Colorado Medicaid
Community Mental Health Services Program

FY 07–08 Site Review Report

for

Foothills Behavioral Health, LLC

May 2008

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

HSAG Health Services Advisory Group
1600 East Northern Avenue, Suite 100 • Phoenix, AZ 85020
Phone 602.264.6382 • Fax 602.241.0757

CONTENTS

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 **Foothills Behavioral Health, LLC** (**FBH**) 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 **FBH**'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 21 Medicaid members) who received or attempted to receive services between July 2006 and December 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 five adult Medicaid members, all of whom received services following the intake assessment, and three individuals whose children were Medicaid members who had received an intake assessment, with two 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, or its contracted provider.

[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 below. The call 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

FBH's Access to Services policy stated that all members requesting services are provided a comprehensive assessment of service needs during the initial routine intake appointment or emergency/urgent contact. The 2007 Routine Medical Record Audit conducted by **FBH** provided evidence that **FBH** monitored for the presence and completeness of the assessment and accompanying treatment plan through a peer review process. Parallel audit processes were used for both network community mental health centers (CMHCs) and the independent provider network (IPN). During each call the HSAG reviewer made to the **FBH** network CMHCs, the clinician 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.

The Access to Services policy included the requirements for timely access to services as specified by the Department. Orientation and annual training agendas and outlines for both network CMHCs provided evidence that CMHC providers and other appropriate CMHC staff members (front office, receptionist, and other staff members whose job descriptions required consumer contact) were informed of the timeliness standards for access to care. In addition, the provider manual included the timeliness standards. During the on-site interview, **FBH** IPN management staff reported that newly contracted providers received an on-site or telephone orientation on the provider manual.

Each of the Medicaid members (or the parent/guardian of a member) interviewed reported that he or she attended an intake assessment appointment. One parent reported having had some difficulty obtaining the assessment appointment. Based on the information reported by this individual, the reason for this difficulty could not be definitively determined. During the on-site interview, **FBH** management staff reported that they were familiar with the case and had worked with the provider to correct the situation. Four of the eight individuals interviewed reported satisfaction with the intake appointment. Three individuals gave a neutral response to the question about satisfaction

with the intake appointment and one individual expressed dissatisfaction with the intake appointment. Each individual attributed his or her satisfaction or dissatisfaction to the relationship with the therapist during the appointment. The parent that reported not having returned for subsequent therapy reported that she had an appointment scheduled, but did not keep the appointment. Two individuals reported having stopped therapy due to scheduling issues, with one stating that evening appointments would have helped.

During each assessment call to **FBH** staff made by the HSAG reviewer, the next appointment that could be offered to a member was within the timeliness standards, as appropriate to the situation (see Appendix B). **FBH** provided evidence that following a determination that timeliness results for access to services were at 98 percent and 99 percent compliance for two consecutive quarters in FY 06–07, **FBH** requested a corrective action plan from the appropriate CMHC. The quality assessment and performance improvement (QAPI) program quarterly reports provided evidence that the latest data analyzed during FY 07–08 showed 100 percent compliance with the timeliness standards.

The Access to Services policy stated that if Medicaid members do not request a specific provider, they are directed to call the nearest network CMHC, and if they prefer not to receive services from the CMHC, they are offered services from the IPN. Each of the staff members the HSAG reviewer spoke to during the assessment calls described the IPN and indicated that there were circumstances in which members could choose to receive services from a provider within the IPN.

Summary of Strengths and Opportunities for Improvement

FBH had processes in place to ensure that members are assessed during the intake appointment, and that the intake appointment is provided within the time frames required by the Medicaid contract with the Department. These processes included monitoring, the use of corrective action plans, training, and repeated monitoring to assess the efficacy of the training provided to staff and providers.

While the member handbook indicated that members may call **FBH** directly in order to receive services from an independent provider, the calls HSAG placed were consistently referred to the CMHCs, and specific attempts to reach the IPN managers were met with confusion on the part of **FBH** staff members. While the HSAG reviewer was not denied access to the IPN network, she found the process to be frustrating and not a consumer-friendly experience. **FBH** may want to assess this process further to determine how it can be improved.

During one of the telephone calls to assess **FBH**'s access processes, the HSAG reviewer presented a situation that was intended to appear urgent to the clinician. The clinician indicated that an appointment could not be scheduled with a family member unless the individual in need of services called directly. **FBH**'s Access to Care policy stated that a routine appointment could not be offered to individuals older than 14 years of age without permission from the individual in need of services. However, the issue of permission from the individual in need of services was not mentioned in the section of the policy that addressed access to urgent or emergent services. During the on-site interview, **FBH** management staff indicated that the policy was related to a resource management issue, and that often if the identified patient was not involved in making the appointment, the likelihood of a missed appointment would increase. **FBH** may want to clarify this policy and

evaluate how staff are interpreting and implementing this policy as it relates to appointments for services that are urgent or emergent in nature.

During one of the telephone calls to assess **FBH**'s access process, a staff member from Jefferson Center for Mental Health (JCMH) indicated that an appointment for a resident of a nursing home could not be made until a letter describing the member's diagnoses was submitted by the facility. During the on-site interview, management staff members from both **FBH**'s network CMHCs confirmed that this was the process used and were unable to clarify that services were not delayed as a result of this process. **FBH** management staff members indicated that this practice was not based on an **FBH** policy. Neither the Access to Mental Health Services in Nursing Homes and Assisted Living Facilities policy nor the Access to Care policy described this process.

Summary of Required Actions

FBH must review its access policies and procedures and evaluate how the **FBH** network CMHC staff members have been implementing those policies regarding services for Medicaid members who reside in nursing facilities. **FBH** must clarify Medicaid managed care regulations regarding access to services with the CMHCs and ensure that, while responding to requests from the nursing facilities, the CMHCs do not require processes that delay access to services for members residing in nursing facilities.

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 **FBH** Coordination and Continuity of Care policy described the process for coordinating with medical care providers, other health care agencies, and supportive services. The Coordination and Continuity of Care policy and the Commitment to Recovery policy included processes for ensuring that Medicaid members and their family members are included in service planning and encouraged to participate in their treatment. The Collaborative Projects Description described four collaborative projects (the Federally Qualified Health Center [FQHC] Integrated Health Care project, the Metro Community Provider Network [MCPN] Integrated Health Care Specialist Project, the Medical Home Project, and the Depression Screening Project) designed to enhance colocation and coordination of behavioral and medical health services. Results of satisfaction surveys distributed to nursing facilities and assisted care facilities demonstrated coordination with those facilities. Examples of clinical practice guidelines included crucial aspects of coordinating with medical care providers and involving members in their treatment. Examples of training agendas, outlines, and PowerPoint presentations

were evidence of provider training regarding person-centered planning, strategies for inspiring positive clinical outcomes, and for creating a recovery-oriented system of care. Examples of flyers and meeting announcements provided evidence of trainings and education designed to encourage members to participate in both their behavioral health and medical care.

The coordination-of-care record review included 10 records of children who received a medication management visit within the review period. No records from the oversample were reviewed. In one record the reference medication management visit was an initial evaluation. There were no records in the sample that included documentation of communication with the PCP within the 90-day period before and following the medication visit used as the reference date. One record included documentation of communication with a school nurse. One record indicated that the parent did not know who the PCP was (this was the record for which the reference medication management visit was the initial evaluation). Eight of the 10 records contained documentation of communication with family members regarding the child's status, progress, goals, and strategies for treatment. Five of those records indicated that the primary therapist also discussed the child's medications or response to medications with the parent or guardian. Three records contained documentation that the prescriber (or other medical staff such as a registered nurse) had communicated with the family member regarding medications or response to medications in communication outside of the medication management visit. In two records there was no documentation of communication with the family during the reference period regarding the child's progress or medications other than communication that occurred during the medication management visit. One of those records indicated that the child had been stable on the same medications for an extended period. In the other record, there were no therapy sessions that had occurred during the reference period and, therefore, no coordination with the family was indicated.

Summary of Strengths and Opportunities for Improvement

FBH had a variety of creative methods to enhance the quality of care coordination. The collaborative projects included features such as CMHC staff located at FQHC clinics and integrated as part of the treatment team, and an IPN provider located at a pediatrician's office for provision of behavioral health services. The depression screening project used a standardized assessment tool for each Medicaid member receiving services at several independent PCP offices and FQHC facilities. **FBH** also used several methods to monitor care coordination. The QAPI program included the use of satisfaction surveys administered to medical providers and agencies with which **FBH** coordinated care.

A particularly interesting program included the development of a survey administered to assess that a "recovery-oriented system of care" existed. The survey included an administrative portion, a portion for providers to complete, and a portion for consumers to complete.

FBH had a performance improvement project (PIP) to improve communication with PCPs. The intervention consisted of sending a letter to the PCP listing prescribed medications and encouraging the PCP to contact the prescriber to coordinate care. The record review found that none of the records contained this letter within the reference period chosen (45 days prior to and following a specific medication management encounter). The limitation of the PIP intervention was that the letter to the PCP was sent only following an initial medication evaluation. A letter would not be sent

following a routine medication management visit, even those during which medications may have been changed. While **FBH** followed its policies and procedures regarding when it is appropriate to communicate with PCPs, **FBH** may want to consider developing additional criteria or guidelines to ensure that coordination and communication occurs at other appropriate times during the member's treatment.

Summary of Required Actions

There are no corrective actions required at this time, as **FBH** 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 CMHCs' supervision 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

The quarterly Network Adequacy and Performance Indicator Reports demonstrated that **FBH** monitored the services and the service delivery system through monitoring of enrollment numbers, penetration rates, adherence to access standards, and a variety of utilization indicators such as hospital recidivism and over- and underutilization. **FBH**'s quarterly QAPI program reports, as well as the QAPI program annual impact analysis report, included an analysis of results of the Mental Health Statistical Improvement Project (MHSIP) and Youth Services Survey for Families (YSS-F) survey indicators, an analysis of grievance and appeal trends, and several indicators that measured outcomes of services. Outcome measures included improvement in problem severity over time, gaining and maintaining employment for adults with serious mental illness, gaining and maintaining independent living (adults), and gaining and maintaining a family-like setting (youth). The Quarterly Alternative Service Report demonstrated that **FBH** monitored access to and utilization of

alternative services. The QAPI program description and reports included review of critical incidents, inpatient seclusion and restraint reports, and reports of quality-of-care concerns. Evidence of review and analysis of the data presented in these reports was found in the QAPI committee meeting minutes.

Review of the provider directory and interviews with the BHO management staff indicated that the database used to track providers (CMHC employees as well as the IPN providers) was capable of sorting and searching for providers based on language spoken, licensure, focus of treatment, location, and whether the provider was accepting new clients. In addition, a hard copy of the provider directory was distributed as an attachment to the member handbook. Examples of clinical practice guidelines included a prompt for providers to consider cultural factors in developing service plans.

The 2007 Routine Medical Record Review Report demonstrated that **FBH** used a peer review process to audit medical records and monitor the appropriateness and quality of services provided, as well as monitor for the distribution and discussion of member rights. The Encounter Record Audit Report described the results of **FBH**'s monitoring of encounter record accuracy. **FBH** provided evidence of having requested corrective action plans when CMHC performance was found to be below standards or benchmarks. **FBH** also provided evidence that the CMHCs responded, as requested.

During the on-site interview, **FBH** management staff reported that additional methods of monitoring the CMHCs included review and approval of provider training agendas and outlines, and review and approval of policies and procedures that pertain to Medicaid contract compliance (utilization management, quality management, corporate compliance, critical incidents, member rights, grievance, and appeal).

Summary of Strengths and Opportunities for Improvement

In addition to the MHSIP and YSS-F surveys administered by the Department of Human Services, Division of Mental Health, **FBH** administered these satisfaction surveys quarterly to obtain more timely information. **FBH** approved and tracked required training provided by the CMHCs and completed follow-up surveys and reassessments of providers to determine the effectiveness of training.

During the on-site interview, **FBH** staff described development of a program to survey the CMHCs for the presence of a "recovery-oriented system of care." The survey consisted of separate components for assessing administrative systems, the providers, and the members. Staff reported that the first set of data was being analyzed at the time of the site review.

Summary of Required Actions

There are no corrective actions required at this time, as **FBH** 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 **FBH** member handbook contained a complete description of required and alternative services available and how to access services. **FBH** used a letter to introduce the member handbook when distributed through initial and annual mailings, and a letter for use by the IPN for distributing the handbook. The letters were easy to understand and provided a quick reference to the information that could be found in the member handbook.

The **FBH** Member Rights policy and Member Information policy described the processes for ensuring that Medicaid members are informed of their rights. The Access to Services policy contained the process to ensure that members have the right to choose providers in the IPN or have a provider of their choice added to the IPN. JCMH and the Mental Health Center Serving Boulder & Broomfield Counties (MHCBBC) orientation and annual training agendas and outlines informed CMHC providers of their responsibility to distribute and discuss the member handbook, and to specifically discuss member rights during the intake assessment. The provider manual and provider newsletters informed IPN providers of their responsibility to distribute and discuss the member handbook, and to discuss member rights during the intake assessment. The IPN service authorization form included a check box to indicate that the member handbook was provided to the member. **FBH** tracked distribution of the member handbook by providers via the peer review medical record audits at the CMHCs and review of the IPN service authorizations.

During the on-site interview, **FBH** management staff described consumer and family advocate groups that provided periodic education and training to help Medicaid members understand services available and benefits of the State plan. **FBH** provided examples of posters that were required to be posted in the CMHCs and flyers that were included in the annual mailings. The posters and flyers

informed members that the Office of Consumer and Family Affairs (OCFA) staff members are available to explain benefits and services available and how to obtain services.

During the member interviews, six of eight individuals remembered receiving written information about **FBH**. Two members remembered something about the content of that information. Two additional members stated that they did not remember anything about the information, but had it in a file in case they needed to consult it.

Summary of Strengths and Opportunities for Improvement

FBH had a variety of mechanisms designed to help Medicaid members understand the requirements and benefits of the State plan. **FBH**'s policies provided for several mechanisms to ensure that Medicaid members were informed of their rights.

During each of the assessment calls to **FBH**'s access line or **FBH**'s contractors, the clinicians were aware of and seemed to understand how to refer a Medicaid member to the staff member at **FBH** who could arrange for services from the IPN. However, the two staff members from the MHCBBC provided information that was inconsistent with the **FBH** policy. The MHCBBC staff members stated that Medicaid members could only be scheduled with the IPN if the specific services requested were not available at the network CMHCs. **FBH** management staff confirmed during the on-site interview that any request for services by the IPN could be accommodated, as stated in the **FBH** policy. **FBH** may want to consider revising or enhancing training content for MHCBBC staff to ensure MHCBBC staff members understand that their members have access to IPN providers as described in **FBH**'s policy.

Summary of Required Actions

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

6. Component 5—Corrective Action Plan and Document Review

for Foothills Behavioral Health, LLC

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 **FBH**'s FY 06–07 corrective action plan, **FBH** 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

FBH completed all required actions for Standard I—Delegation, Standard II—Provider Issues, Standard IV—Member Rights and Responsibilities, Standard VI—Utilization Management, 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 Foothills Behavioral Health, LLC

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 Rachel Henrichs	BHO Name: Foothills Behavioral Health
Member ID: _____ *(not to appear in the report)*	Member Name: _____

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

Where services were received:

Member #1: SCA at Children's Hospital
Member #2: JCMH—Colfax office
Member #3: JCMH—Lakewood office
Member #4: Dr. B. at first then Coffman clinic (Longmont)
Member #5: Private therapist used in the past
Member #6: Imagine
Member #7: MHCBBC
Member #8: Southwest office (Bowles and Wadsworth)

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

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: "Fine after we were finally seen."
Member #2: "I felt OK. I didn't feel at first that it was going to meet our needs."
Member #3: "Satisfied."
Member #4: "Dr. B. treated me poorly."
Member #5: "Good."
Member #6: "I didn't know at first."
Member #7: "Worried—he was younger than me."
Member #8: "Good."

Were you satisfied?

Member #1: "Yes, with Children's."
Member #2: "Yes."
Member #3: "Yes."
Member #4: "Not during the first four appointments with Dr. B. I was with the Coffman clinic."
Member #5: "Yes, because it was with a private therapist I had seen in the past."
Member #6: "I didn't know at first."
Member #7: "Yes."
Member #8: "Yes"

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

Member #1: "It was a nightmare, trying to get it set up. It took 1 ½ years of fighting to get services. They wouldn't see us as a family or see the boys together because one of my sons is DD (not the son that was seen). Jefferson wouldn't see us, but told us we couldn't go anywhere else to be seen either."
Member #2: "The therapist seemed knowledgeable, efficient, and effective and seemed to cover what was needed."
Member #3: "I got a lot of issues taken care of."
Member #4: "Dr. B. treated me like someone I am not. I know who I am. She wouldn't even look at me. Everything I said went in one ear and out the other."
Member #5: "It worked out well."
Member #6: "I thought it was good."
Member #7: "He had good intentions. He did make me think, but I guess I didn't need it as much as I used to."
Member #8: "I had a good rapport with that therapist and didn't go back after she left because I didn't want to start over with someone else."

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

Member #1: "I was frustrated that you have to go to JCMH if you live in Jefferson County."
Member #2: "No."
Member #3: "No."
Member #4: "She didn't care about me or my history. She never even asked me about my medical history. She just kept upping my meds."
Member #5: "No."
Member #6: "No."
Member #7: "Sometimes I felt like it was a waste of time."
Member #8: "No."

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

Member #1: "I called FBH and they agreed to do a SCA, then I never heard from them. I had to call them back three or four weeks later, then it got worked out."
Member #2: N/A
Member #3: N/A
Member #4: "I complained to the 'normal' person at the clinic and she said that Dr. B. was the only doctor there and there was nothing they could do about it.
Member #5: N/A
Member #6: N/A
Member #7: "No."
Member #8: N/A

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

Member #1: "No."
Member #2: N/A
Member #3: N/A
Member #4: "No one ever sent a letter."
Member #5: N/A
Member #6: N/A
Member #7: N/A
Member #8: 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: "No."
Member #2: "I don't remember."
Member #3: "Yes, I was told often."
Member #4: "No, but I kept looking for some place else, then I found the Coffman clinic and started going there."
Member #5: "Yes."

Member #6: "Yes."
Member #7: "No."
Member #8: "Yes."

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

Member #1: "I never received anything from FBH before or after I started treatment."
Member #2: "Yes, in the mail."
Member #3: "Yes, when I first went in."
Member #4: "Not at the first place, but I did at the Coffman Clinic."
Member #5: "Yes."
Member #6: "I think so."
Member #7: "I got paperwork from the counselor. I'm not sure what it was."
Member #8: "Yes, in the mail."

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

Member #1: N/A
Member #2: "No, but I kept it. That's how I got in contact with them."
Member #3: "No."
Member #4: "There were about three packets of stuff, rights and complaint stuff, everything."
Member #5: "Nothing, but it's filed somewhere."
Member #6: "Not sure what I got."
Member #7: "Not sure."
Member #8: "No, but I felt that it covered everything."

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

Member #1: "No, I was told I had to go through JCMH. At one point they gave me a number for a private therapist, but he never called me back."
Member #2: "No."
Member #3: "I was told after the first session that I could go to a place closer if I needed to."
Member #4: "The first place gave me no options. I had to figure it out for myself."
Member #5: "I was going to the specific therapist I chose."
Member #6: "I think so."
Member #7: "Not really."
Member #8: "Yes."

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

Member #1: "Yes. I saw the psychologist and a psychology intern once a week. I was very impressed"
Member #2: "No."
Member #3: "Yes."
Member #4: "Yes, I quit the first place after four visits, then I found the other place."
Member #5: "Yes, I'm still attending."
Member #6: "Yes, still. She's good."
Member #7: "Yes, I had more than one therapist. The first one left."
Member #8: "I went back because I felt I had a good therapist."

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

Member #1: N/A
Member #2: "I had an appointment scheduled, but I didn't go."
Member #3: N/A
Member #4: N/A
Member #5: N/A
Member #6: N/A
Member #7: N/A
Member #8: 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: "No."
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

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

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

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

Member #1: "After the single-case agreement was set up and I had an appointment then Children's stopped taking Medicaid. I ended up paying $1,200 for the assessment. Also, since they weren't taking Medicaid, they said the seven-day rule didn't apply and I waited four weeks for the appointment. I couldn't find a therapist in the community that would take Medicaid."
Note: Following the receipt of this information, the Department worked directly with FBH to investigate this case.

Member #2: "It would have been nicer if they had evening appointments. I would have kept going. I'm a grandmother with custody of these kids, and I can't take time off work to go."
Member #3: "I'm satisfied with everything and who I've been seeing. I have no complaints."
Member #4: "Coffman has been great."
Member #5: "I had trouble just getting a list of mental health providers. I didn't know where to go."
Member #6: "No."
Member #7: "There's a couple of things about mental illness you should know. There's a stigma. People feel like they are looked down on. It's still good to talk to a therapist. It's still OK, right? I have a degree in psychology. Everyone has a reason beyond life on this earth. The reason they don't want to go is they don't want to feel incapacitated, but I like the people. You can say anything you want and it won't hurt your social life."
Member #8: "I watch my grandchildren. I just quit because it's too hard to schedule."

Appendix B. Telephone Assessment Worksheet for Foothills Behavioral Health, LLC

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: Foothills Behavioral Health Telephone number called: 303.432.5958

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

Caller: Diane Somerville

Name of person answering the phone: M, W

Offered name: X Had to ask name: _____

Notes:

The HSAG caller used the number published in the member handbook on the FBH Web site as the number to call if the member wants services from an independent provider. After nine rings the call was forwarded to voice mail, which said "to leave a message press 1 (for M) and 2 (for P)." The caller returned to the member handbook and called the main number for FBH. The answering service picked up and stated the call was being transferred back to the FBH offices; however, the call went to a specific staff member's voice mail. The HSAG caller left a message, but received no call back. Meanwhile, the HSAG caller checked the Web site again and called the number for JCMH, where she was told by the staff member who answered the phone that she couldn't answer any questions because she was just filling in to answer the phones while everyone was in a meeting for the next hour. When the HSAG caller pressed, asking what would a member in need of services do, the call was transferred to intake. The intake worker was very helpful and able to answer the questions.

Person assigned to help or transferred to: C

Offered name: X Had to ask name: _____

Notes:

CW was very helpful and proficient.

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)?*

   The clinician appeared very knowledgeable and stated that the developmental diagnosis of Asperger's would not preclude mental health services being offered. She indicated that she would ask the name of the parent and other demographic information; establish whether there are any custodial issues; ask if there are any medical records relevant to the Asperger's diagnosis so that they could be obtained prior to the intake appointment, if possible; and ask for a description of the symptoms of depression the parent has observed. She stated that she would schedule an intake appointment and indicated that the first appointment would not have to wait until the medical records were received. She indicated that the first available appointment was the next day at the Lakewood location.

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.)

   The clinician stated that providing services to nursing home residents was a slightly different process than the one described in Question 1. She stated that there was an agreement with nursing homes that specified that a cover letter identifying the patient's diagnoses had to be written and submitted before the appointment could be scheduled. She also stated that there is a staff member who travels to nursing homes to provide therapy and that this staff member would travel to the patient's nursing home within seven days of receipt of the letter. She was unsure of the procedure if a nursing home resident wanted to come to the mental health center, but indicated that probably the letter still needed to be submitted.

General questions asked during each call:

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

   Call 1 (JCMH): Tomorrow at 1 p.m.

   Call 2 (Saturday, MHCBBC): This information is not available to the weekend staff.

   Call 2 (Repeated—call placed at 12:30 p.m. on Monday, January 28, JCMH): The next available routine appointment is Thursday, January 31, at 5:15 p.m. (adult)

   Call 3 (Call placed at 9:30 a.m. on Wednesday, January 23, MHCBBC): The next available routine appointment is Monday, January 28, at 10 a.m. at Boulder.

   Call 4 (Call placed at 4 p.m. on Tuesday, January 29, JCMH): The next available routine appointment is Thursday, January 31, at 9:30 a.m.

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 (JCMH): The HSAG caller was told that if members call the access line, then they are provided their choices. If members don't want to go to the CMHC, they are referred to the FBH independent provider network (this is the number that directed the caller to Press 1 for M or 2 for P).

Call 2 (Saturday, MHCBBC): This information is not available to the weekend staff.

Call 2 (repeated, JCMH): The HSAG caller was told that when scheduling the intake appointment, if the CMHC does not have the availability the member needs, the members are sent to FBH to get them into the independent provider network.

Call 3 (MHCBBC): L did not know the answer, so she put the call on hold and went to ask her supervisor. She was gone for a while before returning and answering, "We would direct them to come here (MHCBBC) if we had the service they wanted available. If they wanted an external provider we would refer back to FBH for a referral to an external provider, but only if we didn't have the services to offer."

Call 4 (JCMH): The HSAG caller was told, "It depends on what they want. If they want something closer to their home, or to see a particular kind of therapist, say a male, and we didn't have one available, we would refer them to the IPN."

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 (JCMH): Members are told about the FBH independent provider network (M and P). A release of information is asked for, and with permission, the intake staff member sends an e-mail to M and P, advising them of the referral.

Members are told that if they have a provider already active in the FBH network, they can see that provider. (The BHO will do a behind-the-scenes administrative opening and the client does not have to go through a routine intake.)

Call 2 (Saturday, MHCBBC): This information is not available to the weekend staff.

Call 2 (repeated, JCMH): Members are told about the Foothills network and calls can be transferred.

Call 3 (MHCBBC): The HSAG caller was told that if members wanted an external provider, they would be referred to FBH for a referral to an external provider, "but only if we didn't have the services to offer."

Call 4 (JCMH): They refer the caller to the IPN network.

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 (JCMH): If the provider is not already known to FBH, and is willing, the BHO will credential that provider.

Call 2 (Saturday, MHCBBC): This information is not available to the weekend staff.

Call 2 (repeated, JCMH): D said she would first check to see if they are in the Foothills network. If they are in the network, "I tell them to just call the provider, they are good to go." If not, the caller will be transferred to Foothills and "Foothills will be happy to credential the provider if the provider is qualified."

Call 3 (MHCBBC): L put the HSAG caller on hold to obtain the answer. The HSAG caller asked to speak directly to whom L had been conferring with. O resumed the call and said that MHCBBC would see the member for medication management and that the member could see one of the MHCBBC doctors. O said that they (MHCBBC) would recommend that the member receive all of his or her treatment "in-house" for coordination purposes. The HSAG caller asked, "What if I had been seeing someone, then I became Medicaid-eligible and wanted to continue with the therapist? Is there any way?" O answered, "I would tell them, 'You can see them if you want, but if you want it covered you have to come see us.'"

Call 4 (JCMH): The HSAG caller was told that if the provider wanted to become part of the network, FBH will work with them to get them credentialed. These calls are referred to FBH.

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

Call 1 (JCMH): The HSAG caller was told the next urgent appointment was "tomorrow at 1:00." CW went on to say that she would assess whether the situation really was urgent or if it was an emergency. If she felt it was an emergency, she might refer the caller to their emergency team, send the police, or tell the member to go to a hospital emergency department, depending on the circumstances. She would be gathering information and entering it in the system throughout the call to be able to provide sufficient referral information.

Call 2 (Saturday, MHCBBC): This information is not available to the weekend staff.

Call 2 (repeated, JCMH): The HSAG caller was told that callers would be screened to determine if it was an emergency, and depending on the situation, an appointment would be available the same day or the next day.

Call 3 (MHCBBC): The HSAG caller was told that if it was determined to be a crisis, a same-day appointment would be created. If it was determined not to be a crisis, an appointment would be scheduled for the next day.

Call 4 (JCMH): The HSAG caller was told that the next available appointment is at "10:00 tomorrow."

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 (JCMH): CW would assess for the critical nature of the call and refer as clinically indicated to their own emergency team that is fairly readily available, advise the caller to go to an emergency room, or send a police referral.

   Call 2 (Saturday, MCBBC): The clinician said she would discuss the symptoms/problems. She might urge the individual to go to the emergency room, as well as try to see if there was a family member available to go with the member. She might call the police for a welfare check.

   Call 2 (repeated, JCMH): The member would be directed to go to the emergency room.

   Call 3 (MHCBBC): The HSAG caller was told, "I would refer them to the crisis team or I would ask them to go to the emergency room and we will meet them there to evaluate. If they can't get there safely, I might call the police for a welfare check. If I felt they didn't need the security level of an emergency room, I would ask them to come in as a walk-in client."

   Call 4 (JCMH): The HSAG caller was told, "I would transfer the call to the emergency team. They would probably send the member to the emergency room and go to see the member at the hospital."

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 (JCMH): The HSAG caller was told, "This happens all the time." The call/intake is handled just like any other and appointments scheduled per the clinical necessity (urgent, etc.). They then contact the home BHO and request an authorization. CW did not think it was ever a problem to get the other BHO to provide authorization for services provided.

   Call 2 (Saturday, MHCBBC): The HSAG caller was told, "This is routine." The home BHO would be contacted for authorization.

   Call 2 (repeated, JCMH): C said she would not deny the appointment. She would schedule the appointment and would direct the member to get his or her Medicaid transferred.

   Call 3 (MHCBBC): L said she would ask the screening questions, she would call the other BHO and ask for authorization, and would schedule an intake appointment.

   Call 4 (JCMH): S said they would get authorization from the other area and advise the member to have eligibility changed to this area.

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: Foothills Behavioral Health Telephone number called: (Saturday) 303.432.5950 (repeated—303.425.0300)

Date of call: Saturday, January 12, 2008 (repeated on Monday, January 28, 2008)
Time of call: 3 p.m. (repeated—12:30 p.m.)

Caller: Diane Somerville

Name of person answering the phone: Saturday—S (repeated—D)

Offered name: X Had to ask name: _____

Notes:

S agreed to answer the questions only after checking with her supervisor. Due to the structure of the on-call situation, this individual could not answer all the questions, so she transferred me to the Boulder area crisis line to address certain questions.

The questions in the Telephone Assessment Worksheet 2 were asked during the Saturday call (to the on-call clinician) and repeated on a later date when the call was placed directly to JCMH.

Person assigned to help or transferred to: Saturday—M at Boulder (repeated—C)

Offered name: X Had to ask name: _____

Notes:

(Saturday) M, the on on-call clinician for the Boulder area, was very knowledgeable and willing to participate. However, she was very busy and could not stay on the phone with me very long.

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

Saturday—Urban
Repeated—Urban and Rural

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.)*

   Saturday (FBH main number): S stated that she does not pay attention to eligibility issues. She would perform a clinical screening for safety, gather demographic data, and refer to the appropriate level of services—that is, she would make a referral for the person to come in during the week, or for more urgent or emergent situations, she would refer to the on-call clinician in the area where the member was calling from.

   Saturday (Boulder): M would discuss his symptoms for clinical assessment of urgent/emergent needs and attend to those as clinically indicated. Absent there being any immediacy issues, she would determine if he was an individual with a serious mental illness or a serious and persistent mental illness, because then he would clearly be a BHO candidate. Otherwise, if he was dually eligible, she would endeavor to find him a Medicare provider.

   Repeated (JCMH): C said she would schedule him at JCMH. She said they try to save their appointments for Medicaid, but that if he had been unable to find a Medicare provider, he has a right to services at JCMH. She would schedule an appointment for him within seven days or refer him to the independent provider network if she couldn't get him in within seven days. (She explained that sometimes they have more availability in the IPN since it is such a large network.)

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

   Saturday (FBH main): S provides telephone service only.

   Saturday (MHCBBC): M didn't think it would make a difference. She assumes all Medicare providers have ADA-accessible facilities.

   Repeated (JCMH): C said it would not make a difference. She believed that all offices are handicapped accessible. However, if he was coming on a bus, she would tell him a particular bus stop to take if he was coming "here" because one stop is closer to the door than the other.

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?*

   FBH main: S would call the on-call clinician in the area.

   MHCBBC: M would discuss the clinical symptoms to make a determination if it was urgent or an emergency. If it was not, she would advise the staff or guardian to call on Monday and get the client scheduled for an intake.

Repeated (JCMH): C would make the appointment, but would want a referral from Developmental Disabilities Resource Center (DDRC) or whoever knows the member best. She would not deny or postpone the appointment, but felt the CMHC could do a better job of assessing and treating if it had more information up front. If it was an emergency, C would send them to the nearest emergency room.

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: Foothills Behavioral Health Telephone number called: 866.245.1959

Date of call: January 23, 2008 Time of call: 9:30 a.m.

Caller: Diane Somerville

Name of person answering the phone: D then L

Offered name: X Had to ask name: _____

Notes:

The HSAG caller told the individual who answered (D) that she was in Broomfield County and wanted to talk to someone about how to begin receiving mental health services. She was transferred to "someone who will help." The call was transferred to J, who answered the phone with "independent network." The HSAG caller identified herself and described the purpose of the call. She stated she was filling in on the switchboard for the secretary who is on maternity leave. In response to the questions, she was puzzled why she was being called. She stated that they are a payor for providers and that they don't typically get client calls.

The HSAG caller then called the FBH main number (303.432.5950) and got D again and explained what had happened. D was puzzled. She thought she had transferred the call correctly. She then transferred the call to L with FBH. The HSAG reviewer explained the purpose of the call to L. She said she would ask screening questions and then, based on that information, she would refer the caller to the Mental Health Center serving Boulder & Broomfield Counties (MHCBBC). The HSAG reviewer asked if she would transfer the call or provide the telephone number. She said she would provide the telephone number, which was 303.443.8500.

Person assigned to help or transferred to: L

Offered name: X Had to ask name: _____

Notes:

The HSAG reviewer then called the MHCBBC number and a nameless person transferred the call to "intake," where there was a recording directing callers to press numbers for what they needed. The HSAG caller pressed "2" for English-speaking adult services and was connected with a different L.

The HSAG reviewer explained the purpose of the call again. L identified herself as a relief worker and stated that she wanted to immediately transfer the call to her colleague; however, the reviewer asked her to remain on the line for the initial questions because she needed to assess the experience an actual client would have.

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

Urban and rural mixed

Specific questions for the third call:

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

   L did not know what an alternative care facility was. She put the call on hold. Upon her return, she said that she would screen to see if the caller met criteria (she did not elaborate what "criteria" meant) and if so, she would offer an appointment within seven days in the caller's choice of either Longmont or Boulder.

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.)

   L said she would ask for more information to assess the situation and determine the level of crisis. She said she would then possibly refer the call to the EPS (emergency team). Then, she said, to make an appointment, the individual would have to call and request services himself.

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: Foothills Behavioral Health Telephone number called: 303.432.5950

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

Caller: Diane Somerville

Name of person answering the phone: M

Offered name: X Had to ask name: _____

Notes:

M said he was the receptionist. He asked for the HSAG caller's name. The HSAG caller explained the purpose of the call and was transferred to JCMH.

Person assigned to help or transferred to: S

Offered name: X Had to ask name: _____

Notes:

This intake worker was very sharp, very pleasant.

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

Urban and rural

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.*

   S said that she would get him in as soon as possible. She looked on the computer system and the first available appointment was on the 31st, so she said she would arrange for the member to see the emergency team doctor—or if the member could get there by 5:00 the member could be seen today. After hours, the person would have to go to an emergency department. Also, an appointment was offered at 10:00 the next day.

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?*

   S explained that the JCMH has relationships with the hospitals, that the hospitals do discharge planning, and that they call JCMH when they have a Medicaid member approaching discharge. The hospital faxes over the paperwork, discharge summary, and medication list. JCMH coordinates with the hospital and sets up an appointment with the emergency intake team.

   The member will need medication within seven days.

   S said that they have a doctor on the emergency intake team.

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

   S said yes, the intake clinician would do an assessment and provide supportive counseling as part of the intake assessment, then the member would be assigned to a therapist.

Appendix C. Record Review Worksheet
for Foothills Behavioral Health, LLC

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: 4/23/07
Reviewer Name: Barbara McConnell	Review Date: 3/6/08

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
4/23/07	Psychiatric Note	MD	Mother	N/A	Medication Management	Yes

Content of Documentation (Brief Description):

This note documented the medication management encounter referenced and discussion with the mother regarding the child's symptoms, seizures, medications, and side effects.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
5/10/07	Progress Note	BA	Mother	N/A	Family Therapy Session	No

Content of Documentation (Brief Description):

This note documented discussion with the mother regarding the child's behavior during a therapy session.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
5/31/07	Progress Note	LCSW	Mother	Mother	Telephone	No

Content of Documentation (Brief Description):

This note documented a voice mail exchange (both ways) between the mother and the therapist regarding referral to another therapist per the mother's request.

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

Member ID: Sample 2	Encounter Reference Date: 5/22/08
Reviewer Name: Barbara McConnell	Review Date: 3/6/08

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
4/17/07	Medical Progress Note	MD	Mother	N/A	Medication Management	Yes

Content of Documentation (Brief Description):

This note documented a medication management visit in addition to the referenced visit. Discussion with the mother included problems at school, symptoms, and medications.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
5/22/07	Medical Progress Note	MD	Mother	N/A	Medication Management	Yes

Content of Documentation (Brief Description):

This note documented the medication management visit referenced and discussion with the mother regarding the child's progress and medications.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
6/13/07	Case Management Note	LPC	Mother	N/A	Case Management	Yes

Content of Documentation (Brief Description):

This note documented a treatment planning session during which the child's strengths, goals, and treatment strategies, including medications, were discussed.

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

Member ID: Sample 3	Encounter Reference Date: 6/26/07
Reviewer Name: Barbara McConnell	Review Date: 3/6/08

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

Content of Documentation (Brief Description):

This note documented a medication management visit prior to the referenced medication management visit. Symptoms, behaviors, mood, and medications were discussed.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
5/23/07–7/13/07	Case Management Notes	LPC	Caseworker Mother Father	All	Telephone	No

Content of Documentation (Brief Description):

There were numerous telephone contacts between the family, the primary therapist, and the social services caseworker regarding placement. Telephone contacts were 5/23/07, 5/29/07, 5/31/07, 6/18/07, 6/19/07, 6/20/07, and 7/13/07.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
5/24/07	Case Management Note	LPC	Caseworker	N/A	Case Management Meeting	No

Content of Documentation (Brief Description):

This note documented a meeting between the therapist and the caseworker to discuss placement in foster care and referral to another therapist for specialty services.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
5/25/07	Therapy Progress Note	LPC	Father and Grandmother	N/A	Family Therapy Session	No

Content of Documentation (Brief Description):

This note documented a family therapy session where family issues, family dynamics, and treatment strategies were discussed.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
6/7/07	Family Therapy Progress Note	LPC	Mother and Father	N/A	Family Therapy	No

Content of Documentation (Brief Description):

This note documented a family therapy session where evaluation needs and placement were discussed.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
6/26/07	Medical Progress Note	MD	Foster Father	N/A	Medication Management	Yes

Content of Documentation (Brief Description):

This note documented the medication management encounter referenced and discussion with the foster father regarding biological mother visitation and medications.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
6/28/07	Case Management Note	LPC	Mother	N/A	Family Therapy	No

Content of Documentation (Brief Description):

This note documented a family therapy session where they discussed closing the family therapy case.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
7/13/07	Case Management Note	LPC	Mother	LPC	Telephone	No

Content of Documentation (Brief Description):

This note documented a telephone contact with the mother to discuss family issues.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
7/24/07	Case Management Note	LPC	Mother	N/A	Family Meeting	No

Content of Documentation (Brief Description):

This note documented a family meeting with the new therapist (specialty) and the transitioning therapist to provide history, progress, and transition information.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
7/31/07	Case Management Note	LPC	Mother	N/A	Family Therapy	No

Content of Documentation (Brief Description):

This note documented the final family therapy session.

Member ID: Sample 4	Encounter Reference Date: 5/23/07
Reviewer Name: Barbara McConnell	Review Date: 3/6/08

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
4/11/07	Medical Progress Note	MD	Mother	N/A	Medication Management	Yes

Content of Documentation (Brief Description):

This note documented a medication management visit prior to the encounter referenced. Written medication instructions were provided to the mother.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
5/1/07	Case Management Note	LCSW	Mother	LCSW	Telephone	Yes

Content of Documentation (Brief Description):

This note documented a telephone contact with the mother during which she asked the therapist if new symptoms were medication side effects.

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

Content of Documentation (Brief Description):

This note documented a medication management visit prior to the referenced medication management date, during which the child's behavior, symptoms, and medications were discussed.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
5/2/07	Case Management Note	LCSW	School Nurse	LCSW	Telephone	No

Content of Documentation (Brief Description):

This note documented a telephone conversation during which the therapist called the school nurse to ask if she would check the symptoms that the mother had reported to the therapist.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
5/2/07	Psychiatric Progress Note	MD	Therapist	Therapist	E-mail	No

Content of Documentation (Brief Description):

This note documented the receipt of the e-mail from the therapist regarding the concerning symptoms, and that the physician left a voice mail message for the mother to discuss the symptoms.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
5/3/07	Psychiatric Progress Note	MD	Mother	N/A	Medication Management	Yes

Content of Documentation (Brief Description):

This note documented a medication management visit prior to the referenced medication management encounter. The new physical symptoms and the medications were discussed.

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

Content of Documentation (Brief Description):

This note documented a telephone contact. The mother had left a message for the psychiatrist and the psychiatrist returned her call. They discussed the child's symptoms and responses to the medication changes.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
5/14/07	Case Management Note	LCSW	Mother	Mother	Telephone	No

Content of Documentation (Brief Description):

This note documented a telephone call during which the mother discussed the previous status of the child's case as medications only and requested to obtain therapy services again.

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

Content of Documentation (Brief Description):

This note documented the medication management encounter referenced, during which the child's behaviors, medications, and side effects were discussed.

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

Content of Documentation (Brief Description):

This note documented an additional medication management visit. They discussed the child's noncompliance with medications and strategies for dealing with his behavior.

Member ID: Sample 5	Encounter Reference Date: 4/12/07
Reviewer Name: Barbara McConnell	Review Date: 3/6/08

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
2/27/07	Therapy Progress Note	LMFT	Mother	Mother	Telephone	No

Content of Documentation (Brief Description):

This note documented a telephone conversation during which the mother requested advice regarding how to respond to the child's behavior.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
3/1/07	Therapy Progress Note	LMFT	Mother	Mother	Telephone	No

Content of Documentation (Brief Description):

This note documented a telephone call with the mother during which they discussed the child's behavior and power struggles.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
3/5/07	Therapy Progress Note	LMFT	Mother	Mother	Telephone	No

Content of Documentation (Brief Description):

The mother called because she needed advice for managing the child's behaviors.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
3/8/07	Therapy Progress Note	LMFT	Grandmother	Grand-mother	Telephone	No

Content of Documentation (Brief Description):

The grandmother called to discuss her concerns about the father's relationship with the child.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
3/10/07	Therapy Progress Note	LMFT	Mother	N/A	Family Therapy	No

Content of Documentation (Brief Description):

This note documented a family therapy session where they discussed family relationships and the child's behavior.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
3/12/07	Medical Progress Note	MD	Mother	N/A	Medication Management	Yes

Content of Documentation (Brief Description):

This note documented a medication management visit prior to the referenced medication management encounter. The child's status, progress, and medications were discussed.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
3/14/07	Therapy Progress Note	LMFT	Mother	N/A	Therapy session	No

Content of Documentation (Brief Description):

This note documented a therapy session with the child during which the therapist discussed the child's relationship with the family.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
4/12/07	Medical Progress Note	MD	Mother	N/A	Medication Management	Yes

Content of Documentation (Brief Description):

This note documented the referenced medication management encounter. The child's progress and medications were discussed.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
4/13/07	Case Management Note	RN	Mother	Mother	Telephone	Yes

Content of Documentation (Brief Description):

The mother called to discuss the child's refusal to take medications.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
5/23/07	Case Management Note	LCSW	Mother	Mother	Telephone	No

Content of Documentation (Brief Description):

The mother called, concerned that the child may be suicidal. She was urged to take him to the emergency room.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
5/31/07	Therapy Progress Note	LCSW	Mother	N/A	Therapy	No

Content of Documentation (Brief Description):

This note documented a therapy session during which the therapist discussed the child's behaviors and symptoms with the mother.

Member ID: Sample 6	Encounter Reference Date: 5/31/07
Reviewer Name: Barbara McConnell	Review Date: 3/6/08

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
5/1/07	Progress Note	PhD	Mother	N/A	Therapy	Yes

Content of Documentation (Brief Description):

This note documented a therapy session during which the therapist discussed the child's behavior, symptoms, and treatment strategies.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
5/3/07	Nursing Progress Note	RN	MD	RN	Telephone	Yes

Content of Documentation (Brief Description):

The note stated that the mother requested an increase of medications and that the RN discussed this with the doctor.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
5/3/07	Nursing Progress Note	RN	Mother	RN	Telephone	Yes

Content of Documentation (Brief Description):

This note documented a conversation with the mother regarding her request for an increase of the child's medications and the psychiatrist's response.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
5/31/07	Psychiatric Progress Notes	MD	Mother	N/A	Medication Management	Yes

Content of Documentation (Brief Description):

This note documented the referenced medication management encounter during which medications, behavior, and symptoms were discussed.

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

Member ID: Sample 7	Encounter Reference Date: 5/3/07
Reviewer Name: Barbara McConnell	Review Date: 3/6/08

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
5/3/07	Medical Progress Note	MD	Foster Mother	N/A	Medication Management	Yes

Content of Documentation (Brief Description):

This note documented the referenced medication management encounter. The record indicated that this case was a "medication management only" case.

Member ID: Sample 8	Encounter Reference Date: 3/28/07
Reviewer Name: Barbara McConnell	Review Date: 3/8/08

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
2/21/07	Progress Note	MSW	Mother and Father	N/A	Family Therapy	Yes

Content of Documentation (Brief Description):

This note documented a family therapy session during which they discussed the child's symptoms and medications.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
3/23/07	Case Management Note	RN	Hospital	Hospital	Fax	Yes

Content of Documentation (Brief Description):

This documentation was a copy of the fax sent to the hospital following a request related to the child's hospitalization. The fax contained history and medications.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
3/28/07	Medical Progress Note	MD	Unknown	N/A	Medication management	Yes

Content of Documentation (Brief Description):

This note documented the referenced medication management encounter. The note was unclear whether the child (16 years of age) was the only one present at the visit.

Member ID: Sample 9	Encounter Reference Date: 5/25/07
Reviewer Name: Barbara McConnell	Review Date: 3/6/08

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
5/25/07	Medical Progress Note	MD	Mother	N/A	Medication Management	Yes

Content of Documentation (Brief Description):

This note documented the referenced medication management encounter during which they discussed the child's progress and medications. No other documentation of contact with the family outside of the medication management visit was found in the record.

Member ID: Sample 10	Encounter Reference Date: 5/10/07
Reviewer Name: Barbara McConnell	Review Date: 3/6/08

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
4/16/07	Intake Assessment	LCSW	Mother	N/A	Intake Assessment	Yes

Content of Documentation (Brief Description):

This note documented the intake assessment during which the child's behavior, previous treatment, and medications were discussed.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
4/20/07	General Note	Unknown	N/A	N/A	N/A	N/A

Content of Documentation (Brief Description):

This note indicated that the child's PCP was unknown.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
4/26/07	Medical Evaluation	MD	Mother	N/A	Medication Evaluation	Yes

Content of Documentation (Brief Description):

This note documented the initial medication evaluation and was the referenced encounter. The child's history, symptoms, and treatment strategies were discussed.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
5/11/07	Progress Note	LCSW	Mother	Mother	Telephone	Yes

Content of Documentation (Brief Description):

The mother called to discuss with the therapist the fact that medications were not prescribed at that time.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
5/21/07	Progress Note	LPC	Mother	LPC	Telephone	No

Content of Documentation (Brief Description):

The therapist called the mother to offer a specialized therapy program.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
5/30/07	Medical Progress Note	MD	Mother	N/A	Medication Management	Yes

Content of Documentation (Brief Description):

This note documented a medication management visit following the referenced encounter date. The note indicated that the child came to the visit alone and the psychiatrist talked to the mother on the telephone to discuss the results of the visit and medications.

Appendix D. Oversight and Monitoring of Providers Worksheet
for Foothills Behavioral Health, LLC

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 opinion, 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/certification, 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?)

Appendix E. FY 06–07 Corrective Action Plan for Foothills Behavioral Health, LLC

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* FBH				
Evaluation Elements	**Required Actions**	**Planned Intervention**	**Due Date**	**# of Attachment With Evidence of Compliance**
Standard I: Delegation				
3. Content of Agreement D. Specifies that the subcontractor shall comply with the standards specified in the contract between the BHO and the Department for any responsibilities delegated to the subcontractor.	FBH must revise its contract with InNET to specify that InNET shall comply with standards in the contract between the Department and FBH related to authorization functions.	FBH will revise its contract with InNET to specify that InNET shall comply with standards in the contract between the Department and FBH related to authorization functions. **September 2007 HCPF/HSAG comments:** Plan accepted.	7/1/07	I. 3. BHO InNET Amended Agreement.doc (pg 2, Article 2.9) I. 3. Signatures_InNET.pdf
Standard I: Delegation—FY 07–08 Document Review				
3. Content of Agreement Document(s) reviewed: ◆ Contract between FBH and InNET dated October 18, 2007—signatures dated October 18 and 19, 2007 The revised contract between FBH and InNET contained the required clause. This required action has been completed.				

Table E-1—FY 06–07 Corrective Action Plan *for* FBH				
Evaluation Elements	**Required Actions**	**Planned Intervention**	**Due Date**	**# of Attachment With Evidence of Compliance**
Standard II: Provider Issues				
8. Termination of Provider Agreements The Contractor notifies the Department in writing of its decision to terminate any existing provider agreement where such termination causes the delivery of covered services to be inadequate in a given area and provides the notice at least ninety (90) days prior to termination of the services unless the termination is based on quality or performance issues.	FBH must have a process for notifying the Department in writing of its decision to terminate any existing provider agreement where such termination causes the delivery of covered services to be inadequate in a given area.	FBH will revise its Corrective Action policy to include procedures for notifying the Department of provider agreement terminations and will revise the JCMH and MHCBBC agreements to include language describing the requirement for notification of provider terminations. **September 2007 HCPF/HSAG comments:** To clarify, it is not necessary for JCMH and MHCBBC to notify the Department of individual provider terminations. Rather, as the BHO, FBH must notify (and have a process for notifying) the Department of any provider agreement terminations that cause the delivery of covered services in a given area to be inadequate. Please provide evidence of this process, clarify the intent of the planned revisions to the JCMH and MHCBBC agreements, and provide the new language that has been included.	7/1/07	II. 8. FBH Policy Assurance of Adequate Capacity & Services rev. doc (see pg 2, Sec E) II. 8. Community Mental Health Center Service Agreement rev. doc (see pg 15, Article VIII, Sec 8.02)
Standard II: Provider Issues—FY 07–08 Document Review				
8. Termination of Provider Agreements Document(s) reviewed: ◆ The Assurances of Adequate Capacity and Services policy (revision February 14, 2007) ◆ Community Mental Health Center Service Agreement template The Assurance of Adequate Capacity and Services policy included a description of the process for notifying the Department when termination of provider contracts may cause the delivery of covered services to be inadequate in a given service area. The Community Mental Health Center Service Agreement template clearly described FBH's responsibility with regard to notifying the Department should that contract be terminated. FBH staff reported that the revised template agreement will be submitted to the Department for approval on November 15, 2007, and that the agreements with MHCBBC and JCMH would be executed following Department approval. This required action has been completed.				

Table E-1—FY 06–07 Corrective Action Plan *for* FBH				
Evaluation Elements	**Required Actions**	**Planned Intervention**	**Due Date**	**# of Attachment With Evidence of Compliance**
13. Record Review: Documentation of Services	FBH must continue to take measures to review encounter data for inappropriate or inaccurate coding and continue to follow-up on existing corrective action plans.	FBH requested and received a corrective action plan (CAP) from the two network CMHCs regarding encounter record errors found in the FY 06 Annual Audit, beginning October 2006. In addition, FBH implemented a CAP with any IPN provider with errors in this same audit in the same time period. FBH implemented a quarterly audit of the encounter data against the medical record to assess for improvement in encounter record accuracy. **September 2007 HCPF/HSAG comments:** When submitting evidence of compliance, please include the results of the quarterly audits conducted since February 2007.	10/31/06 Began 2/1/07	II. 13. CAP Request to MHCBBC 10_11_06.doc II. 13. MHCBBC_CAP 10_30_06.doc II. 13. CAP Request to JCMH 10_11_06.doc II. 13. JCMH CAP 411 Audit letter 10_24_06.doc II. 13. MHCBBC_CAP Audit follow-up 7_9_07.doc (MHCBBC follow-up to CAP) II. 13. JCMH CAP Audit follow-up 5_28_07 (JCMH follow-up to CAP) II. 13. FBH Encounter Audit report 1st_2nd qtr final.doc (FBH internal quarterly audit) II. 13. FBH Encounter Audit report qtr 3 FY 07 final.doc (FBH internal quarterly audit)

Table E-1—FY 06–07 Corrective Action Plan *for* FBH				
Evaluation Elements	**Required Actions**	**Planned Intervention**	**Due Date**	**# of Attachment With Evidence of Compliance**
Standard II: Provider Issues—FY 07–08 Document Review				
13. Record Review: Documentation of Services ◆ Request for corrective action plan (letter) to JCMH dated October 11, 2006 ◆ Request for corrective action plan (letter) to MHCBBC dated October 11, 2006 ◆ JCMH response to request for corrective action plan (letter) dated October 24, 2006 ◆ MHCBBC response to request for corrective action plan (letter) dated October 30, 2006 ◆ JCMH follow-up report (letter dated May 28, 2007) regarding CAP ◆ MHCBBC follow-up report (letter dated April 9, 2007) regarding CAP ◆ Encounter Audit Report for first and second quarters FY 06–07—report date March 8, 2007 ◆ Encounter Audit Report for third quarter FY 06–07—report date May 22, 2007 FBH submitted the original requests for corrective actions sent to JCMH and MHCBBC dated October 11, 2006, and evidence that FBH staff received corrective action plans as well as follow-up reports from each CMHC indicating that the corrective actions were implemented. In addition, FBH provided reports of audits performed for the first, second, and third quarters of FY 06–07, which demonstrated ongoing monitoring of the accuracy of encounter data submitted by the CMHCs as well as independent providers. These required actions have been completed.				

Table E-1—FY 06–07 Corrective Action Plan *for* FBH				
Evaluation Elements	**Required Actions**	**Planned Intervention**	**Due Date**	**# of Attachment With Evidence of Compliance**
Standard IV: Member Rights and Responsibilities				
5. Advance Directives A. The Contractor has written policies and procedures for Advance Directives.	FBH must implement a mechanism to ensure that its providers in the IPN document in the medical record whether a consumer has executed an advance directive.	The form used by the IPN to document inquiry about advance directives with the member was revised to include a question about whether or not the member has completed an advance directive. **September 2007 HCPF/HSAG comments:** Plan accepted.	3/1/07	IV.5. IPN Service Auth Request.doc (top of form)
Standard IV: Member Rights and Responsibilities—FY 07–08 Document Review				
5. Advance Directives Document(s) reviewed: ◆ Foothills Behavioral Health IPN Service Authorization Request (revised September 2007) The IPN service authorization request included a check box for the provider to indicate whether the member has an advance directive. This required action has been completed.				

Table E-1—FY 06–07 Corrective Action Plan *for* FBH				
Evaluation Elements	**Required Actions**	**Planned Intervention**	**Due Date**	**# of Attachment With Evidence of Compliance**
Standard VI: Utilization Management				
4. Clinical Expertise The Contractor ensures that any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope, that is less than requested, is made by a health care professional who has appropriate clinical expertise in treating the member's condition or disease.	FBH must ensure that it follows its policies and procedures regarding decisions to deny requests for authorization of services.	FBH revised its Notice of Action letter to reflect its Policy on Prior Service Authorizations. The letter now includes the name and credentials of the individual making the authorization decision. This individual making the authorization decision will always have credentials that reflect the FBH policy requirement. **September 2007 HCPF/HSAG comments:** When submitting evidence of compliance, please submit a sample Notice of Action letter and FBH's Policy on Prior Service Authorizations.	3/1/07	VI. 4 and 7. FBH Policy Prior Service Auth.doc VI. 4 and 7. FBH Policy Routine NOA_070301.doc (see changes on pg 1, 1. a & b) VI. 4 and 7. FBH NOA Template_070301.doc (see addition bottom of pg 1)
Standard VI: Utilization Management—FY 07–08 Document Review				
4. Clinical Expertise Documents reviewed: ◆ Prior Service Authorization policy (not revised as a response to the FY 06–07 site review—policy submitted for reference) ◆ Notice of Action—Routine policy (revision March 1, 2007) ◆ Notice of Action letter template (revision March 2, 2007) The Prior Service Authorization policy stated that any decision to deny or modify a service authorization request will be made by a licensed behavioral health professional with appropriate clinical expertise in assessing and treating the member's mental health disorder. The revised Notice of Action—Routine policy stated that if the coordinator responsible for making the decision to deny or modify a service is not a licensed behavioral health professional, the case would be referred to the FBH director of utilization management for disposition. The Notice of Action letter template included a field for the staff member sending the letter to enter the name and credentials of the staff member who made the decision to deny or modify services. This required action has been completed.				

Table E-1—FY 06–07 Corrective Action Plan *for* FBH				
Evaluation Elements	**Required Actions**	**Planned Intervention**	**Due Date**	**# of Attachment With Evidence of Compliance**
7. Record Review: Denials	FBH must ensure that a Notice of Action is sent timely to the consumer and provider following a UR denial decision. In addition, FBH must ensure that it follows its policies and procedures regarding decisions to deny requests for authorization of services.	FBH revised the Routine Notice of Action Policy and Procedures to include the request of an extension when notice of action time frames cannot be met. An extension request letter template was developed for use by the Utilization Management (UM) Department. UM staff were trained on the revised policy and the use of the letter described above. **September 2007 HCPF/HSAG comments:** Please explain the steps that will be taken to meet required timelines for providing a Notice of Action. Also explain the method of tracking timeliness. The other required action involved FBH's procedures indicating that a licensed provider makes decisions regarding denials. In two cases in the record review, a certified alcohol counselor made the decision, which was inconsistent with FBH's policies. Please respond to this required action. When submitting evidence of compliance, please submit a sample Notice of Action letter and FBH's Policy on Prior Service Authorizations.	3/1/07	VI. 7. FBH NOA Report-Q1FY07.doc (example of using tracking method) VI. 7. FBH NOA Report-Q2FY07.doc (example of using tracking method) VI. 7. FBH NOA Report-Q3FY07.doc (example of using tracking method) VI. 7. FBH NOA Report-Q4FY07.doc (method of using tracking method) VI. 7. FBH NOA Reporting Template-090107.xls (method of tracking timelines) VI. 7. FBH Extension Request Template-0907.doc VI. 4 and 7. FBH Policy Prior Service Auth.doc VI. 4 and 7. FBH Policy Routine NOA_070301.doc (see change pg 1, procedures 1 a and b)

Table E-1—FY 06–07 Corrective Action Plan *for* FBH				
Evaluation Elements	**Required Actions**	**Planned Intervention**	**Due Date**	**# of Attachment With Evidence of Compliance**
				VI. 4 & 7. FBH NOA Template_070301.doc (see change bottom of letter pg 1)
Standard VI: Utilization Management—FY 07–08 Document Review				
7. Record Review: Denials Documents reviewed: ◆ Quarterly summaries of audits performed assessing timeliness and accuracy of notices of actions (Quarters 1–4 for FY 06–07) ◆ Notice of Action reporting template ◆ Prior Service Authorization policy (revision September 27, 2006) ◆ Notice of Action—Routine policy (revision March 1, 2007) ◆ Notice of Action letter template The Notice of Action reporting template demonstrated FBH's method for tracking the timeliness of notices sent. The audit reports demonstrated ongoing monitoring of the timeliness of notices sent to members served by the CMHCs as well as for members served by or requesting services from independent contractors. These required actions have been completed.				

Table E-1—FY 06–07 Corrective Action Plan *for* FBH				
Evaluation Elements	**Required Actions**	**Planned Intervention**	**Due Date**	**# of Attachment With Evidence of Compliance**
Standard X: Credentialing				
3. Content of Policies and Procedures Q. The procedure for ongoing monitoring of sanctions, complaints and adverse events (for high-volume providers).	FBH must revise the Credentialing Manual or other appropriate policies to describe ongoing monitoring for both State and federal sanctions that meet NCQA guidelines, and must implement the policies, as written.	FBH's Credentialing and Recredentialing Manual and Monitoring of Provider Performance policy were revised, adding procedures for ongoing monitoring of sanctions, complaints, and adverse events. **September 2007 HCPF/HSAG comments:** Please explain how the revised policy will be implemented and monitored.	2/7/07 and 2/15/07	X. 3. Credentialing Manual 8_3_07 rev.doc (see pg 8, Sec E) X. 3. FBH Policy Monitoring of Providers 070215.doc (see pg 2, Sec B)
Standard X: Credentialing—FY 07–08 Document Review				
3. Content of Policies and Procedures Documents reviewed: ◆ Credentialing and Recredentialing Manual (revision February 7, 2007) ◆ Monitoring of Provider Performance policy (revision February 8, 2007) The FBH Credentialing and Recredentialing Manual described the procedures for ongoing monitoring of State and federal sanctions. The Monitoring of Provider Performance policy described the responsibilities of the FBH credentialing coordinator with respect to the procedures described in the manual. These required actions have been completed.				

Appendix F. Site Review Participants for Foothills Behavioral Health, LLC

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

Table F–1—HSAG Reviewers and BHO Participants	
HSAG Review Team	**Title**
Barbara McConnell, MBA, OTR	Project Director
Diane Somerville, MSW	Associate Director (conducted telephone assessment calls)
Rachel Henrichs	Project Coordinator (conducted member interviews)
FBH Participants	**Title**
Dennis Armstrong	Director, Internal Provider Network, FBH
Mick Barrett, LMFT	Independent Provider Network, FBH
Don Bechtold, MD	Medical Director, FBH
Hazel Bond	Director of the Office of Consumer and Family Affairs, FBH
Elizabeth Carleo	Team Leader Access and Child Crisis, MHCBBC
Melvin Conley	Data Analyst, FBH
Bret Dice	Quality Improvement and Research Coordinator, FBH and MHCBBC
Peter Hine, LCSW	Internal Provider Network Clinical Care Manager, FBH
Lisa Kaplan	Utilization Management Coordinator, FBH
Wendy Kidd, LPC	Director of Utilization Management, FBH
Michael Litwin	Utilization Management Data Analyst, FBH
Toni Moon	Clinical Quality Improvement Manager, MHCBBC
Tom Olbrich	Director of Access and Emergency, JCMH
Maritza Ovalles	Credentialing Coordinator, FBH
Vicki Rodgers	Deputy Chief Operations Officer, FBH
Donald Rohner	Executive Director, FBH
Linda Runyon	Community Liaison, Office of Consumer and Family Affairs, FBH
Barbara Smith, PhD	Director of Quality Assurance and Performance Improvement, FBH
Michael Smithson	Business and Data Analyst, FBH
Sharon Stremel, PhD	Quality Improvement Coordinator, JCMH
Department Observers	**Title**
Rick Dawson	MCB Project Coordinator, Department of Health Care Policy & Financing
Sue Carrizales	Behavioral Health Policy Specialist, Department of Health Care Policy & Financing

Appendix G. Corrective Action Plan Process for FY 07–08 for Foothills Behavioral Health, LLC

FBH 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* FBH				
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 Foothills Behavioral Health, LLC

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.