PerformCARE®
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Provider Notice

To: **HealthChoices Network Providers**

From: **Sheryl Swanson, MBA, Vice President of Network Operations**

Date: **February 6, 2012, 2012**

Subject: **AD 12 100 Common Problem Areas and Provider Performance Reports**

PerformCare is required to maintain and manage a great deal of information and it is critical that providers are our partners in this effort. With this in mind, we ask that providers pay special attention to the following areas that are commonly identified as concerns by staff at PerformCare.

PerformCare staff notates the areas identified below as they occur and will be reported back to you via regular reports through your Provider Relations Representative. This information is intended to improve communication, understanding of expectations and to increase quality for Members we jointly serve. In upcoming months, Provider Relations Representatives will be meeting more frequently with providers to review each providers performance and to provide consultation to promote improvement where needed.

The areas you will receive feedback on are listed below:

Provider did not complete discharge review within designated timeframes.

Definition: Used when the provider failed to call in to Care Management (UR) to give discharge information to the UR CCM within one day of member's discharge from PHP or IP (SA/MH).

Provider was not prepared with required information for clinical review such as:

Assessment Information
Treatment Planning
Anticipated discharge date
Recovery/Resiliency Principles
Diagnosis
Recommendations

D*efinition: Used when the provider failed to have all of the information available at the time of the continued stay review (UR) or team meeting (BHRS) for the reasons listed above.*

Provider did not follow plan of care developed by treatment team.

Definition: Used when the team comes up with a plan of action for treatment but does not follow through.

Discharging provider did not set up aftercare within 7 days of discharge from Inpatient or Partial

Definition: Used when IP & PHP levels of care discharge member without setting up aftercare within 7 days of discharge (Item 1). Used when Follow up specialists call to check on member appointment arrivals and there is either no record of the appointment or incorrect date/time of the appointment (item 2).

Provider did not set up aftercare upon discharge

Definition: Used when **FBMHS, CRR or RTF levels of care** *discharge the member without setting up aftercare appointments.*

Used By: Care Management-BHRS teams.

Provider submitted late treatment packet or request late:

Use for one of these reasons:

1. FBMHS Concurrent Reviews
2. DD Bulletin Reviews
3. Late Request Submission

Definition: Used for concurrent reviews, DD Bulletin Reviews & late request submissions. In the text box list the number of days late and the applicable # above for the specific issue it relates to.

Psychological /Psychiatric Evaluation below standards for the following reasons:

1. Evaluation not signed
2. Wording of Eval recommendation
3. QI review of eval

Definition: This entry is made related to the provider (not evaluator) since the provider is responsible for submitting the packet complete/accurately.

Provider submitted treatment plan lacking necessary information. The missing information is:

1. Assessment Information (examines symptom-free periods, member strengths, addresses all life domains)
2. Treatment Planning (goals build on quality of life, are member/family driven)
3. Anticipated discharge date and plan
4. Diagnosis

5. Recommendations build on quality of life issues in all life domains- can be part of a wellness recovery action plan (WRAP) or other recovery-type plan
6. Strengths/Assets that are incorporated into the treatment plan.
7. Identification of previous treatments that have resulted in symptom-free periods and use of those interventions incorporated into the current treatment plan.
8. Cultural preferences.
9. Objective, measurable, specific details addressing all appropriate life domains.
10. Details of the roles of the professional and family/community supports.
11. Crisis plan that is individualized

Provider did not assess SA/Dual treatment needs.

Definition: Providers should assess all members ages 10 and above via a formalized screening tool such as the AUDIT or the DAST.

Provider did not collaborate with other treating providers.

Definition: Used when a provider does not coordinate or communicate with other authorized providers, including physical health providers. This can apply to treatment team meeting invites, packet submissions, and/or CCM requests.

Provider submitted request with incomplete information including:

1. Components of request missing (essential forms or documents)
2. Required team members missing on ISPT signature sheet
3. Date of treatment plan not included
4. Identifying member information (MAID#, name, DOB, etc.)
5. Addendum used to recommend a higher level of care
6. Authorization period on POC/submission sheet/evaluation incorrect or conflicting

Definition: Used when request is submitted lacking coordination with other treatment providers; no school or outpatient feedback

Provider failed to respond to PerformCare request

Use for only one of the reasons listed below:

1. Late invite to initial RTF/CRR
2. No invite to initial RTF/CRR
3. Late invite to concurrent RTF/CRR
4. No invite to concurrent RTF/CRR
5. Request information or ask for a return call and provider does not respond

Definition: Used when a CASSP, INITIAL RTF/CRR ISPT or RTF/CRR team meeting invite is sent in less than 5 days from the date of the meeting, or when provider does not respond to a request.

If you have any questions, please do not hesitate to contact your Provider Relations Representative at 1-888-700-7370.