that she was aware of the complaint process from the poster on the wall at the facility where she received services.

Summary of Strengths and Opportunities for Improvement

BHI had several mechanisms in place to help Medicaid members understand the benefits of the State plan and services available through **BHI**. **BHI**'s collaboration with community organizations and peer-run service programs, and the colocation of peer specialists within nursing homes and hospital units, were methods to assist members transitioning to outpatient services and to help members understand services even after they were admitted to the **BHI** system of care. Member materials, including the handbook and member newsletters, were easy to understand, had a consumer-friendly layout, were available in Spanish and alternative formats such as large print, and included consumer-focused information.

Summary of Required Actions

There are no corrective actions required at this time as **BHI** was found to be in compliance with this component.

6. Component 5—Corrective Action Plan and Document Review

for Behavioral HealthCare, Inc.

Methodology

As a follow-up to the FY 06–07 site review, each BHO was required to submit a corrective action plan (CAP) to the Department addressing all elements for which it received a score of *Partially Met* or *Not Met*. The plan was to include interventions to achieve compliance and the timeline. HSAG reviewed the CAP and associated documents submitted by the BHO and determined whether the BHO successfully completed each of the required actions. HSAG and the Department continued to work with the BHO until HSAG and the Department determined that the BHO completed each of the required actions from the FY 06–07 compliance monitoring site review, or until the time of the on-site portion of the BHO's review.

Summary of Findings

Following the approval of **BHI**'s FY 06–07 corrective action plan, **BHI** submitted all documentation as evidence of completion of each required action. No corrective actions or documents were outstanding at the time of the FY 07–08 site review.

Summary of Strengths and Opportunities for Improvement

BHI completed all required actions for Standard I—Delegation; Standard II—Provider Issues; Standard V—Access and Availability; Standard VI—Utilization Management; Standard IX—Grievances, Appeals and Fair Hearing; and Standard X—Credentialing prior to the FY 07–08 site review.

Summary of Required Actions

There are no required actions continued from the FY 06–07 site review.

Appendix A. Member Interview Worksheet for Behavioral HealthCare, Inc.

The member interview worksheet follows this cover page.

Colorado Department of Health Care Policy & Financing
Behavioral Health Organization (BHO)
Member Interview Worksheet

Interviewer Name: Barbara McConnell Hector Cariello (Spanish-Speaking)	BHO Name: Behavioral HealthCare, Inc.
Member ID: _____ *(not to appear in the report)*	Member Name: _____ *(not to appear in the report)*

Introduce Yourself and Describe (Briefly) HSAG

The State of Colorado has asked us to interview a few Medicaid members to ask about their recent experiences at _____ (name the provider or make a general reference to services if the provider agency is unknown). Do you have a few minutes to talk about your experiences?

Members: (If child, parent was interviewed)

Member #1: Adult
Member #2: Adult
Member #3: Adult
Member #4: Adult
Member #5: Child
Member #6: Child
Member #7: Child
Member #8: Child
Member #9: Child
Member #10: Child

Where services were received:

Member #1: North Metro Community Services
Member #2: Arapahoe/Douglas Mental Health Network
Member #3: Arapahoe/Douglas Mental Health Network
Member #4: Aurora Mental Health Center
Member #5: Community Reach Center
Member #6: Community Reach Center
Member #7: Arapahoe/Douglas Mental Health Network
Member #8: Contracted Therapist
Member #9: Arapahoe/Douglas Mental Health Network
Member #10: Arapahoe/Douglas Mental Health Network

1. *How did you feel about your first appointment at _____? Were you satisfied with your experience during your first appointment at _____?*

How did you feel?

Member #1: "I thought it was OK."
Member #2: "I really liked it."
Member #3: "Disappointed."
Member #4: "A little worried at first."
Member #5: "Very satisfied."
Member #6: "My daughter (teen) wasn't very receptive to being there."
Member #7: "I felt good about it."
Member #8: "It seemed OK."
Member #9: "I felt good."
Member #10: "They were nice."

Were you satisfied?

Member #1: "I just wanted an assessment and got what I needed."
Member #2: "Yes."
Member #3: "The counselor was nice to me."
Member #4: "Yes."
Member #5: "Yes."
Member #6: "I was."
Member #7: "Yes."
Member #8: "Just ok."
Member #9: "Yes."
Member #10: "Yes."

2. *Can you tell me why you felt that way? Describe why you were/were not satisfied.*

Member #1: "I got what I needed."
Member #2: "They did a good job."
Member #3: "The forms were excruciating."
Member #4: "I felt comfortable with the therapist."
Member #5: "We were treated well by the staff, and the medical staff was friendly."
Member #6: "My daughter didn't think it was necessary."
Member #7: "They took time to answer questions and explained things."
Member #8: "It seemed like the counselor was blaming us."
Member #9: "The counselor was friendly and very organized."
Member #10: "The counselor that saw my daughter talked to me and was nice and was friendly."

3. Was there anything that bothered you about the appointment or the person you talked to?

Member #1: "No."
Member #2: "No."
Member #3: "No."
Member #4: "I was worried about transportation because I wasn't familiar with the process, but it turned out ok."
Member #5: "No."
Member #6: "No."
Member #7: "No."
Member #8: "It seemed like the counselor was blaming us."
Member #9: "No."
Member #10: "No."

4. If so, did you ever talk to anyone about it, or do anything about it?

Member #1: N/A
Member #2: N/A
Member #3: N/A
Member #4: N/A
Member #5: N/A
Member #6: N/A
Member #7: N/A
Member #8: "No, we were in the process of moving. I did complete the survey when it came, though."
Member #9: N/A
Member #10: N/A

5. If yes, did you receive anything in the mail about your complaint?

Member #1: N/A
Member #2: N/A
Member #3: N/A
Member #4: N/A
Member #5: N/A
Member #6: N/A
Member #7: N/A
Member #8: N/A
Member #9: N/A
Member #10: N/A

6. *Were you ever told what you can do if you are unhappy about the help you are getting from your counselor? Did you ever get something about this in the mail?*

Member #1: "I can't recall."
Member #2: "No."
Member #3: "Yes, I got paperwork about it."
Member #4: "No, but I never asked, either."
Member #5: "Yes, I was provided a pamphlet about it."
Member #6: "Yes."
Member #7: "I saw the flyers on the wall about that."
Member #8: "I didn't feel like I needed to."
Member #9: "No."
Member #10: "No."

7. *Did you ever get any written information about the BHO (either when you went there or in the mail)?*

Member #1: "Yes, I got a packet."
Member #2: "I got my rights."
Member #3: "I got paperwork about everything."
Member #4: "I got a little flyer."
Member #5: "Yes."
Member #6: "I may have."
Member #7: "I got information in the mail, and also when I went there. Also, they gave me the whole assessment to take to the school."
Member #8: "No."
Member #9: "No."
Member #10: "No."

8. *(If yes): What do you remember about the information?*

Member #1: "Nothing."
Member #2: "Rights."
Member #3: "About complaints, but I didn't have any complaints about Arapahoe."
Member #4: "Information about benefits, or who to call for stuff, and a provider manual."
Member #5: "It provided information about benefits and services at the clinic."
Member #6: "Nothing."
Member #7: "Places I could go."
Member #8: N/A
Member #9: N/A
Member #10: N/A

9. Where were you told you could get counseling? Were you given more than one place to go?

Member #1: "I went where I requested to go."
Member #2: "No, I went where I was referred to go to."
Member #3: "No."
Member #4: "I was given the three centers."
Member #5: "Yes."
Member #6: "Social Services told me where to go. They said there was only one place that had what we needed."
Member #7: "Several places."
Member #8: "Yes, I was given a choice of two offices."
Member #9: "No."
Member #10: "No, but I liked where I went."

10. Did you go back for counseling after your first appointment?

Member #1: "No."
Member #2: "For a while, but then they said I couldn't."
Member #3: "Yes."
Member #4: "Yes."
Member #5: "No."
Member #6: "Yes."
Member #7: "No."
Member #8: "Yes, four or five times."
Member #9: "Yes."
Member #10: "Yes, twice."

11. (If no): Do you mind telling me why?

Member #1: "The therapist didn't feel like he needed services (developmentally disabled adult). I needed to explore whether he did. I'm OK with the decision. I could go again if I change my mind. He seems to be handling things well."
Member #2: "They said that I couldn't have services because I didn't have a drug or alcohol problem."
Member #3: N/A
Member #4: N/A
Member #5: "My daughter doesn't need a lot of medical attention."
Member #6: N/A
Member #7: "It was just an assessment. He didn't need treatment."
Member #8: N/A
Member #9: N/A
Member #10: N/A

If the Member Was Denied Services (or Told He or She Didn't Qualify)

12. Did you get a letter explaining why they couldn't help you?

Member #1: "I think so."
Member #2: "No, the lady I saw was fairly new. Maybe she didn't know."
Member #3: N/A
Member #4: N/A
Member #5: N/A
Member #6: N/A
Member #7: N/A
Member #8: N/A
Member #9: N/A
Member #10: N/A

13. (If yes): Did it explain anything else you could do to get help if you didn't agree with the letter?

Member #1: "Yes, I think so."
Member #2: N/A
Member #3: N/A
Member #4: N/A
Member #5: N/A
Member #6: N/A
Member #7: N/A
Member #8: N/A
Member #9: N/A
Member #10: N/A

14. Is there anything else you would like to tell me about the Medicaid mental health services you have received?

Member #1: "I feel like I could pursue it again in the future if I need to."
Member #2: "They did a good job. I felt like I got good progress. I felt safe talking there. I was upset that I couldn't continue."
Member #3: "I kept having transportation problems. LogistiCare kept standing me up. Then the counselor called and said he had to close my case because I wasn't showing up. No one seemed to care about the transportation problem. I really wanted to continue. I would go back if I didn't have to re-do all the paperwork."

"I called the emergency line once because I needed help and T.M. was very kind. She was extremely nice and talked to me for about an hour."
Member #4: "I saw the therapist every three weeks. She gave me a number in case I needed more meds or needed to talk to someone. K.L. was fantastic."
Member #5: "I was very happy with the overall experience."

Member #6: "When my daughter didn't really connect with her therapist, they switched therapists for us. They accommodated my schedule."

"Once I called the hotline and didn't get a call back. Another time, I called on a weekend when my daughter was finally ready to open up, but the only option was to go to the emergency room. It wasn't an emergency but she was ready to talk right then."

"It took two weeks to get an appointment for medications. I was worried about her during that time, but again, my only option was to go to the emergency room—nothing in between."

Member #7: "No."

Member #8: "They seemed nice enough, but it was just not what my daughter needed. She is doing better now. Overall, it wasn't very helpful."

Member #9: "No."

Member #10: "No."

Appendix B. Telephone Assessment Worksheet for Behavioral HealthCare, Inc.

The telephone assessment worksheet follows this cover page.

Telephone Assessment Worksheet 1

At the beginning of the call identify yourself as an HSAG employee calling on behalf of the Colorado Department of Health Care Policy & Financing for the purpose of assessing the BHO's access system and processes. If the staff member asks about HSAG you may briefly explain the EQRO processes, but quickly continue the call.

Make sure that the staff member you speak to understands that you are assessing Medicaid processes, so any of the potential clients you may be discussing would be eligible for Medicaid.

BHO: Behavioral HealthCare, Inc. Telephone number called: 303-889-4805

Date of call: Tuesday, January 8, 2008 Time of call: 2 p.m.

Caller: Diane Christensen

Name of person answering the phone: C

Offered name: X Had to ask name: _____

Notes:

The phone rang several times, then an automated message said "please hold." The message repeated once, and about one minute later, the phone was answered by C of Aurora Mental Health Center, who said that the BHI phones rolled over to the Aurora Mental Health Center when incoming calls to BHI are on hold for too long. The HSAG caller explained who she was and the purpose of the call (twice, as C did not understand). Then C told the HSAG caller that another call was coming in and that she was the only switchboard operator, so she would need to put the call on hold. When she returned she stated that she needed to transfer the call to "intake."

Person assigned to help or transferred to: S and K (Aurora Mental Health Center—Intake)

Offered name: X Had to ask name: _____

Notes:

S answered the phone and the HSAG caller asked the first question when the call was cut off. The HSAG caller called the BHI number again, and again the call rolled over to Aurora Mental Health Center, where the HSAG caller was again was transferred to "intake." K answered the phone and was very helpful. At one point, K said she heard the sound that indicated the call was going to be dropped again. She gave the HSAG caller her direct number so she could call back. The call did drop, and the HSAG caller called the direct line, which was stable during the rest of the call.

Does this BHO (or the CMHC) provide services in an urban, rural, or frontier area?

Urban

Specific questions for the first call:

1. *How would someone (perhaps a parent) obtain services for a child with Asperger's syndrome who has additional symptoms (i.e., if the parent describes symptoms of psychosis or depression)?*

   K said she would gather enough information from the parent to get a sense of the situation and need. She said that BHI has an Intercept program for children with both a developmental disability and a mental health diagnosis. K would then contact and forward the information to the Intercept program director, who would call the parents to gather additional information and schedule the first appointment.

2. *How would you (the BHO) respond to a nursing home calling to obtain services for a resident (for depression)?*

   (If the BHO indicates that the resident would have to travel to a CMHC or provider office, ask how transportation could be arranged or services could be provided at the nursing home.)

   K explained that BHI has a protocol that it follows. K would take the initial information and description of what is happening with the individual, including whether he or she could be transported to one of the BHI clinics or needed to schedule the intake at the nursing home. K would forward the information to the director of the older adult team who works with individuals of any age who live in nursing homes. The director would contact the nursing home, assess the urgency of the situation, and schedule the intake accordingly.

General questions asked during each call:

3. *What is your next availability for a routine appointment?*

Call #1: K stated that it depends on the situation. They start all clients with an orientation session, and those are scheduled at different times in different locations. K said she could get someone in at the south side clinic or the north side clinic the next evening (they have orientations on Mondays and Wednesdays). The orientations are scheduled for a specific day and time for adults. They begin as group sessions for orientation and education about services and are followed by a brief individual session with a clinician, who will assess the needs and schedule the first appointment with the appropriate therapist.

For children, parents and children can come anytime between noon and 5 p.m., and they are on a first come, first served, basis. The HSAG caller asked how long the parents would have to wait. K answered 10 to 15 minutes at the most.

Call #2:

BHI after hours: This is a crisis line. S said she would do a safety assessment. If she determined it was not an emergency, she would have the member call the nearest CMHC on Monday.

BHI Utilization Management (UM) Staff: D explained that it depends on the provider, whether he or she is a CMHC or a contracted provider. It could be today, tomorrow, or later this week, but in no case would it be greater than seven days.

Arapahoe Douglas Mental Health Network (ADMHN): J explained that adult intake appointments are Mondays and Wednesdays, and that child appointments are Tuesdays and Thursdays. Members are asked to come in at 8 a.m. (adults) or 8:30 a.m. (children), and appointments are the same day. They also keep a few appointments open during the week for urgent appointments. J said that seeing everyone in a timely manner has never been an issue.

Call #3:

BHI: B said she would refer the caller to the CMHC in the member's area.

BHI: S explained that if she was comfortable that there was not an urgent or emergent need, she would explain the availability of services at the CMHCs and through contracted providers. She would then connect them with the appropriate provider. S said that BHI's CMHCs almost always get folks in within three days.

Community Reach Center (Reach): S said that as far as she knew, Medicaid members always go to the mental health centers, but that she would refer the caller to BHI.

Call #4: Z explained that the first appointment is an orientation, which they can usually schedule very quickly, often the same day. The longest wait would be six to seven days, depending on which site the member needs. At the orientation, the member is assigned to a therapist and given an appointment.

3.a. Are callers always directed to a CMHC for services or are they given the choice between a CMHC or a contractor before the appointment is set?

Call #1: The HSAG caller did not ask this question, since the CMHC answered the call.

Call #2:

BHI after hours: This is a crisis line. S said she would do a safety assessment. If she determined it was not an emergency, she would have the member call the nearest CMHC on Monday.

BHI UM Staff: D said they start by letting the callers know that BHI's process is to have the members call the nearest CMHC, but if a member is not comfortable with that, BHI gives the member the information about appropriate contracted providers he or she can call.

ADMHN: J said that the CMHCs do all the intake appointments. After the initial intake, the member can see anyone he or she wants.

Call #3:

BHI: B told the HSAG caller that members have a choice between a CMHC or a contracted network provider.

BHI: S stated that BHI has a large network of contracted providers in addition to the CMHCs. She said that callers are told about both.

Reach: S said that as far as she knew, Medicaid members always go to the mental health centers, but that she would refer the caller to BHI.

Call #4: Z said that Aurora Mental Health Center would work with the member to see what the member wanted (i.e., another CMHC or a contracted provider).

3.b. If a member asks if he or she can see someone other than a CMHC provider, what do you tell the member?

Call #1: K stated that if someone calls, but doesn't want to be seen at that center, she would refer them to the BHI customer service number to assist the caller.

Call #2:

BHI after hours: This is a crisis line. S said she would do a safety assessment. If she determined it was not an emergency, she would have the member call the nearest CMHC on Monday.

BHI UM Staff: D said that while she is on the phone with the member, she would check to see if the provider is licensed. If he or she is licensed, D would let the member know that BHI could enter into a single-case agreement with the provider. D assured the HSAG caller that it is a simple process and not a problem.

ADMHN: J said that the CMHCs do all the intake appointments. After the initial intake, the member can see anyone he or she wants.

Call #3:

BHI: B said she would transfer the caller to a BHI clinician who assesses the clinical situation and identifies appropriate contracted providers given the clinical situation and the caller's location.

Reach: S said that as far as she knew, Medicaid members always go to the mental health centers, but that she would refer the caller to BHI.

Call #4: Z said that Aurora Mental Health Center would work with the member to see what he or she wanted (i.e., another CMHC or a contracted provider).

3.c. If a member calls with a request to see a specific private therapist who is not in your network, what do you tell the member?

Call #1: K stated that if the therapist isn't part of the Aurora Mental Health Center network, she would refer the caller to BHI customer service to see if the provider is with the BHI network.

Call #2:

BHI after hours: This is a crisis line. S said she would do a safety assessment. If she determined it was not an emergency, she would have the member call the nearest CMHC on Monday.

BHI UM Staff: D said that while she is on the phone with the member, she would check to see if the provider is licensed. If he or she is licensed, D would let the member know that BHI could enter into a single-case agreement with the provider. D assured the HSAG caller that it is a simple process and not a problem.

ADMHN: J said that it would be up to the provider whether he wants to accept Medicaid.

Call #3:

BHI: B said she would have the caller speak with BHI's director of provider relations, who will work to get the member his or her choice of providers within the network.

BHI: S stated that this happens all the time. She said BHI contacts the provider to see if he or she is willing to enter into a single-case agreement.

Reach: S said that as far as she knew, Medicaid members always go to the mental health centers, but that she would refer the caller to BHI.

Call #4: Z said Aurora Mental Health Center would work with the member to see what he or she wanted (i.e., another CMHC or a contracted provider).

4. *What is your next availability for an urgent appointment?*

Call #1: K said that she would gather the information from the individual and give the information to the nearest clinic, including the fact that the individual needs a priority intake for an urgent need. She stated that she didn't have access to scheduling for the clinics. She stated that she thought the time requirement for urgent appointments was 24 – 48 hours.

Call #2:

BHI after hours: S explained that, as with all callers to the crisis line, she would conduct a safety assessment. If S didn't think it was clearly a routine issue, she would page the on-call clinician at the nearest CMHC to call that member.

BHI UM Staff: D said that the member has to be seen within 24 hours, so she would ensure that the provider the member chooses is able to see the member within that time frame. D said she tries to do all the work and then call the member back with the appointment information.

ADMHN: J said she had an appointment available "today at 1:30."

Call #3:

BHI: B said she would transfer the call to a clinician.

BHI: S said she would conduct a safety assessment. If she did not feel it was an emergency, she would work with the nearest CMHC access team and emphasize that the member needed to be seen within 24 hours. If there was an urgent need for medications, the CMHC physicians usually have two to three hours per day when they can see someone for urgent and emergent medication appointments. S also explained that, if needed, they can use BHI's medical director.

Reach: S said a caller could be seen "right now." She explained that callers can come to the Gateway building and ask for the crisis center.

Call #4: Z said he would ask the caller if he or she was going to be safe while waiting for an appointment that would be the next day. If not, Z would send the caller to the nearest emergency room or have the individual call 911. If it was not an emergency, the next appointment could be the same day or the next day, depending on which center was nearest to the caller.

5. *If I was a Medicaid member calling with an emergency what directions would you give me and how long would it take for me to be seen?*

Call #1: K said she would do a risk assessment to see if the need was emergent. S would refer the member to the nearest emergency room where the member would be safe and could get evaluated.

Call #2:

BHI after hours: S explained that, as with all callers to the crisis line, she would conduct a safety assessment. If the assessment determined that the call was an emergency, S would direct the individual to go to the nearest emergency room or call 911. S would talk to the caller about transportation. S would want to be sure she felt comfortable that the caller would follow through or she would take direct action herself (call 911).

BHI UM Staff: D said the caller would be seen within one hour. She would either tell the caller to go directly to the emergency room (ER) and ensure that the caller arrived at the ER within one hour, or ensure that the CMHC crisis services team nearest to the caller could see the caller within one hour.

ADMHN: J said they have same-day appointments for emergencies. She might also instruct the member to go to an emergency room.

Call #3:

BHI: B said she would keep the person on the line while she got in touch with one of the clinicians to whom she would transfer the call.

BHI: S said she would try to get the phone number first, in case the call is disconnected or the individual hangs up, or if she needs to dispatch the police to the individual's location. S said she would do a safety/risk assessment and determine the severity of the situation. If the caller was capable of getting safely to an emergency room, and S felt comfortable that he or she would follow through, she would tell them to go to the nearest emergency room. If S didn't feel comfortable sending the caller to the emergency room she would call 911 and have the police do a welfare check or respond to the situation. For individuals who are directed to the emergency room, BHI's emergency team responds to the emergency room within one hour of the member being medically cleared.

Reach: S said that she would encourage the caller to get to the nearest emergency room. If there was no one to drive the caller to the emergency room, she would tell him or her to call 911.

Call #4: Z stated that if this was an emergency (the member was suicidal, homicidal, etc.) he would see if the individual or caller could get to the emergency room or call 911, or Z would call 911 and send the police for a welfare check.

6. *What is the procedure if a member indicates that he or she has moved from another BHO's catchment area, but the eligibility file does not reflect the change?*

Call #1: K would check the eligibility file. If the individual didn't appear on the BHI eligibility list she would go ahead and schedule the intake appointment and ask the individual to call Medicaid to get his or her county of eligibility changed.

Call #2:

BHI after hours: This is a crisis line. S said she would do a safety assessment. If she determined that it was not an emergency, she would have the member call the nearest CMHC on Monday.

BHI UM Staff: D said that if the member was now living in BHI's area and wanted to be seen, it would not be a problem. D would let the selected provider know that the eligibility was in transition and D would work with the previous BHO to get authorization for the services.

ADMHN: J said they see all Medicaid members. She would schedule the appointment, then get authorization from the other BHO.

Call #3:

BHI: B would contact an authorization coordinator to be sure that the caller got services while eligibility was being transferred.

BHI: S said BHI would call the other BHO and make sure that the caller got services while the eligibility question was being resolved.

Reach: S said that as long as you're eligible for Medicaid, it doesn't matter where you live. Just come in for the appointment and BHI will work with the other BHO to get authorization.

Call #4: Z said he always checks the eligibility Web site. If the Web site does not show that the individual is eligible in BHI's area, he would tell the member that he will go ahead and schedule the appointment and work out the eligibility issues later.

Telephone Assessment Worksheet 2

At the beginning of the call identify yourself as an HSAG employee calling on behalf of the Colorado Department of Health Care Policy & Financing for the purpose of assessing the BHO's access system and processes. If the staff member asks about HSAG you may briefly explain the EQRO processes, but quickly continue the call.

Make sure that the staff member you speak to understands that you are assessing Medicaid processes, so any of the potential clients you may be discussing would be eligible for Medicaid.

BHO: Behavioral HealthCare, Inc. Telephone number called: 877-349-7379 (Saturday), 303-889-4805 (Monday), 303-730-8858 (Tuesday)

Date of call: Saturday, January 12, 2008; Monday, January 28, 2008; Tuesday, March 18, 2008
Time of call: Saturday—3 p.m., Monday—12:30 p.m., Tuesday—9:30 a.m.

Caller: Diane Christensen (Saturday and Monday) / Rachel Henrichs (Tuesday)

Name of person answering the phone: BHI after-hours line—S, BHI—B, ADMHN—J

Offered name: X Had to ask name: _____

Notes:

During the Saturday call, the line dropped the call twice.

During the Monday call, B transferred the call to S, the UM director. Because S had answered the questions during a previous call, the HSAG caller asked that a different person answer the general questions. S answered the call-specific questions, then transferred the call to D, BHI's UM manager.

During the Tuesday call (ADMHN), J did not refer the call to anyone else.

Person assigned to help or transferred to: BHI after hours—N/A; BHI—S, then D; ADMHN—N/A

Offered name: X Had to ask name: _____

Notes:

Does this BHO (or the CMHC) provide services in an urban, rural, or frontier area?

Urban

Specific questions for the second call:

1. *What would you tell an elderly man if he called to request outpatient counseling (for depression) and indicated that he has both Medicare and Medicaid, but cannot find a Medicare provider? (This man is not in a facility. He either lives independently or with family.)*

   BHI after hours: This is a crisis line. S said she would do a safety assessment. If she determined that it was not an emergency, she would have him call his nearest CMHC on Monday.

   BHI UM Staff: S said she would do the work to help him access a Medicare provider. S said she was sure that Arapahoe/Douglas Mental Health Network has Medicare providers. If the caller indicated that he couldn't find a Medicare provider, S said she would ask who he had already called and, depending on what area he lived in, she would try to find a Medicare provider near him. S said she would ask T—who is responsible for BHI's contracted providers—who she has in the member's area and would facilitate the referral.

   ADMHN: J said that she would confirm that the man was in the catchment area and then schedule an appointment.

2. *Would the answer given above change if this man was in a wheelchair?*

   BHI after hours: This is a crisis line. S said she would do a safety assessment. If she determined that it was not an emergency, she would have the member call the nearest CMHC on Monday.

   BHI UM Staff: S said she would ask him if he had transportation to the provider they selected. She would also ensure that if the provider wasn't with a CMHC (which are all wheelchair accessible) and was a contracted provider, the provider's office was wheelchair accessible. If the caller didn't have transportation available, S would work with BHI's Medicaid transportation contractor, Logisticare, which has a wheelchair ramp.

   ADMHN: J said, "absolutely not." Then added that she would confirm that the caller had transportation. If not, J would help him arrange it.

3. *What would a host home provider need to do to obtain services for an adult with Down's syndrome who is a resident of a host home and who has had behavioral changes recently that staff members of the community-centered board are interpreting as signs of depression?*

   BHI after hours: This is a crisis line. S said she would do a safety assessment. If she determined that it was not an emergency, she would have the member call the nearest CMHC on Monday.

   BHI UM Staff: S said she would work with Aurora Mental Health Center because it is BHI's center of excellence DD/MI program and could do the most thorough evaluation and service planning. She said that Aurora Mental Health Center would do a complete intake assessment and, if needed, an assessment with a prescriber. If for any reason the individual wasn't comfortable with Aurora or wanted a different provider, S would work with either of the other two CMHCs, which could also schedule an intake evaluation/assessment.

   ADMHN: J said the host home would just need to call. She also said she would have to verify whether there was a guardian.

Telephone Assessment Worksheet 3

At the beginning of the call identify yourself as an HSAG employee calling on behalf of the Colorado Department of Health Care Policy & Financing for the purpose of assessing the BHO's access system and processes. If the staff member asks about HSAG you may briefly explain the EQRO processes, but quickly continue the call.

Make sure that the staff member you speak to understands that you are assessing Medicaid processes, so any of the potential clients you may be discussing would be eligible for Medicaid.

BHO: Behavioral HealthCare, Inc. Telephone number called: 303-889-4805 (Wednesday), 303-853-3500 (Tuesday)

Date of call: Wednesday, January 23, 2008; Tuesday, March 18, 2008
Time of call: 9:30 a.m., 9:20 a.m.

Caller: Diane Christensen/Rachel Henrichs

Name of person answering the phone: B/K

Offered name: X Had to ask name: _____

Notes:

The call was answered quickly. B was willing to answer questions, but recognized that she needed to transfer the call to a clinician.

Person assigned to help or transferred to: S/S (different individuals)

Offered name: X Had to ask name: _____

Notes:

S (at BHI) was very professional and quick with her responses. S (at Reach) was very kind and easy to talk to.

Does this BHO (or the CMHC) provide services in an urban, rural, or frontier area?

Urban

Specific questions for the third call:

1. *What is the procedure for alternative care facilities (ACFs) to obtain services for their residents?*

   BHI: B said she would transfer the call to one of BHI's authorization coordinators to determine what is needed and work on scheduling.

   Reach: S was unsure what was meant by "alternative care facility." She said that BHI has an outstanding team that serves nursing homes. All anyone has to do is call and schedule an appointment.

2. *How would you (the BHO) respond if a Medicaid member called and said his or her family member (e.g., son, daughter, spouse, etc.) was having the following symptoms:*
   - *Spending more time alone*
   - *Exhibiting agitation and anxiety when he or she is around people*
   - *Crying frequently*
   - *Making statements of feeling worthless*
   - *Making statements that he or she should be punished (either for something specific or nonspecific)*
   - *Not eating or sleeping*
   - *Not doing the things he or she used to do*

   (Note to caller: The above is a list of classic warning signs that a person may be at risk for suicide. The purpose of this question is to determine if the BHO would assess for suicide risk if these symptoms are reported, even if the caller does not specifically mention suicide.)

   BHI: B said she would ask the wife if she thought this was an emergency. If so, B would direct her to call 911 immediately. If not, B would transfer the call to one of BHI's clinicians.

   Reach: S said she would encourage the caller to bring the family member in for an evaluation. She also offered that if the caller thought that the family member was in danger to himself or others, she would encourage the caller to get the family member to any emergency room right away.

Telephone Assessment Worksheet 4

At the beginning of the call identify yourself as an HSAG employee calling on behalf of the Colorado Department of Health Care Policy & Financing for the purpose of assessing the BHO's access system and processes. If the staff member asks about HSAG you may briefly explain the EQRO processes, but quickly continue the call.

Make sure that the staff member you speak to understands that you are assessing Medicaid processes, so any of the potential clients you may be discussing would be eligible for Medicaid.

BHO: Behavioral HealthCare, Inc. Telephone number called: 303-889-4805, then 303-616-2300 (Aurora Mental Health Center)

Date of call: Tuesday, January 29, 2008 Time of call: 4 p.m.

Caller: Diane Christensen

Name of person answering the phone: B

Offered name: X Had to ask name: _____

Notes:

B was the same receptionist who answered questions during two previous calls. The HSAG caller asked her to assume that the caller was a member living in Aurora. B said that if it was not an emergency she would ask if the caller was comfortable with going to the CMHC. If not she would transfer the call to another BHI staff member to select a contracted provider. The HSAG caller indicated that the CMHC was fine and B gave her the number for the Aurora Mental Health Center.

Person assigned to help or transferred to: Switchboard operator, then Z

Offered name: Switchboard operator—no, Z—yes Had to ask name: Switchboard operator—yes

Notes:

The first individual who answered the phone did not offer her name. When the HSAG caller asked, she would not give her name, stating only that she was the switchboard operator. The HSAG caller then asked what she would do with the call if the caller was a Medicaid member seeking services. The operator stated that she would transfer the call to the access team, which she did.

Does this BHO (or the CMHC) provide services in an urban, rural, or frontier area?

Urban

Specific questions for the fourth call:

1. *What is the procedure if a Medicaid member calls and urgently requests medication? The member may have been on medication from a private provider or might be from another state, but is new to Medicaid eligibility and has not yet received services from the BHO.*

   Z explained that the first step would be to make sure that it wasn't an emergency. If it wasn't an emergency Z would do a brief phone intake, then schedule the caller for an orientation. The orientation could take place quickly—even the same day—if the member called in the morning, but in no longer than six to seven days (which Z said is rare). At orientation the member would be assigned a therapist and given an appointment date and time. The therapist would do an evaluation, determine the need for medications, then set the member up with an appointment with a physician.

2. *How would a member who was recently released from a psychiatric hospital (and who has not previously received psychiatric services from this BHO) obtain outpatient services?*

   The member will need medication within seven days.

   Z explained that the first step would be to make sure that it wasn't an emergency. If it wasn't Z would do a brief phone intake, then schedule the caller for an orientation. The orientation could take place quickly—even the same day—if the member called in the morning, but in no longer than six to seven days (which Z said is rare). At orientation the member would be assigned a therapist and given an appointment date and time. The therapist would do an evaluation, determine the need for medications, then set the member up with an appointment with a physician.

   Can outpatient therapy services and provision of the medication/prescription be handled with the same initial appointment?

   Z explained that if it isn't an emergency, the process is to conduct the telephone intake, schedule the member for the orientation, then schedule the member with the therapist, who will assess the member and schedule an appointment with a physician, if needed.

Appendix C. Record Review Worksheet
for Behavioral HealthCare, Inc.

The completed record review worksheet follows this cover page.

Colorado Department of Health Care Policy & Financing
Behavioral Health Organization (BHO)
Record Review Worksheet

The goal of this record review is to identify and describe specific documentation that provides evidence of ongoing communication between the psychiatrist or nurse prescriber and the parents, therapist/care coordinator/case manager, and/or the primary care physician (PCP) regarding a child who has received services through the BHO.

Documentation to be reviewed: Therapist and physician/prescriber progress notes, specific forms used for documentation of service planning meetings, or other pertinent documentation regularly used by the BHO to document ongoing communication with family members or the PCP.

Member ID: Sample 1	Encounter Reference Date: June 4, 2007
Reviewer Name: Barbara McConnell	Review Date: March 20, 2008

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
5/18/07	Case Management Note	MS	School Personnel	School	Telephone Call	No

Content of Documentation (Brief Description):

This note indicated that the school called to report symptoms of physical illness.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
5/21/07	Case Management Note	MS	Teacher	Teacher	Telephone Call	No

Content of Documentation (Brief Description):

This note documented a telephone call with the teacher, who provided an update regarding the child's behavior in the classroom and with peers.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
5/29/07	Case Management Note	MS	Arapahoe County Department of Social Services Worker	Case Manager	Telephone Call	No

Content of Documentation (Brief Description):

This note documented a conversation regarding physical illness and progression of therapy.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
6/4/07	Case Management Note	LPN	Mother	Mother	Telephone Call	Yes

Content of Documentation (Brief Description):

This note documented that the mother called to say that the family was going out of town and the mother requested extra medication.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
6/4/07	Progress Note	MD	Mother	N/A	Medication Management	Yes

Content of Documentation (Brief Description):

This note documented the medication management encounter referenced for the sample. This note indicated that the therapist and the care coordinator attended the session with the child and the child's mother. The note indicated that they discussed anger outbursts at school and at home, the family structure, social services involvement, symptoms, and a therapy plan.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
6/27/07	General Note	MA	Family	Therapist	Telephone Call	No

Content of Documentation (Brief Description):

This note documented that the therapist left a voice mail message with the family requesting that they call back.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
7/5/07	Case Management Note	MA	Mother	Unknown	Telephone Call	Yes

Content of Documentation (Brief Description):

This note documented a discussion with the mother about the child's response to new medication and a plan for the "home team" to be involved.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
7/12/07	Case Management Note	MA	Father	Unknown	Telephone Call	No

Content of Documentation (Brief Description):

This note documented a discussion with the father about how the child was doing, behavioral outbursts, and the father wanting to be kept in the loop.

Member ID: Sample 2	Encounter Reference Date: June 6, 2007
Reviewer Name: Barbara McConnell	Review Date: March 20, 2008

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
5/9/07	Chart Note	LCSW	MD	N/A	Medication Management	Yes

Content of Documentation (Brief Description):

This note documented that the therapist "sat in on the appointment with Dr. B."

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
5/9/07	Psychiatric Note	MD	Aunt	N/A	Medication Management	Yes

Content of Documentation (Brief Description):

This note documented that the doctor discussed with the child's aunt the child's living environment, symptoms, and lab results and that the child was not going to school.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
6/5/07	Progress Note	LCSW	Aunt	N/A	Therapy	No

Content of Documentation (Brief Description):

This progress note documented discussions about behavior, feelings, plans for coping, and previous discussions with the probation officer.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
6/6/07	Psychiatric Note	MD	Aunt	N/A	Medication Management	Yes

Content of Documentation (Brief Description):

This note documented the medication management encounter referenced for the sample. The note documented a discussion regarding the child's symptoms and mood and noted that the child was doing well at home and at school.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
6/19/07	Progress Note	LCSW	Aunt	N/A	Therapy	No

Content of Documentation (Brief Description):

This note documented a discussion regarding behaviors and strategies at home for handling probation status.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
7/10/07	Progress Note	LCSW	Aunt	N/A	Therapy	No

Content of Documentation (Brief Description):

This note documented a discussion about the child's mother, her plans for job training, coping strategies, and the child's frustration tolerance.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
7/11/07	Psychiatric Note	MD	Aunt	N/A	Medication Management	Yes

Content of Documentation (Brief Description):

This note documented a discussion regarding symptoms, behavior at home, and medication compliance.

Member ID: Sample 3	Encounter Reference Date: January 24, 2007
Reviewer Name: Barbara McConnell	Review Date: March 20, 2008

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
12/15/06	Contact Note	PsyD	Mother	Mother	Telephone Call	No

Content of Documentation (Brief Description):

This note indicated that the mother called to cancel the therapy session. They also discussed plans for changing the treatment modality and seeking therapy outside of BHI.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
12/26/06	Therapy Summary	LCSW	Father	Father	Telephone Call	Yes

Content of Documentation (Brief Description):

This note stated that the father was worried about how to pick up medications. He had scheduling problems.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
1/24/07	Medication Progress Note	MD	Mother	N/A	Medication Management	Yes

Content of Documentation (Brief Description):

This note documented the medication management encounter referenced for the sample. The note indicated that they discussed symptoms, medications, the treatment plan, the diagnosis, changing therapists, and referral suggestions.

Member ID: Sample 4	Encounter Reference Date: January 23, 2007
Reviewer Name: Barbara McConnell	Review Date: March 20, 2008

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
1/23/07	Letter	MD	PCP	MD (at CMHC)	Letter	Yes

Content of Documentation (Brief Description):

This letter informed the PCP of the child's diagnoses, symptoms, medications, response to medications, and lab results.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
1/23/07	Medication Progress Note	MD	Mother	N/A	Medication Management	Yes

Content of Documentation (Brief Description):

This note documented the medication management encounter referenced for the sample. The note documented a discussion about the child's response to medications, mood, symptoms, lab results, and the treatment plan.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
2/7/07	Therapy Summary	LCSW	Mother	Mother	Telephone Call	Yes

Content of Documentation (Brief Description):

This note indicated that the mother was transferring the child's therapy to Children's Hospital.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
3/1/07	Letter	MD	Court	MD	Letter	Yes

Content of Documentation (Brief Description):

This letter to the court addressed the importance of the child receiving the prescribed medications.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
3/1/07	Therapy Summary	LCSW	Mother	N/A	Telephone Call	Yes

Content of Documentation (Brief Description):

This note documented a discussion regarding the father's visitation and filing a petition with the court, as the father was not administering medications.

Member ID: Sample 5	Encounter Reference Date: April 20, 2007
Reviewer Name: Barbara McConnell	Review Date: March 20, 2008

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
3/27/07	Therapy Summary	LCSW	Foster Mother	LCSW	Telephone Call	No

Content of Documentation (Brief Description):

This summary indicated that the LCSW followed up with the foster mother because the foster mother had called the after-hours line the previous evening. The after-hours staff had recommended that the foster mother take the child to the emergency room for suicidal ideations.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
3/30/07	Therapy Summary	LCSW	Foster Mother	N/A	Therapy	Yes

Content of Documentation (Brief Description):

This summary indicated that a risk assessment was completed. Discussion included symptoms, a treatment plan, and plans to have a medication evaluation.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
4/6/07	Therapy Summary	MD	N/A	N/A	Psychiatric Evaluation	Yes

Content of Documentation (Brief Description):

This note documented a psychiatric evaluation. The note did not indicate if the child was accompanied by anyone.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
4/10/07	Therapy Summary	LCSW	Caseworker	LCSW	Telephone Call	No

Content of Documentation (Brief Description):

This note documented a discussion regarding placement plans.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
4/20/07	Medication Progress Note	MD	N/A	N/A	Medication Management	Yes

Content of Documentation (Brief Description):

This note documented the medication management encounter referenced for the sample. The note did not indicate whether the 16-year-old was accompanied by anyone. The note documented discussions about foster placement, school, mood, and symptoms.

Member ID: Sample 6	Encounter Reference Date: May 23, 2007
Reviewer Name: Barbara McConnell	Review Date: March 20, 2008

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
5/9/07	Case Management Note	BA	Mother	Case Manager	Telephone Call	No

Content of Documentation (Brief Description):

This note indicated that the call was to encourage the mother to schedule an appointment for the child.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
5/23/07	Case Management Note	BA	Mother	N/A	Case Management Session	No

Content of Documentation (Brief Description):

The note documented that the case manager reminded the mother of a missed appointment and that the mother declined to meet with the case manager.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
5/23/07	General Note	MD	Mother	N/A	Medication Management	Yes

Content of Documentation (Brief Description):

This note documented the medication management encounter referenced for the sample. This note documented a discussion about symptoms, therapy, medications, side effects of the medications, mood, and a school therapy plan.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
5/31/07	Case Management	BA	Mother	Case Manager	Telephone Call	No

Content of Documentation (Brief Description):

The note indicated that the case manager called the mother regarding a missed appointment. The case manager was concerned that therapy should include more than medication and asked the mother to consider therapy at the school.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
6/4/07	Case Management Note	BA	Mother	Case Manager	Telephone Call	No

Content of Documentation (Brief Description):

This note indicated that the case manager discussed with the mother the option of having the child's therapy on-site at school.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
6/6/07	Case Management Note	BA	Mother	N/A	Case Management	No

Content of Documentation (Brief Description):

This note documented a discussion about an updated treatment plan, a plan to transfer from case management to individual therapy, and plans for school therapy.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
6/8/07	Case Management Note	MA	Mother	MA	Telephone Call	No

Content of Documentation (Brief Description):

This note documented a discussion regarding plans for therapy, symptoms, and summer plans.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
6/20/07	Progress Note	MA	Mother	N/A	Therapy	No

Content of Documentation (Brief Description):

This note documented a discussion about the child's behavior at home and at school, symptoms, treatment history, communication, and goals.

Member ID: Sample 7	Encounter Reference Date: May 16, 2007
Reviewer Name: Barbara McConnell	Review Date: March 20, 2008

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
5/9/07	Progress Note	LPC	Mother	Therapist	Telephone Call	Yes

Content of Documentation (Brief Description):

This note documented an outreach call to the mother to discuss the treatment plan and future services, and to encourage the mother to obtain a medication evaluation for her child.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
5/16/07	Psychiatric Note	MD	Mother	N/A	Medication Management	Yes

Content of Documentation (Brief Description):

This note documented the medication management encounter referenced for the sample. The note documented that there was a discussion regarding compliance with medications, symptoms, progress, school, and the child not attending therapy.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
5/17/07	Chart Note	LPC	Mother	LPC	Telephone Call	No

Content of Documentation (Brief Description):

This note documented an outreach attempt by the licensed professional counselor (LPC). The LPC left a voice mail message for the mother.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
5/22/07	Chart Note	LPC	Mother	LPC	Telephone Call	No

Content of Documentation (Brief Description):

This note documented an outreach attempt by the LPC. The LPC left a voice mail message for the mother.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
5/29/07	Chart Note	LPC	Mother	LPC	Telephone Call	No

Content of Documentation (Brief Description):

This note documented that the LPC contacted the mother and scheduled an appointment to discuss the child's individual therapy verses family therapy.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
5/30/07	Chart Note	LPC	Mother	Mother	Telephone Call	No

Content of Documentation (Brief Description):

This note documented that the mother called and cancelled the appointment. The therapist returned the mother's call, but was not able to speak with her.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
6/12/07	Progress Note	LPC	Mother	N/A	Therapy	No

Content of Documentation (Brief Description):

This note documented a discussion regarding the relationship and communication between the mother and the child and the child's behavior.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
6/26/07	Chart Note	LPC	Mother	LPC	Telephone Call	No

Content of Documentation (Brief Description):

This note indicated that the therapist called the mother to inquire why the child missed a therapy appointment. The mother rescheduled the appointment.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
6/27/07	Chart Note	LPC	Mother	Mother	Telephone Call	No

Content of Documentation (Brief Description):

This note indicated that the mother left a message asking to cancel an appointment. The therapist returned the mother's call and rescheduled the appointment. The mother reported that things were going well.

Member ID: Sample 9	Encounter Reference Date: June 7, 2007
Reviewer Name: Barbara McConnell	Review Date: March 20, 2008

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
5/2/07	Progress Note	MD	Mother	N/A	Medication Management	Yes

Content of Documentation (Brief Description):

This note documented a discussion regarding symptoms, compliance with medications, response to medications, and school.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
7/11/07	Progress Note	MD	Therapist	N/A	Therapy	Yes

Content of Documentation (Brief Description):

This note documented a discussion regarding the child's medications and the treatment plan.

Member ID: Sample 10	Encounter Reference Date: June 12, 2007
Reviewer Name: Barbara McConnell	Review Date: March 20, 2008

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
5/16/07	Progress Note	PhD	Mother	PhD	Telephone Call	No

Content of Documentation (Brief Description):

This note indicated that the PhD spoke with the mother regarding plans for summer therapy.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
5/29/07	Progress Note	PhD	Mother	PhD	Telephone Call	No

Content of Documentation (Brief Description):

This note indicated that the PhD left a message for the mother asking to discuss therapy plans for the summer.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
6/6/07	Progress Note	PhD	Mother	PhD	Telephone Call	No

Content of Documentation (Brief Description):

This note indicated that the PhD left a message for the mother asking to discuss therapy plans for the summer.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
6/25/07	Medication Progress Note	MD	Mother	N/A	Medication Manage-ment	Yes

Content of Documentation (Brief Description):

This note documented a discussion about therapy, medications, the child's relationship with the mother, behavior at school and at home, progress in therapy, and the treatment plan.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
7/10/07	Progress Note	PhD	Mother	PhD	Telephone Call	Yes

Content of Documentation (Brief Description):

This note documented a discussion about transitioning the child to another therapist.

Member ID: Sample 11	Encounter Reference Date: April 25, 2007
Reviewer Name: Barbara McConnell	Review Date: March 20, 2008

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
3/12/07	Chart Note	MSW	Caretakers et al and mother	N/A	Staffing	Yes

Content of Documentation (Brief Description):

This note documented a staffing with the therapist, caretakers, teacher, school liaison, and mother. The group discussed the child's progress, behavior, medications, home environment, and that the child was doing well in school.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
3/12/07	Progress Note	MSW	Mother	N/A	Therapy	No

Content of Documentation (Brief Description):

This note documented a therapy session that included a discussion about strategies for handling behavior and the treatment plan.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
3/21/07	Psychiatric Note	MD	Mother	N/A	Medication Management	Yes

Content of Documentation (Brief Description):

This note documented a medication management visit during which they discussed medications, the child's response to the medications, symptoms, and school.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
3/22/07	Chart Note	MSW	Caretaker	Caretaker	Telephone Call	Yes

Content of Documentation (Brief Description):

This note documented a discussion about the child's (planned) return to his mother.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
4/10/07	Chart Note	MSW	School Liaison	N/A	Annual Review	No

Content of Documentation (Brief Description):

This note documented an annual review with the school liaison and Prince Street Academy staff. The note indicated that the mother was unable to attend due to a scheduling mix-up. The note documented a discussion about educational goals, therapy goals, progress made, and the child's home situation.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
4/12/07	Progress Note	MSW	Mother	N/A	Family Therapy	No

Content of Documentation (Brief Description):

The note documented a discussion about the home situation, transportation issues, progress, the individual education plan, and the child's adjustment to changes in the home situation.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
4/18/07	Progress Note	MSW	Mother	N/A	Family Therapy	No

Content of Documentation (Brief Description):

This note documented a discussion about behavior, transportation issues, and the home situation.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
4/20/07	Chart Note	MSW	School Liaison	MSW	Telephone Call	No

Content of Documentation (Brief Description):

This note documented a discussion about transportation issues, the mother's new job, and the mother's housing plans.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
4/24/07	Progress Note	MSW	Mother	N/A	Family Therapy	No

Content of Documentation (Brief Description):

This note documented a discussion about the mother's new job, communication between the mother and child, the child's progress, transition plans for school, and housing plans.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
4/25/07	Chart Note	MSW	Teacher	Teacher	In person	No

Content of Documentation (Brief Description):

This note documented a discussion about the child's symptoms at school and strategies for handling them.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
4/25/07	Psychiatric Note	MD	Mother	N/A	Medication Management	Yes

Content of Documentation (Brief Description):

This note documented the medication management encounter referenced for the sample. The note documented a discussion about behavior, grades, home status, eating, sleeping, medications, and response to the medications.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
5/2/07	Chart Note	RN	Mother	Mother	Telephone Call	Yes

Content of Documentation (Brief Description):

This note documented that the mother called to ask for a refill of lost medications.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
5/9/07	Progress Note	MSW	Mother	N/A	Therapy	Yes

Content of Documentation (Brief Description):

This note documented discussions about transportation, the child not taking evening medications, symptoms, and side effects of the medications.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
5/15/07	Chart Note	MSW	Mother	Mother	Telephone Call	Yes

Content of Documentation (Brief Description):

This note documented that the mother called to ask about the child not taking medications in the evening, side effects of the medications, and transportation.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
5/18/07	Chart Note	MSW	Teacher	MSW	In Person	No

Content of Documentation (Brief Description):

This note documented a discussion between team members about behavioral issues at the school day program and plans for a behavioral contract.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
5/25/07	Chart Note	MSW	Mother	MSW	Telephone Call	No

Content of Documentation (Brief Description):

This note documented a discussion about transition plans for leaving school and summer plans.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
5/31/07	Progress Note	MSW	Mother	N/A	Therapy	Yes

Content of Documentation (Brief Description):

This note documented a discussion about summer transition plans, plans to continue with therapy for medication management, the mother's new job, and adjustment to family changes.

Appendix D. Oversight and Monitoring of Providers Worksheet for Behavioral HealthCare, Inc.

The oversight and monitoring of providers worksheet follows this cover page.

Colorado Department of Health Care Policy & Financing
Behavioral Health Organization (BHO)
Oversight and Monitoring of Providers Worksheet

The following questions were used to prompt discussion during the on-site portion of the review:

Does the BHO use member satisfaction data to improve the quality of services provided by community mental health centers (CMHCs) and the independent provider network (IPN)? If so, how?

Is member satisfaction information used by the BHO's CMHCs to identify staff training needs?

How does the BHO know whether mental health center staff receives appropriate: (a) supervision, (b) training, and (c) professional development/continuing education?

How does the BHO know that its CMHC providers have a culturally appropriate work force?

How does the BHO know that its provider network (CMHC and IPN) is adequately prepared (in training, skills, and competence) to work with the BHO's members (in terms of member diagnosis, age, etc.)?

Review of the CMHC's policies/procedures for training content to determine if CMHC policies are compliant with BHO policies (intake, grievance system, provider-member communication, advance directives, second opinions, etc.)?

Review of agendas or orientation curriculum and attendance records of the CMHC for compliance with BHO policies?

Review/audit of credentialing records to determine compliance with BHO policies?

Review of policies/procedures for clinical supervision?

Review of forms/tools used for provider supervision?

Provider profiling (reports or data)?

Review of data provided by the CMHC?

Data kept regarding cultural or linguistic competencies?

Review of percentage of Spanish-speaking members at each CMHC?

Utilization data per individual provider?

Trending grievance data?

Other?

How does the BHO ensure that CMHC providers are aware of, and in compliance with, the BHO's practice guidelines and grievance system and of any relevant policies and contract requirements (training completed, skills/certifications, completion of supervisory practices [performance reviews, etc.])?

How does the BHO ensure that the IPN is aware of, and in compliance with, the BHO's practice guidelines, grievance system, policies, and contract requirements?

How has the BHO evaluated the services provided by the CMHC for quality, appropriateness, and patient outcomes (including member satisfaction)?

Quality initiatives?

Chart reviews?

Other?

How has the BHO evaluated the services provided by independent contractors for quality, appropriateness, and patient outcomes (including member satisfaction)?

Has the BHO used complaint/grievance data in the category of professional conduct and competence to improve services provided? (If yes, how? If no, why?)

The FY 06–07 corrective action plan with FY 07–08 findings and results follows this cover page.

Table E-1—FY 06–07 Corrective Action Plan *for* BHI				
Evaluation Elements	**Required Actions**	**Planned Intervention**	**Due Date**	**# of Attachment With Evidence of Compliance**
Standard I: Delegation				
7. Termination of Subcontracts The Contractor notifies the Department in writing of its decision to terminate any existing subcontract applicable to the performance of services under the Contract.	BHI must have a process for notifying the Department in writing of its decision to terminate any existing delegation subcontract applicable to the performance of services under the BHO contract with the State. The process must include a notice to the Department 60 calendar days prior to the termination unless termination of the subcontract is based on quality or performance issues.	BHI will amend the subcontractual Relationships and Delegation policy to address the process for notifying the Department in writing of its decision to terminate any existing delegation subcontract and will include the required notification timeline. **September 2007 HCPF/HSAG comments:** Plan accepted.	July 1, 2007	◆ Subcontractual Relationships and Delegation pp07.doc
Standard I: Delegation—FY 07–08 Document Review				
7. Termination of Subcontracts Document(s) Reviewed: ◆ Subcontractual Relationships and Delegation policy The policy included the process to provide the Department notice 60 calendar days before the effective date of a terminated delegation subcontract unless such termination is due to quality or performance issues. This required action has been completed.				

Table E-1—FY 06–07 Corrective Action Plan *for* BHI				
Evaluation Elements	**Required Actions**	**Planned Intervention**	**Due Date**	**# of Attachment With Evidence of Compliance**
Standard II: Provider Issues				
4. Content of Agreement The written agreement: A. Specifies the activities of the provider.	BHI must update or amend agreements with its CMHCs to specify current activities subcontracted to the provider.	BHI will update its contracts with the CMHCs to specify current activities subcontracted to those providers. **September 2007 HCPF/HSAG comments:** According to HSAG's findings, the outdated portions of the mental health center agreements involved provider network management activities and specific services to be provided by the mental health centers. These issues must be included in the updated contracts.	July 1, 2007	◆ CMHC Contracts o ADMHN o REACH o Aurora ◆ Deliverables Calendar
Standard II: Provider Issues—FY 07–08 Document Review				
4.A. Content of Agreement—The written agreement specifies the activities of the provider. Document(s) Reviewed: ◆ Facility Service Agreement between BHI and Community Reach Center, July 1, 2007 ◆ Facility Service Agreement between BHI and Arapahoe Douglas Mental Health Network, July 1, 2007 ◆ Facility Service Agreement Between BHI and Aurora Mental Health, July 1, 2007 The Facility Service Agreements specified the activities to be performed by the CMHCs, including service provision. The BHI executive director clarified that the CMHCs employ providers rather than contracting with independent contractors on behalf of BHI; therefore, provider network management is not applicable to these agreements. This required action has been completed.				

Table E-1—FY 06–07 Corrective Action Plan *for* BHI				
Evaluation Elements	**Required Actions**	**Planned Intervention**	**Due Date**	**# of Attachment With Evidence of Compliance**
B. Specifies the reporting responsibilities of the provider.	BHI must update or amend agreements with its CMHCs to specify current reporting activities required of the CMHCs.	BHI will update its contracts with the CMHCs to specify current reporting activities required of the CMHCs. **September 2007 HCPF/HSAG comments:** According to HSAG's findings, the outdated reporting responsibilities were specific to data reporting related to new admits to the mental health centers. This issue must be included in the updated contracts.	July 1, 2007	◆ CMHC Contracts o ADMHN o REACH o Aurora ◆ Deliverables Calendar

Standard II: Provider Issues—FY 07–08 Document Review

4.B. Content of Agreement—The written agreement specifies the reporting responsibilities of the provider.

Document(s) Reviewed:

- Facility Service Agreement between BHI and Community Reach Center, July 1, 2007
- Facility Service Agreement between BHI and the Arapahoe Douglas Mental Health Network, July 1, 2007
- Facility Service Agreement Between BHI and the Aurora Mental Health, July 1, 2007

The Facility Service Agreements specified the reporting responsibilities of the CMHCs and referred to Attachment F, which provided further detail regarding specific reports and due dates. This required action has been completed.

Table E-1—FY 06–07 Corrective Action Plan *for* BHI				
Evaluation Elements	**Required Actions**	**Planned Intervention**	**Due Date**	**# of Attachment With Evidence of Compliance**
13. Record Review: Documentation of Services	BHI must ensure that providers submit accurate encounter codes that represent the services provided.	BHI has the following processes under way or planned for completion by September 30, 2007, to further ensure accuracy of encounter codes used to describe services rendered: 1) Review coding crosswalk with each CMHC. 2) Audit all FY 07 first and second quarter encounters to analyze the CPT codes/local codes (and descriptions) crosswalk for accuracy by CMHC. 3) Encounter validation audit: Review a sample of 411 encounters. Codes and descriptions of services in the encounters will be compared to the corresponding treatment record documentation for accuracy. **September 2007 HCPF/HSAG comments:** Evidence of compliance must include any corrective actions taken.	September 30, 2007	◆ Notes of Coding Crosswalk review ◆ Audit Reports

Standard II: Provider Issues—FY 07–08 Document Review

13. Record Review: Documentation of Services

Document(s) Reviewed:

- Review of a statistically valid sample of encounter claims report
- Coding crosswalk review

BHI's report of its review of a statistically valid sample of encounter claims demonstrated that BHI monitored for accuracy and completeness of encounter claims as well as the presence of documentation in the medical record that coincided with the encounter submitted. BHI's report of its review of the coding crosswalk indicated that BHI reviewed whether its CMHCs had translated their internal encounter codes to the correct Department-approved encounter codes. Minutes of the Provider Advisory Council meetings demonstrated that BHI requested and received corrective actions plans from each CMHC and that BHI followed up to correct any issues discovered during the audit of a statistically valid sample of encounter records. This required action has been completed.

Table E-1—FY 06–07 Corrective Action Plan *for* BHI				
Evaluation Elements	**Required Actions**	**Planned Intervention**	**Due Date**	**# of Attachment With Evidence of Compliance**
Standard V: Access and Availability				
3. Access to Services B. The contractor meets standards for timeliness of service including the following: 3. Routine services are available within seven calendar days.	BHI must revise the Access and Availability policy to clarify that routine services are available within seven days.	4) Change the language in the Access and Availability policy to state that BHI adheres to the following standards established by the Department: ◆ Routine appointments available in seven days 100 percent of the time ◆ Urgent appointments available in 24 hours 100 percent of the time ◆ Emergency face-to-face evaluations within 60 minutes 100 percent of the time September 2007 HCPF/HSAG comments: Plan accepted.	Done	◆ CAP Evidence/ Access and Availability pp07.doc
Standard V: Access and Availability—FY 07–08 Document Review				
3.B.3 Access to Services—Routine services are available within seven calendar days. Document(s) Reviewed: ◆ Access and Availability policy The policy stated that routine services are available within seven days. This required action has been completed.				

Table E-1—FY 06–07 Corrective Action Plan *for* BHI				
Evaluation Elements	**Required Actions**	**Planned Intervention**	**Due Date**	**# of Attachment With Evidence of Compliance**
Standard VI: Utilization Management				
7. Record Review: Denials	BHI must ensure that a Notice of Action is sent in a timely manner to the consumer and provider following a UR denial decision.	BHI will: 1) Implement its mandatory, electronic, desk-based notice of action/appeal training for all programmatic CMHC staff, including support staff. 2) Revise the delegation agreement to reflect the above requirement for mandatory training and reporting of training done by CMHCs. 3) Report and track training in the quarterly OCFA Report Card. **September 2007 HCPF/HSAG comments:** Documents provided as evidence must include a training agenda or outline if the training is BHO-developed, or the BHO approval of each CMHC's training outline if it was developed at the CMHC level. Evidence should also include the delegation agreement and the first OCFA Report Card that reports training information.	July 1, 2007	◆ Action Training Outline ◆ Delegation Agreements o ADMHN o REACH o Aurora ◆ UM Report Card

Table E-1—FY 06–07 Corrective Action Plan *for* BHI				
Evaluation Elements	**Required Actions**	**Planned Intervention**	**Due Date**	**# of Attachment With Evidence of Compliance**
Standard VI: Utilization Management—FY 07–08 Document Review				
7. Record Review: Denials. Document(s) Reviewed: ◆ Action training outline ◆ PowerPoint presentation—Actions ◆ Delegation agreements for ADMHN, Reach, and Aurora Mental Health Center ◆ UM Report Card The training presentation included the time frames for sending notices of action. The revised delegation agreement included the requirement for BHI's network CMHCs to provide the action training presentation to staff and providers. BHI's FY 07–08 second quarter Utilization Management Program Evaluation demonstrated that BHI tracked the timeliness of notices of actions sent by the CMHCs. Minutes of the Provider Advisory Council meetings demonstrated that BHI informed the CMHCs of the results of the encounter audit and worked with them through corrective action plans, as needed, to resolve any issues. This required action has been completed.				

Table E-1—FY 06–07 Corrective Action Plan *for* BHI				
Evaluation Elements	**Required Actions**	**Planned Intervention**	**Due Date**	**# of Attachment With Evidence of Compliance**
Standard IX: Grievances, Appeals, and Fair Hearings				
1. Grievance and Appeal Records The Contractor maintains a record of grievances and appeals.	BHI must ensure that all complaints and expressions of dissatisfaction are considered grievances; are processed to ensure written acknowledgment, timely resolution, and reasonable assistance to the consumer; and are included in the analysis and reporting of grievances.	1) BHI will notify all consumer representatives that, pending final policy language from the Department, BHI will consider all statements of dissatisfaction as grievances until further notice and process them per established grievance procedures. Grievances are monitored quarterly through the OCFA Report Card **September 2007 HCPF/HSAG comments:** Plan accepted.	May 10, 2007	◆ E-mail notification to Consumer Reps. ◆ OCFA Report Card
Standard IX: Grievances, Appeals, and Fair Hearings—FY 07–08 Document Review				
1. Grievance and Appeal Records. Document(s) Reviewed: ◆ Copy of e-mail notification to OCFA representatives ◆ OCFA Report Card—Second quarter, FY 07–08 ◆ BHI action training PowerPoint presentation Copies of e-mail communication and the PowerPoint presentation demonstrated that BHI informed the CMHCs of the requirement to consider all expressions of dissatisfaction as grievances and the requirements for timely processing and acknowledgment of grievances. The FY 07–08 second quarter OCFA Report Card indicated that BHI tracked the timeliness of grievance processing and the content of grievances to ensure that all expressions of dissatisfaction were processed according to State requirements. This required action has been completed.				

Table E-1—FY 06–07 Corrective Action Plan *for* BHI				
Evaluation Elements	**Required Actions**	**Planned Intervention**	**Due Date**	**# of Attachment With Evidence of Compliance**
7. Record Review: Grievance	BHI must ensure that it provides timely acknowledgment of all grievances.	BHI will continue doing individual training with its consumer representatives regarding timely acknowledgment of all grievances and will do quarterly audits for timeliness and follow-up training. **September 2007 HCPF/HSAG comments:** Plan accepted.		◆ Training materials ◆ Audit results in the OCFA Report Card.
Standard IX: Grievances, Appeals, and Fair Hearings—FY 07–08 Document Review				
7. Record Review: Grievances. Document(s) Reviewed: ◆ OCFA Report Card—Second quarter, FY 07–08 The FY 07–08 second quarter OCFA Report Card demonstrated that BHI performed an audit of grievances processed to ensure timely acknowledgment of grievances. This required action has been completed.				

Table E-1—FY 06–07 Corrective Action Plan *for* BHI				
Evaluation Elements	**Required Actions**	**Planned Intervention**	**Due Date**	**# of Attachment With Evidence of Compliance**
Standard X: Credentialing				
3. Content of Policies and Procedures The written policies and procedures specify: I. The process to ensure that practitioners are notified of the credentialing decision within 60 calendar days of the committee's decision.	BHI must revise the Credentialing and Recredentialing policy to describe the process to ensure that practitioners are notified of the credentialing decision within 60 calendar days of the committee's decision.	BHI will revise the Credentialing and Recredentialing policy to describe the process to ensure that practitioners are notified of the credentialing decision within 60 calendar days of the committee's decision. **September 2007 HCPF/HSAG comments:** Plan accepted.	July 1, 2007	◆ Credentialing P&P
Standard X: Credentialing—FY 07–08 Document Review				
3.I. Content of Policies and Procedures specifies the process to ensure practitioners are notified of the credentialing decision within 60 calendar days. Document(s) Reviewed: ◆ Credentialing and Recredentialing policy The policy stated that providers are informed of a denial of acceptance to the network within seven days of the committee's decision. This required action has been completed.				

Table E-1—FY 06–07 Corrective Action Plan *for* BHI				
Evaluation Elements	**Required Actions**	**Planned Intervention**	**Due Date**	**# of Attachment With Evidence of Compliance**
9. Policy Content—Organizational Provider Credentialing The Contractor's written policies and procedures include: C. If there is no accreditation status, the Contractor conducts an on-site quality assessment.	BHI must revise its Credentialing and Recredentialing policy to clarify BHI's processes for performing on-site quality reviews for nonaccredited organizational providers and processes for substituting a regulatory body review that meets the requirements. If BHI chooses to use a review by a regulatory body to meet this requirement, it must ensure that the criteria used during that review meets the standards in the BHI policy as required by NCQA.	BHI will revise the Credentialing and Recredentialing policy to clarify BHI's processes for performing on-site quality reviews for nonaccredited organizational providers and processes for substituting a regulatory body review that meets the requirements. If BHI chooses to use a review by a regulatory body to meet this requirement, it must ensure that the criteria used during that review meets the standards in the BHI policy as required by the National Committee for Quality Assurance (NCQA). **September 2007 HCPF/HSAG comments:** Plan accepted.	July 1, 2007	◆ Credentialing P&P

Standard X: Credentialing—FY 07–08 Document Review

9.C. Policy Content—Organizational Provider Credentialing—if there is no accreditation status, the Contractor conducts an on-site quality assessment.

Document(s) Reviewed:

- Credentialing and Recredentialing policy

The Credentialing and Recredentialing policy described the process and required content for an on-site visit of organizational providers. The policy included circumstances under which a regulatory audit could and could not substitute for BHI's site visit. This required action has been completed.

Appendix F. Site Review Participants for Behavioral HealthCare, Inc.

Table F–1 lists the participants in the FY 07–08 site review of **BHI**.

Table F–1—HSAG Reviewers and BHO Participants		
HSAG Review Team		**Title**
	Barbara McConnell, MBA, OTR	Project Director
	Diane Christensen, LPC, MC	Associate Director (telephone assessment calls)
	Hector Cariello, MPH-HCAHPS	Project Coordinator (conducted member interviews in Spanish)
	Rachel Henrichs	Project Coordinator (telephone assessment calls)
BHI Participants		**Title**
Mary Adams		Assistant Controller
Diane Cannizzaro, LCSW		Utilization Review Manager
Julie Holtz, MS		Chief Executive Officer
Susan James-Padilla, LCSW		Director of Utilization Management
Jennifer Koberstein		Director, Office of Consumer and Family Affairs
Samatha Kommana		Quality Improvement Director
Melissa Kulasekere		Program Evaluator/Disease Management Specialist
Christina Mitsch		Authorization Coordinator
Alicia Nix		Quality Improvement Support Coordinator
Rian G. Nowitzki		Chief Financial Officer/Controller
Joseph Pastor, MD		Medical Director
Heather Piernik		Acting Director of Quality Improvement, Utilization Management, at Community Reach Center
Joe Phillips		Data Analyst, Quality Improvement
Nik Savastinuk		Information Systems and Data Specialist
Teresa Summers		Director of Provider Relations
Department Observers		**Title**
Sue Carrizales		Behavioral Health Policy Specialist

Appendix G. Corrective Action Plan Process for FY 07–08 for Behavioral HealthCare, Inc.

BHI is required to submit to the Department a corrective action plan for all components scored as *In Partial Compliance* or *Not In Compliance*. The corrective action plan with supporting documents must be submitted within 30 days of receipt of the final report. For each element that requires correction, the plan should identify the planned interventions to achieve compliance with the requirement(s) and the timeline for completion.

Table G-1—Corrective Action Plan Process

Step 1	**Corrective action plans are submitted**
	Each BHO will submit a corrective action plan to the Department within 30 calendar days of receipt of the final EQR site review report via the file transfer protocol (FTP) site with an accompanying e-mail notification regarding the posting. For each of the components receiving a score of *In Partial Compliance* or *Not In Compliance*, the corrective action plan must address the planned intervention(s) to complete the required actions and the timeline(s) for the intervention(s).
Step 2	**Documents submitted with the corrective action plan**
	The BHOs should complete the required actions and submit documentation substantiating the completion of all required corrective actions.
Step 3	**Prior approval for timelines exceeding 30 days**
	If the BHO plans to complete the required action later than 30 days following the receipt of the final report, it must obtain prior approval from the Department in writing.
Step 4	**Progress reports may be required**
	For any planned interventions receiving an extended due date beyond 30 days following receipt of the final report, the Department may, based on the nature and seriousness of the noncompliance, require the BHO to submit regular reports to the Department detailing progress made on one or more open elements in the corrective action plan.
Step 5	**Documentation substantiating implementation of the plans is reviewed and approved**
	Following a review of the corrective action plan and supporting documentation, the Department will inform the BHO as to whether: (1) the documentation is sufficient to demonstrate completion of all required actions and compliance with the related contract requirements, or (2) the BHO must submit additional documentation. The Department will inform each BHO in writing when the documentation substantiating implementation of all Department-approved corrective actions is deemed sufficient to bring the BHO into full compliance with all the applicable contract requirements.

The template for the corrective action plan follows.

Table G-2—FY 07–08 Corrective Action Plan *for* BHI				
Site Review Component	**Required Actions**	**Planned Intervention**	**Date Completed**	**Documents Submitted as Evidence of Completion**
1. Access to Care				
2. Coordination of Care				
3. Oversight and Monitoring of Providers				
4. Member Information				
5. Review of Corrective Action Plans and Supporting Documentation				

Appendix H. Compliance Monitoring Review Activities for Behavioral HealthCare, Inc.

The following table describes the activities that were performed throughout the compliance monitoring process. The activities listed below are consistent with CMS' final protocol, *Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs)*, February 11, 2003.

Table H–1—Compliance Monitoring Review Activities Performed

For this step,	HSAG…
Activity 1:	**Planned for Monitoring Activities**
	Before the compliance monitoring review: ◆ HSAG and the Department held teleconferences to determine the content of the review. ◆ HSAG coordinated with the Department and the BHO to set the date of the review. ◆ HSAG coordinated with the Department to determine timelines for the Department's review and approval of the tool and report template and other review activities. ◆ HSAG staff provided an orientation at the B-QuIC meeting on November 27, 2007, for the BHO and the Department to preview the FY 07–08 compliance monitoring review process and to allow the BHOs to ask questions about the process. HSAG reviewed the processes related to the request for information, CMS' protocol for monitoring compliance, the components of the review, and the schedule of review activities. ◆ HSAG assigned staff to the review team. ◆ Prior to the review, HSAG representatives responded to questions from the BHO related to the process and federal managed care regulations to ensure that the BHO was prepared for the compliance monitoring review. HSAG maintained contact with the BHO as needed throughout the process and provided information to key management staff members about review activities. Through this telephone and/or e-mail contact, HSAG responded to the BHO's questions about the request for documentation for the desk audit and about the on-site review process.
Activity 2:	**Obtained Background Information From the Department**
	◆ HSAG used the FY 07–08 BHO contract to develop HSAG's monitoring tool, desk audit request, on-site agenda, and report template. ◆ HSAG submitted each of the above documents to the Department for its review and approval.
Activity 3:	**Reviewed Documents**
	◆ Sixty days prior to the scheduled date of the on-site portion of the review, HSAG notified the BHO in writing of the desk audit request and sent a documentation request form and an on-site agenda. The BHO had 30 days to provide all documentation for the desk audit. The desk audit request included instructions for organizing and preparing the documents related to the review of the five components. ◆ Documents requested included applicable policies and procedures, minutes of key BHO committee or other group meetings, reports, logs, and other documentation. ◆ The HSAG review team reviewed all documentation submitted prior to the on-site portion of the review and prepared a request for further documentation and an interview guide to use during the on-site portion of the review.

Table H–1—Compliance Monitoring Review Activities Performed	
For this step,	**HSAG…**
Activity 4:	**Conducted Interviews**
	Prior to the on-site portion of the review: ◆ HSAG conducted interviews of Medicaid members who had received or requested to receive services from the BHO. ◆ HSAG conducted telephone assessments of the BHO's access processes. During the on-site portion of the review: ◆ HSAG met with the BHO's key staff members to obtain a complete picture of the BHO's compliance with contract requirements, explore any issues not fully addressed in the documents, and increase overall understanding of the BHO's performance.
Activity 5:	**Collected Accessory Information**
	During the on-site portion of the review: ◆ HSAG collected additional documents. (HSAG reviewed certain documents on-site due to the nature of the document, i.e., the original source documents were of a confidential or proprietary nature.) ◆ HSAG requested and reviewed additional documents that HSAG needed during its desk audit. ◆ HSAG requested and reviewed additional documents that HSAG needed to review during the on-site interviews.
Activity 6:	**Analyzed and Compiled Findings**
	Following the on-site portion of the review: ◆ HSAG met with BHO staff to provide an overview of preliminary findings of the review. ◆ HSAG used the FY 07–08 Site Review Report to compile the findings and incorporate information from the pre-on-site and on-site review activities. ◆ HSAG analyzed the findings and assigned scores. ◆ HSAG determined opportunities for improvement based on the review findings. ◆ HSAG determined actions to be required of the BHO to achieve full compliance with managed care regulations.
Activity 7:	**Reported Results to the Department**
	◆ HSAG completed the FY 07–08 Site Review Report. ◆ HSAG submitted the site review report to the Department for review and comment. ◆ HSAG coordinated with the Department to incorporate the Department's comments. ◆ HSAG distributed a second draft report to the BHO for review and comment. ◆ HSAG coordinated with the Department to incorporate the BHO's comments and finalize the report. ◆ HSAG distributed the final report to the BHO and the Department.