



Optum Idaho Clinical Model 2.0

June 2014

Agenda

- Introductions
- Our Commitment
- Lessons Learned
- Changes to the Clinical Model
 - Care Coordination
 - Clinical Quality
 - Utilization Management
 - Service Categories
 - Grievance Process and Provider Disputes
- Using Secure Message Center on Provider Express
- Reminders: Call Back Process and Psych Testing Workflow
- Medical Necessity
- Coordination of Care
- Questions and Answers

Our Commitment to Idaho

With our shared goal of better outcomes for members, Optum's commitment to Idaho is to transform the behavioral health outpatient system of care.

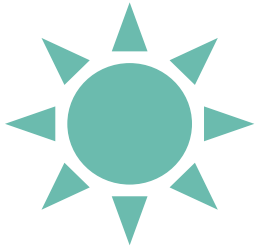
Our approach is founded on a recovery model that includes reliance on medical necessity guidelines offering the right care, at the right time and in the right place.

Lessons learned

Provider training is a key component to successful collaboration

- Calls into the care management line quickly became as much about educating providers on medical necessity as creating authorizations for services
 - These personalized interactions with providers yielded notable improvements in the clarity of the care message and increased provider understanding of the methodology for care management
- The volume of authorizations in combination with the need for provider education in the process of authorization overwhelmed the system
- We need to increase our presence in the regions to provide more high-touch support for members and providers

Clinical Model 2.0: Key Components



Field Care Coordination

- Addressing member and provider needs on a regional basis
- Increasing positive member outcomes



Clinical Quality

- Increasing quality of care accountability for system and providers
- Identifying opportunities for improvements and partnering with providers to implement changes



Utilization Management

- Building provider confidence in managed care
- Adapting levels of care to the dynamics of the Idaho behavioral health system

New Model: Reorganization, New Positions

Before: Regional Care Manager

- Completed audits
- Had oversight of Intensive Care Management cases
- Responsible for provider education

Now: Two distinct positions

Field Care Coordinators

Manager and 6 staff members

- Point of contact for members engaged with multiple providers
- Participates in treatment team meetings
- Collaborates with inpatient facilities regarding discharges and outpatient services

Provider Quality Specialists

Three staff members

- Collaborates with providers to improve the quality of services
- Conducts all audits
- Conducts education with network Providers



Field care coordination

- The Intensive Care Management (ICM) process and role have been significantly revised - we are moving out into the field with Field Care Coordinators (FCC)
 - A field care coordinator is a **pivotal link** in the communities they serve
 - They can help a member access community-based resources and develop a plan for recovery
 - As a clinician, they work with **providers and members** to improve understanding of a recovery-based model
 - A field care coordinator impacts change across the spectrum and provides the **high-touch support** we believe Idaho communities need



Focus of field care coordination

High Needs Members

- Meet with the provider and/or family members to assist with treatment plans
- Single point of contact for facilitation of care with multiple stakeholders, providers, family
- Diversion of cyclic returns to high intensity care

Inpatient (IP) Discharge

- Works with IP discharge team prior to discharge date
- Meets with member at facility to identify member's community needs
- Assists IP discharge planner to coordinate seamless transition from IP status to Outpatient (OP) care

Support System Transformation

- Identifying opportunities to address region-specific gaps in care
- Provider training on clinical best practices and system transformation
- Clinical and referral resource for providers and State stakeholders



Field care coordination allows for local community engagement

- **System Transformation:** Collaborating with Quality Improvement and Network teams to deliver technical and clinical support and education onsite with providers
- **Identifying opportunities for inpatient diversion** and addressing system of care gaps in rural and frontier areas
- Assignment of Field Care Coordinators as **clinical liaisons for regional divisions of Idaho Department of Health and Welfare (IDHW)** and our provider network

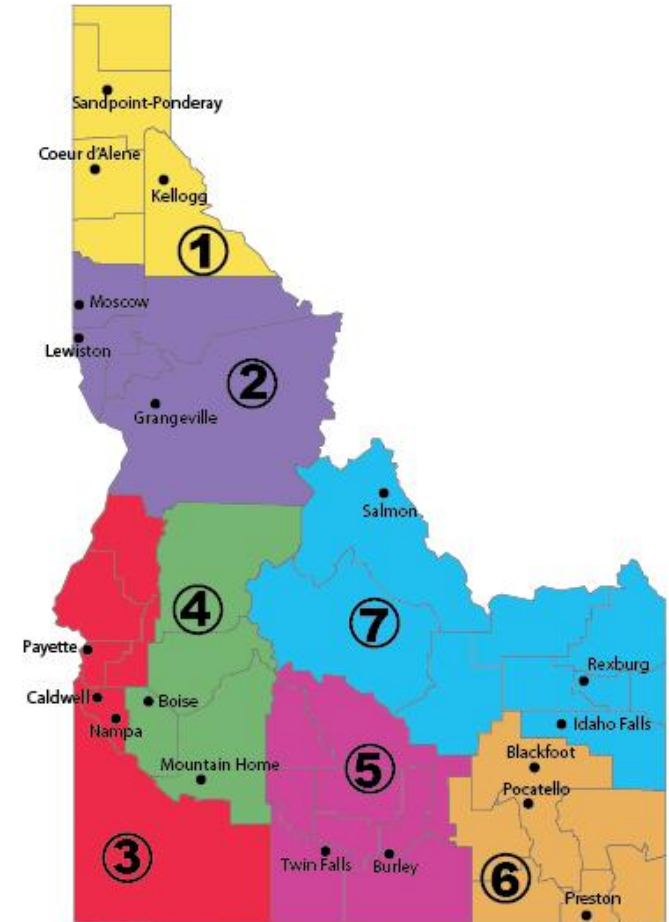


Field care coordination roles

- **Field Care Coordinator (FCC):** Dedicated and independently licensed care coordination staff in the field covering Idaho's seven regions

Responsible for:

- Intensive care coordination cases
 - Care coordination cases
 - Discharge coordination cases
- **Discharge Coordinator (DC):** will link with IDHW regional staff who assist in the discharge transition process, make referrals to FCCs, collect data from IP facilities and Idaho's inpatient utilization management vendor, Qualis Health
- **Care Coordination Manager:** independently licensed manager will have clinical and supervisory oversight of the Care Coordination program



Goals

Collaborating with Providers

- Increase the quality of the behavioral health network and the quality of care for a stronger system of care through education, audits and technical assistance
- Promote coordination of care and collaboration between network providers, PCPs and other community-based contacts

Improve Efficiencies

- Ongoing auditing and provider education will increase authorization requests that meet medical necessity criteria
- When indicated by audit findings, facilitate appropriate referrals for further review

Clinical quality

Support system transformation through ongoing Provider monitoring and education, this process promotes continual improvements to the quality of care provided to members

- Conduct clinical audits to assess documentation
 - Appropriateness of care (medical necessity)
 - Compliance with clinical standards
 - Clear indication of what services were rendered
 - When indicated based on the audit outcome, corrective action plans are requested and re-audits are conducted
- Promote the understanding and use of clinical best practices
- Use of provider training teams comprised of the Provider Quality Specialist, Field Care Coordinator, and Regional Network Manager
- Investigate quality of care issues
- Link audit data to improvement activities

Utilization Management focus

Prior Authorization Services

- Applying medical necessity standards
- Streamlining process to decrease administrative burden for providers

Supporting System Transformation

- Increase member involvement in their care and recovery journey
- Combine provider services to better meet the needs of members

Improving Outcomes for Members

- Ensuring the right care at the right time in the right place
- Measurable goals in therapy resulting in progress identified for members

Collaborating with Providers

- Build confidence in managed care process
- “We Can Do Better”
- Using treatment that works (Best Practices) results in better outcomes

Utilization management plan

What's changing effective 7/1/14:

- Moving from a telephonic to a portal based system for Category 3 prior authorization requests
- Moving some Category 3 services to a new Category (4) with relaxed prior authorization requirements
- Care Managers will now be called Care Advocates to better reflect their role within the care system

What we will continue to do:

- Adhere to the Medicaid regulation requiring a turn around time of 14 days for non-urgent requests for services
- Refine inter-rater reliability to improve consistency among the Care Advocates
- Train providers on revised processes and practice constructs

Service categories

- Category 1: No authorization required
 - Assessments
 - Medication Management

- Category 2: Open authorization required
 - Individual Therapy
 - Family Therapy
 - Group Therapy

Service categories

- Category 3: Provider specific authorization required
 - Behavioral Health Targeted Case Management
 - Substance Abuse Case Management
 - Telephonic Case Management
 - Behavioral Health
 - Substance Abuse
 - Peer Support Services (PSS)
 - Psychological and Neuropsychological Testing
 - Community Based Rehabilitation Services (CBRS)
 - Skills Training and Development, per 15 minutes; Partial Care

Service categories

- Category 4
 - Crisis Services (H2011)
 - Crisis services should be used at the time of the crisis
 - Authorization for crisis services is completed on a retrospective basis (after the crisis)
 - Treatment Plan: the following services may bill using H0032
 - Peer Support Services
 - Case Management
 - CBRS
 - Extended Office Visits
 - May be used for EMDR
 - BH Assessment (H0031, includes PECFAS/CAFAS)
 - Optum requires an updated PECFAS/CAFAS every 90 days

Service categories: Category 4 thresholds (per Member)

Crisis Services

- Threshold is 40 units per calendar year
- Additional services must be authorized
 - Retro request through utilization management (current process)
 - Address denial via dispute process

Treatment Plan

- Threshold is 16 units per calendar year
- Additional services must be authorized
 - Prior authorization process (before units run out)
 - Address denial via dispute process

Extended Office Visits

- Threshold is 12 units per calendar year
- Additional services must be authorized
 - Prior authorization process
 - Address denial via dispute process

BH Assessment

- Threshold is 4 units per calendar year (PECFAS/CAFAS); 3 units each for case management and peer support
- Additional services must be authorized
 - Prior authorization process
 - Address denial via dispute process

Grievance Process and Provider Disputes

If you receive a partial or full denial for a service, you have the right to file a grievance on behalf of the member

- In the future, the denial letter will include information on how to file the grievance (currently the letter states that if you need help you can call us)
- Your grievance needs to include the following elements
 - A cover letter indicating that you wish to file a grievance, including
 - The specific service
 - The specific date(s)/unit(s)
 - Member demographics
 - Your grievance should include any clinical documentation (progress notes, assessment, treatment plan, etc.) that supports the medical necessity of the service that you are grieving
- The grievance process is not used to dispute the payment of claims
 - For details on the dispute process, refer to the provider manual

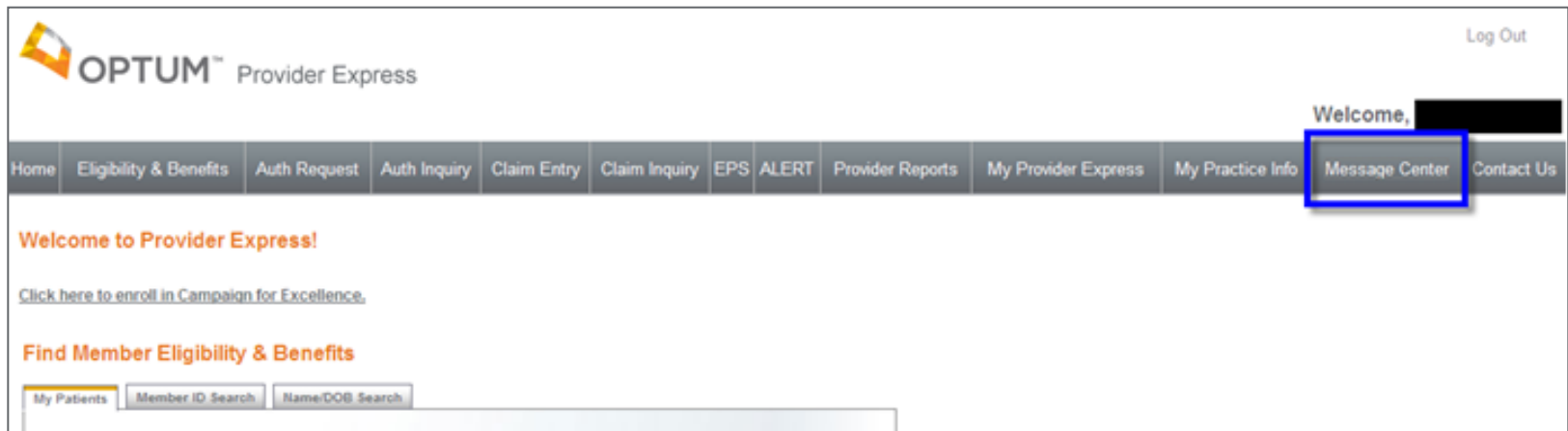
Grievance Process and Provider Disputes

- You may file a grievance related to a denied service on behalf of a member via email, fax, or mail:
 - Email: Optumidaho.appeals_grievance@optum.com
 - Fax: 855-272-7053
 - Mail: 205 E Water Tower Lane Meridian, ID 83642
- You may file a dispute related to payment via email, fax, or mail:
 - Email: optum.idaho.provider.dispute@optum.com
 - Fax: 855-272-7053
 - Mail: 205 E Water Tower Lane Meridian, ID 83642

Using Secure Message Center on Provider Express

You will be able to begin using the Message Center upon completion of this training; we expect that all providers will be using Message Center by July 1, 2014

- Provider Express registered users have access to the Message Center (as long as they are granted rights to their User ID)
- Upon logging in, you will see “Message Center” in the gray menu bar, second from the right



The screenshot displays the OPTUM Provider Express web application interface. At the top left is the OPTUM logo and the text "Provider Express". In the top right corner, there is a "Log Out" link and a "Welcome, [redacted]" message. A horizontal gray navigation menu contains several items: Home, Eligibility & Benefits, Auth Request, Auth Inquiry, Claim Entry, Claim Inquiry, EPS, ALERT, Provider Reports, My Provider Express, My Practice Info, Message Center, and Contact Us. The "Message Center" item is highlighted with a blue rectangular box. Below the navigation menu, the main content area features a "Welcome to Provider Express!" message, a link to "enroll in Campaign for Excellence", and a section titled "Find Member Eligibility & Benefits" with search buttons for "My Patients", "Member ID Search", and "Name/DOB Search".

Secure Message Center

- When you click on Message Center, a separate window pops up

The screenshot displays the OPTUM Provider Message Center interface. At the top left is the OPTUM logo and the text "Provider Message Center". At the top right, it says "Welcome, [redacted]".

Filters:

- Date Range:** From: 03/02/2014, To: 05/01/2014
- Message Folder:** Inbox, Draft, Sent
- Message Category:** All, CFE/FQM, Authorizations, Claim Inquiry, Contracting, Credentialing, Demographic Changes, Eligibility/Benefits, Network Services, Web Portal

Inbox:

Buttons: |

To create a new message click "Compose" above. To delete a message check the corresponding checkbox and click the "Delete" button.

Message Category	Date	Subject
Nothing found to display.		

Secure Message Center

Within the Provider Message Center window, there are several sections:

- Date Range (blue box) – defaults to the last 60 days, but can be changed for specific searches
- Message Folder (green) – defaults to Inbox, but you can choose any option
- Message Category (yellow) – defaults to All, but you can filter to look for specific messages
- Filter (purple) - if you change any of the above options for specific searches, you will need to click on the [Filter] button to complete the search

Note: changes made using the filter function will default back to original settings after you close the Message Center; to modify your default setting for either the message Category View or to modify the categories for which you receive Email Notification, use the Preferences feature

- Preferences (teal) – you can make permanent changes to the Message Category and to the emails you receive
- Compose (red) – click this to compose a message
- Message Center (orange) – you can view messages, delete, and to filter any of the three headings

Secure Message Center

The screenshot displays the OPTUM Provider Message Center interface. At the top left is the OPTUM logo and the text "Provider Message Center". At the top right, it says "Welcome: [redacted]".

The main content area is titled "Inbox". Below the title are two buttons: "Compose" (highlighted with a red box) and "Delete" (highlighted with a grey box). Below these buttons is a text instruction: "To create a new message click 'Compose' above. To delete a message check the corresponding checkbox and click the 'Delete' button." Below this instruction is a table with three columns: "Message Category", "Date", and "Subject". The table is currently empty, with the text "Nothing found to display." below it.

On the left side, there is a sidebar with several sections:

- Date Range:** Shows "From: 03/02/2014" and "To: 05/01/2014".
- Message Folder:** Includes radio buttons for "Inbox" (selected), "Draft", and "Sent".
- Message Category:** Includes a "Filter" button and a list of categories with checkboxes: "All", "CFE/FQM", "Authorizations" (checked), "Claim Inquiry", "Contracting", "Credentialing", "Demographic Changes", "Eligibility/Benefits", "Network Services", and "Web Portal".

Message Center: Composing and sending messages

- When you click on **Compose** on the main page, the *Compose Message* page comes up
 - Choose the “about authorization/notification” option from the *I have a question* dropdown
 - Fill in State, Subject (see template info) and type in free-form text as specified in template
- Provider Name, TIN and NPI are automatically filled in and cannot be modified
- You are required to fill in the Provider State and Subject fields. Final box is free-form to enter any text necessary
- For all authorization requests, the subject line of the request must read “Optum Idaho Authorization Request”

Please note: You cannot add/send attachments to your message

- Once message is complete, click the **Send** button (you can also **Save Draft**, or **Cancel** if needed)

Message Center: Required fields

Compose Message

| |

*All fields with * are required*

Please tell us the reason for your communication today by selecting from the following list of options:

I have a question:* ▼

Provider Name:

Tax ID:

NPI:

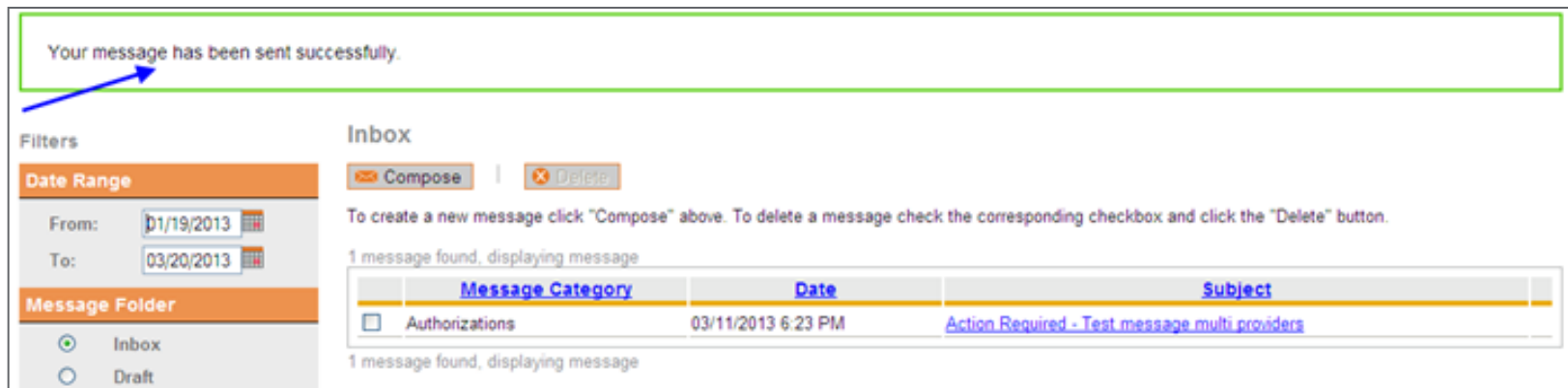
Provider State:*

Auth #:

Subject:*

Message Center: Confirmation your message was sent

- Upon sending, you will be brought back to main screen with a confirmation message



The screenshot displays a web interface with a confirmation message at the top: "Your message has been sent successfully." A blue arrow points to this message. Below the message, the interface is divided into two main sections: "Filters" and "Inbox".

Filters:

- Date Range:** From: 01/19/2013, To: 03/20/2013
- Message Folder:** Inbox, Draft

Inbox:

Compose | Delete

To create a new message click "Compose" above. To delete a message check the corresponding checkbox and click the "Delete" button.

1 message found, displaying message

	Message Category	Date	Subject
<input type="checkbox"/>	Authorizations	03/11/2013 6:23 PM	Action Required - Test message multi providers

1 message found, displaying message

Message Center: Filtering Messages

- Choose the Message Folder (e.g. *Sent*)
- Click the [Filter] button

“Sent” Example:

The screenshot displays the Message Center interface. On the left, the 'Filters' sidebar is visible. The 'Date Range' section is set to 'From: 01/16/2014' and 'To: 03/17/2014'. The 'Message Folder' section has 'Sent' selected. The 'Message Category' section has 'All' selected, and a list of categories is shown below, with 'Authorizations' checked. A blue box highlights the 'Filter' button at the bottom of the sidebar. On the right, the 'Sent' folder is open, showing a 'Compose' and 'Delete' button. Below these buttons, a message list is displayed with columns for 'Message Category', 'Date', and 'Subject'. Two messages are shown, both categorized as 'Authorizations' and dated '03/17/2014 12:30 PM' and '03/17/2014 12:18 PM', with the subject 'Optum Idaho Authorization Request'.

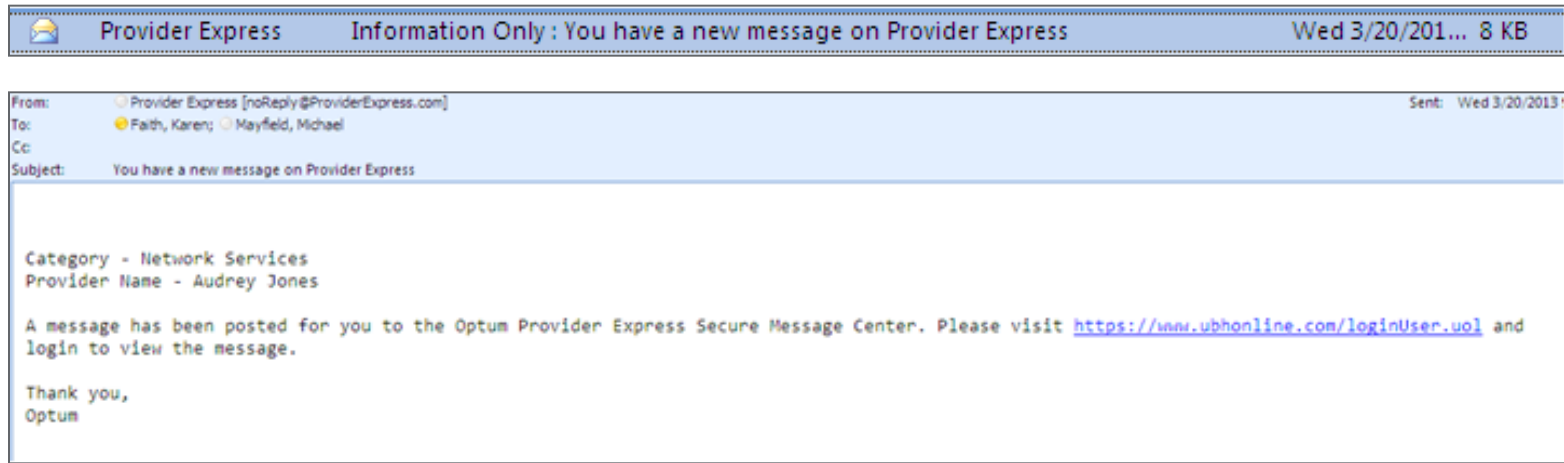
	Message Category	Date	Subject
<input type="checkbox"/>	Authorizations	03/17/2014 12:30 PM	Optum Idaho Authorization Request
<input type="checkbox"/>	Authorizations	03/17/2014 12:18 PM	Optum Idaho Authorization Request

Sent messages are pulled up. You can filter further by modifying the Date Range and/or selecting specific category(ies) before clicking the [Filter] button. To review any of the messages, simply click on the Subject line for that specific message

Message Center: Incoming message notifications

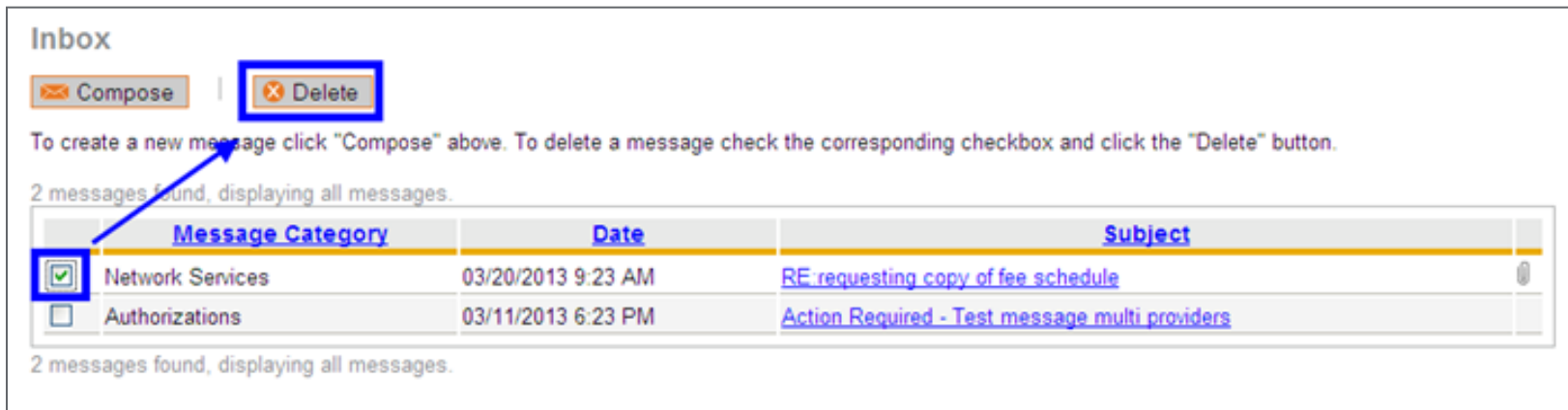
- Each individual who listed an email address upon registration of their User ID will receive an email notice that they have a new message online
- The email states that a message has been posted and provides a link to the Provider Express login page

*Please note: ALL USERS tied to the provider/group/facility that is receiving the message will receive the same email. **Any users that do not wish to receive these emails can modify their preferences.***



Message Center: Deleting messages

- Click on the box next to each message you want to delete
- Click the [Delete] button

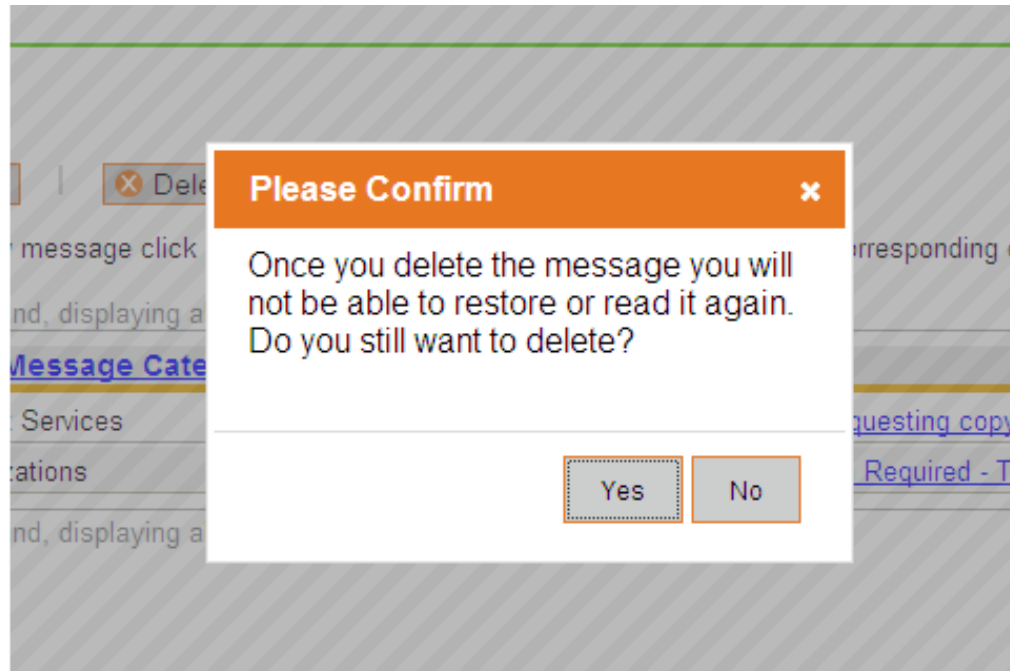


The screenshot shows an email inbox interface. At the top, there are two buttons: 'Compose' and 'Delete'. The 'Delete' button is highlighted with a blue box. Below the buttons, there is a text instruction: 'To create a new message click "Compose" above. To delete a message check the corresponding checkbox and click the "Delete" button.' Below this, it says '2 messages found, displaying all messages.' A table lists two messages. The first message, 'Network Services', has a checked checkbox in the first column. The second message, 'Authorizations', has an unchecked checkbox. A blue arrow points from the 'Delete' button to the checked checkbox. Below the table, it says '2 messages found, displaying all messages.'

	Message Category	Date	Subject	
<input checked="" type="checkbox"/>	Network Services	03/20/2013 9:23 AM	RE: requesting copy of fee schedule	
<input type="checkbox"/>	Authorizations	03/11/2013 6:23 PM	Action Required - Test message multi providers	

Message Center: Are you sure you want to delete?

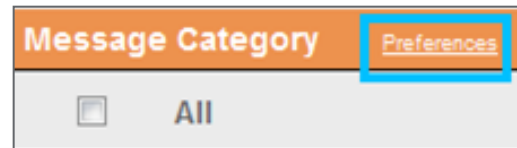
- You will receive a message to confirm that you want to delete the message(s)



- When you click “Yes,” you will receive confirmation that the message(s) has/have been deleted

Message Center: Preferences

- Each user can modify their preferences to limit the messages seen and/or emails sent to those categories related to their own work (e.g., a staff member that works with claims can modify their preferences to only see messages and receive emails specific to claims)



- Click “Preferences” in the Message Category box
 - Allows each user with a unique email address to determine which messages and/or which email notifications they receive
 - Each user can uncheck (or re-check) options and then click on the “Update my preferences” button at the bottom of that page
- *This is an important step for all users, since messages in the in-box are not specific to the user, but to the group/provider as a whole. As noted in the deletion section above, once a user deletes a message, it is deleted for all users*

Message Center: Preferences

Preferences

By updating your selections, you may not be able to see certain messages or receive email notifications even if you submit an inquiry under one of the unchecked categories.

In most cases, you will want your selection under Update Default Category View to match your selections under Update Email Notification.

Update Default Category View [What's this ?](#)

Select the Message Category you want to see (check all that apply):

- CFE/FQM
- Authorizations
- Claim Inquiry
- Contracting
- Credentialing
- Demographic Changes
- Eligibility/Benefits
- Network Services
- Web Portal

Update Email Notification [What's this ?](#)

Select the Message Category you want to receive (check all that apply):

- CFE/FQM
- Authorizations
- Claim Inquiry
- Contracting
- Credentialing
- Demographic Changes
- Eligibility/Benefits
- Network Services
- Web Portal

Message Center: Reminders and tips

- As a reminder, for all authorization requests, the subject line of the request must read “Optum Idaho Authorization Request”
- The system will time out after 30 minutes and does not automatically save your work; use the “Save Draft” option as needed
- Messages are not specific to an individual user, they are accessible by all users within the group; if a user deletes a message from the in-box, it is deleted for all users
- We recommend that your agency/group have a process to monitor who has access to the secure section of Provider Express and that the number of people who have access is limited
- We also recommend that your agency/group identify one person who will be designated to delete emails; this can help prevent accidental deletions
- If you make any edits to the authorization template (for example, changing the order of sections or deleting a section), we will return the request back to you for resubmission
- All routine requests for services have a turnaround time of 14 calendar days

Call back process

- If the clinical information submitted through Provider Express is not sufficient to make a benefit determination based on medical necessity, an Optum Idaho Team Assistant (not a clinician) will contact the provider who submitted the information in order to schedule a clinical review with a Care Advocate
 - We have added additional team assistants to the clinical team to better manage the call back volume; these staff members are not clinicians
- The clinical review will focus on collecting any additional or missing information needed to make a determination based on medical necessity

Reminders on the psych testing authorization protocol

- The authorization form to request psych/neuropsych testing is located on www.optumidaho.com on the Provider tab
 - Each of the subsections within the form are relevant to the consideration for testing hours
 - Listing specific tests and sub-components of test batteries is also important to obtain optimum authorization
 - Legibility and accuracy support timely completion of the authorization request
- Requests are faxed to

888-216-4795

This is not a direct line to the Optum Idaho office, so no other information should be faxed to this number

Medical necessity: UM Authorization Template

The utilization management (UM) template request for additional services may be submitted 2-3 weeks prior to the expiration of the existing authorization.

- Outlines review elements
- Page one
 - Provider demographic information
 - Services requested
 - Diagnostic information
 - Current medications/services
 - Coordination with other care providers
 - Other services being received
 - Recent inpatient care or legal history
 - Risk factors
- Pages two, three, and four
 - CBRS
 - Partial Care
 - Case Management

Medical necessity: UM Authorization Template

UM Authorization Template

Provider Agency:

Staff Contact:

Contact Number:

Member Name:

Medicaid Number:

Service(s) Requested:

___ CBRS ___ Partial Care ___ Case Management

Diagnosis (include 5 digit code)

Axis I:

Axis II:

Axis III:

Total PECFAS/CAFAS score:

Current medications:

Collaboration of care with primary care physician?

Current behavioral health, developmental disabilities, or school-based services:

Other service providers:

Recent psychiatric or substance abuse hospitalizations in the past year (reason for admission and dates):

Current legal history (details):

Are suicidal or homicidal ideations/actions a factor? What is the specific risk and what is the specific safety plan:

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Community Based Rehabilitation Services (CBRS) or Partial Care

1. What are the specific/detailed, current behaviors and symptoms (include triggers for current symptoms) and specific functional limitations in the following areas:
 - a. Family/Home
 - b. Vocation/Education
 - c. Legal
 - d. Social/ Community
 - e. Resource access: physical location; housing, finance, medical services, etc.
2. If participant has been in CBRS services previously, what was the frequency and duration Member received this service:
3. What improvements/setbacks has Member experienced:
4. For children, describe the parental involvement:
5. What less restrictive/invasive treatment has been tried and what was the outcome:
6. Current treatment goals for each identified functional limitation being addressed:
7. What skills and knowledge are needed for Member to achieve rehabilitation goals:
8. What is Member's motivation to engage in treatment: (action oriented; contemplative, etc.)
9. What is the Member's capacity to engage in services: age specific (demonstrated cognitive capacity to benefit from the services):
10. What is the anticipated outcome of intervention at the next review and how will this be measured:

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Medical necessity: UM Authorization Template

Community Based Rehabilitation Services (CBRS):

In an effort to expedite needed care, we will authorize 154 units of CBRS for a 90 day period if the clinical information that you have provided meets medical necessity for this member. You have the right to decline this authorization and request a call back from an Optum Care Advocate to discuss the case. This discussion will review medical necessity and your recommended treatment options.

I agree to accept the authorization of 154 units of CBRS for a 90 day period: yes or no

I would like a call back from an Optum Care Advocate to have a discussion regarding what treatment options are best for the member: yes or no

Partial Care (Adults only):

In an effort to expedite needed care, we will authorize 480 units of Partial Care for a 90 day period if the clinical information that you have provided meets medical necessity for this member. You have the right to decline this authorization and request a call back from an Optum Care Advocate to discuss the case. This discussion will review medical necessity and your recommended treatment options.

I agree to accept the authorization of 480 units of Partial Care for a 90 day period: yes or no

I would like a call back from an Optum Care Advocate to have a discussion regarding what treatment options are best for the member: yes or no

Case Management:

1. Which specific social, behavioral, or medical services does the Member need assistance to link with:
2. How often will each linkage occur, and how much time will it take to make these linkages:

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3. What is the evidence that the Member, the Member's family, or natural supports cannot make these linkages:
4. If the request is for a child, list the specifics on why a parent/guardian is unable to assist the Member with accessing community based services, utilizing behavioral health or medical care:
5. Will the Case Management service(s) duplicate any other state or federally funded services?

Case Management (CM):

In an effort to expedite needed care, we will authorize: 48 units of Case Management for a 90 day period if the clinical information that you have provided meets medical necessity for this member. You have the right to decline this authorization and request a call back from an Optum Care Advocate to discuss the case. This discussion will review medical necessity and your recommended treatment options.

I agree to accept the authorization of 48 units of CM for a 90 day period: yes or no

I would like a call back from an Optum Care Advocate to have a discussion regarding what treatment options are best for the member: yes or no

All cases are subject to a clinical review.

Should you feel more services are necessary at the close of this authorization please feel free to contact us for further discussion about this member's needs.

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Medical necessity: Treatment Record Review Tool

Key components of medical necessity

- The documentation in the treatment record includes the onset, duration, and frequency of the symptoms the member is experiencing
- The documentation in the treatment record identifies functional deficits the member is experiencing
- The documentation in the treatment record indicates how the services that are rendered will address the functional deficits
- The documentation in the treatment record indicates that a lack of treatment could result in increased impairment for the member
- The documentation in the treatment record indicates that the services the member needs cannot be effectively rendered at a lower level of care (example, a PCP office)
- The documentation in the treatment record indicates that not receiving the treatment could result in decompensation and a need for treatment at a high level of care (example, inpatient)

Coordination of care: reminders

- Optum expects all providers to obtain the member's consent to coordinate care and exchange treatment information with other treating providers and professionals involved in the member's care including, but not limited to
 - Primary care physicians and other medical professionals
 - Other treating behavioral health clinicians
 - Probation/parole officers
- If a member refuses to allow coordination of care to occur, this refusal (and the reason the member provides for the refusal) should be clearly documented
 - Providers should offer education to the member about why coordination of care is important
- Coordination of care should occur at the time of intake, during treatment, at the time of discharge, between levels of care, and at any other time that is appropriate

Coordination of care: reminders

Coordination of care improves the quality of care for members in several ways:

- Allows for the creation of a comprehensive care plan
- Allows the PCP to know that the member followed through on a behavioral health referral
- Helps to minimize potential adverse medication interactions
- Allows for better management of members with co-existing behavioral and medical disorders
- Helps promote safe and effective transition from one level of care to another
- Helps to reduce the risk of relapse

Coordination of care: reminders

The Treatment Record Review Form includes questions that relate to coordination of care:

- Evidence/documentation that coordination of care was completed
- Evidence/documentation that the member refused to allow coordination of care

Coordination of care may be documented in a variety of ways including, but not limited to:

- Documentation of case staffings between providers
- A copy of a fax or email confirmation indicating what information was shared with the other provider
- A progress note summarizing the content of a phone call with another provider

Moving Toward Success

We believe that by relying on lessons learned and provider feedback to improve the clinical model we can work together to create a system that works better for everyone including providers and the individuals and families we jointly serve.

Together we can offer the right care, at the right time and at the right place.

Questions?



Thank you for attending!