



JEFFERSON
BEHAVIORAL
HEALTH

Managed Mental Health Care Organization for Coos, Curry, Jackson, Josephine, and Klamath Contractor and/or subcontractor

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Delegation and Oversight Policy and Procedures

Board Approved: 11/2/09

State Approved Date goes here

JBH POLICY & PROCEDURE

Delegation and Oversight

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PART 1: JBH POLICIES ON DELEGATED ACTIVITIES:

POLICY DESCRIPTION

The purpose of this policy is to establish a consistent method in which Jefferson Behavioral Health (JBH), under its contract with the Addictions and Mental Division (AMH), reviews those activities that are delegated to a contractor and/or subcontractor providers. Such audits will be conducted on a yearly cycle and represent a valid sample of services provided to JBH members from all contractors and/or subcontractors.

This policy should serve as a standard for Jefferson Behavioral Health (JBH) staff, Provider agency staff, OHP Members and/or their Representatives, stakeholders, and regional and/or allied agencies in providing the most expeditious, most confidential, least formal, and least costly process for resolving specific concerns about any aspect of service provided by or through Jefferson Behavioral Health.

APPLICABILITY

For the purposes of this policy, the term Jefferson Behavioral Health (JBH) includes the Jefferson Behavioral Health staff and its authorized representatives. JBH shall follow this policy as it applies to the OHP mental health services governed by the Mental Health Organization Agreement between the State of Oregon and JBH. Participating Providers shall follow this policy to the extent that it applies to the mental health services that they provide to JBH Members. The responsibilities outlined in this policy shall also include, but not be limited to, the Local Mental Health Authorities (LMHA) in the JBH service area, and any agency delegated with the responsibility for managing mental health services for JBH members in the LMHA's contractor and/or subcontractor regions.

PART II: DEFINITIONS

The following key terms relate to and/or support this procedure have been included in this Section.

1. Access is the ease with which a member can enter a provider's network at the appropriate level of care. Accuracy of referral, location of services in relation to members' homes, timeliness of response to service requests, availability of services at every level of care, and the ability to serve high acuity and other difficult problems are aspects of access that are measured. Standards for

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“Emergent”, “Urgent” and “Routine” levels of acuity are monitored and reviewed by the JBH Quality Management Committee.

2. Acute care means care provided at an inpatient psychiatric facility or sub-acute facility contracted with JBH to provide acute care. Acute Care is facility based treatment provided at one of the following:
 - A Hospital certified or licensed by the State Department of Human Services under OAR 309-032-0850 through 309-32-0890, Standards for Regional Acute Care Psychiatric Services for Adults.
 - A Hospital with a hold room certified by the State Department of Human Services under OAR 309-033-0540 through 309-033-0560, Administrative Requirements for Hospitals and Non-hospital Facilities Approved to Provide Services to Persons in Custody.
 - A Hospital or Non-Hospital facility certified by the State Department of Human Services under OAR 309-033-0530, Approval of Hospitals and Non-hospital Facilities to Provide Services to Committed Persons and Persons In Custody or on Diversion.
 - A Hospital approved by the State Department of Human Services for transport holds under OAR 309-033-0550 through 309-033-0650, Standards for the Approval of Hospitals Detaining Persons in Custody Pending Transport to an Approved Holding Hospital or Non-hospital Facility, OAR 309-033-0600.
 - A Secure or Non-Secure Residential Care Facility licensed by the State Department of Human Services under OAR 309-035-0100 through 309-035-0190.
 - A Residential Treatment Home licensed by the State Department of Human Services under OAR 309-035-0250 through 309-035-0600.
 - A Child/Adolescent Residential Psychiatric Treatment Service licensed by the State Department of Human Services under OAR 309-034-0150 through 309-034-0320.

3. Advance Directive: A document that allows an individual to say in writing, ahead of time, how they would want to be treated if seriously ill or injured. The Advance Directive allows individuals to name a health care representative. The health care representative does not need to be a lawyer or health care professional but must agree in writing to represent the needs and wishes of the individual. This will allow the health care representative to work with health care providers to make decisions based on the wishes of that person if they become unable to direct their own care. The Advance Directive is only valid if voluntarily signed while the person is in sound mind. It will not expire unless the writer limits the duration. An individual may revoke their Advance Directive at any time. Even with an advance directive, individuals have the right to decide their own health care as long as they are able. Completing the Advance Directive is voluntary, if an individual chooses not to fill out and sign the Advance Directive; it will not affect their health

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plan coverage or access to care. Any changes in the Oregon law regarding Advance Directives will be reflected no later than ninety (90) days after the effective date of that change.

4. Appropriate and necessary service: are typically understood to be reflected in several criteria; that the services are necessary for treatment of the focus problem, that the services are generally professionally accepted and not considered experimental, and that the problem is likely to be responsive to those particular services. These services refer to medical, hospital or therapy services and supplies for treatment of an active mental disorder which has been established in accordance with generally accepted professional standards and approved for use by JBH's Quality Management Committee.
 - They are expected to be:
 - rendered for the treatment and diagnosis of a mental disorder as defined by the current Diagnostic and Statistical Manual of Mental Disorders appropriate for the severity of symptoms, consistent with the diagnosis, and otherwise in accordance with generally accepted medical practice and professionally recognized standards;
 - not furnished primarily for the convenience of the member, the attending physician, or other provider of service (including the provider making referral to inpatient care); and
 - furnished at the least restrictive level which may be provided safely and effectively to the member.
 - In addition, for the services to be eligible for reimbursement there must be a reasonable expectation that the condition of the member will improve or show improvement. Such an expectation would be based both on empirical evidence about efficacy of the procedure and the probability that the member's particular condition will be responsive to the procedure.
5. Case management: A clinical service focused on those individuals who are determined to need assistance with coordination of services; daily living skills; finding and maintaining housing, jobs and friends; and in some cases, a single long-term relationship with a professional caregiver or helper. Case management includes: identifying strengths and needs; identifying, brokering and linking community services and resources; assisting in obtaining entitlements; advocating on behalf of children and families; providing support and consultation to families; facilitating access to intensive services; and providing crisis planning , prevention, and intervention services.

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6. **Care Coordination:** A set of activities by which a system of care assures that every person served by the system has a single approved care or service plan that is coordinated, not duplicative and within prescribed parameters designed to assure cost effective and good outcomes. The purpose of care coordination is managing limited resources while ensuring the highest quality care possible. Care coordination includes: facilitating communication between the family, natural supports, community resources, and involved child providers and agencies; organizing, facilitating and participating in team meetings at which strengths and needs are identified and safety planning occurs; and providing for continuity of care by creating linkages to and managing transitions between levels of care and transitions for older children to the adult service system.
7. **Community Mental Health Program (CMHP):** The organization of all services for persons with mental or emotional disorders and developmental disabilities operated by, or contractually affiliated with, a LMHA, operated in a specific geographic area of the state under an intergovernmental agreement or direct contract with DHS.
8. **Client Process Monitoring System (CPMS):** DHS's client information system for community based services.
9. **Clinical Record:** The individual client service record. For the purpose of confidentiality, it is considered the medical record defined in ORS Chapter 179.
10. **Credentialing:** All programs operated directly or by subcontract must be accredited by nationally recognized organizations (e.g., Council on Accredited Rehabilitation Facilities (CARF), JCAHO and/or are certified under OAR 309-012-0130 et. seq. or licensed under ORS Chapter 443 by the State of Oregon to deliver specified Services (e.g. OAR 309-032-0525 through 309-032-0605, Standards for Adult Mental Health Services; OAR 309-032-0950 through 309-032-1080, Standards for Community Treatment Services for Children; OAR 309-032-1100 through 309-032-1230, Intensive Treatment Services; and OAR 309-032-1240 through 309-032-1305, Intensive Community Based Treatment and Support Services; and OAR 309-039-0500 through 309-039-0580, Standards for Approval of Providers of Non-Inpatient Mental Health Treatment Services).

Contractor credentialing records shall document academic degrees, licenses, certifications, and/or qualifications of Participating Providers, programs and facilities. If the Covered Service is Acute Inpatient Hospital Psychiatric Care, Contractor need not maintain Credentialing records of hospital staff but shall maintain records documenting that the facility is appropriately licensed.

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11. DHS: means the Department of Human Services established in ORS Chapter 409, including such divisions, programs and offices as may be established therein. Wherever the former Office of Medical Assistance Programs or OMAP is used in this Contract or in rule, it shall mean the Division of Medical Assistance Programs or DMAP. Wherever the former Office of Mental Health and Addiction Services or OMHAS is used in this Contract or in rule, it shall mean the Addictions and Mental Health Division or AMH. Where the former Seniors and People with Disabilities or SPD is used in this Contract or in rule, it shall mean the Seniors and People with Disabilities Division or SPD. Where the former Children, Adults and Families or CAF is used in this Contract or rule, it shall mean the Children, Adults and Families Division (CAF). Where the former Health
12. Encounter : An outpatient contact, residential, day treatment, Acute Inpatient Hospital Psychiatric Care Admission, including all Covered Services provided to an OHP Members.
13. Grievance: is an OHP Member's or OHP Member Representative's expression of dissatisfaction to Contractor or to a Participating Provider about any matter other than an Action, as "Action" is defined in this section.
14. Grievance System: refers to the overall system that includes Grievances and Appeals handled at the Contractor level and access to the State fair hearing process. (Possible subjects for Grievances include, but are not limited to, the quality of care or services provided and aspects of interpersonal relationships such as rudeness of a Provider or employee, or failure to respect the OHP Member's rights.)
15. Medically Necessary (Medical Necessity): Medically Necessary services, as defined by the American Psychiatric Association, shall mean health care services that a Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and (c) not primarily for the convenience of the patient or Physician, or other Physician, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

Services should be the most cost effective of the alternative levels of service which can be safely and effectively be provided to the child and family, as determined by the JBH UM staff or UM CERTIFICATE OF NEED team.

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16. Member: An individual found eligible by a program of the Oregon Department of Human Services (DHS) to receive health care services under the Oregon Health Plan (OHP) Medicaid Demonstration Project or State Children's Health Insurance Program (SCHIP) and who, for purposes of this policy, is assigned to JBH for mental health services.
17. Member Representative: A person who can make OHP related decisions for a Member who is not able to make such decisions him or herself. A Member Representative may be, in the following order of priority:
- A person who is designated as the Member's health care representative;
 - A court-appointed guardian, a spouse, or other family member as designated by the Member;
 - The Individual Service Plan Team (for OHP Members with developmental disabilities);
 - The DHS case manager, or other DHS designee.
 - For Members in the care or custody of DHS's Children, Adults and Families division or the Oregon Youth Authority (OYA), the Member Representative is DHS or OYA, as applicable.
 - For Members placed by DHS through a Voluntary Placement Agreement (CF Form 499), the Member shall be represented by his or her parent or legal guardian.
18. Mental Health Declaration: A document that allows an individual to state in writing their wishes for mental health care if they were in a mental health crisis or if something prevented them from making decisions about their mental health treatment. This document is completed prior to a crisis when the individual can understand and make decisions about their mental health care. This document allows an individual to name an adult representative to make decisions about their care. This person named must agree to represent the individual and must follow their wishes. If their wishes are unknown, this person must decide what the individual would want. A declaration form is only good for three (3) years. If during those three (3) years the individual becomes unable again to make their own decisions then the declaration will remain good until the individual can make their own decisions. The individual may change or cancel their declaration if they can understand and make choices about their care. The individual must give the new form to their Primary Care Physician, their mental health provider and the

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person they named to make decisions. Completing the Mental Health Declaration is voluntary, if an individual chooses not to fill out and sign the Mental Health Declaration; it will not affect their health plan coverage or access to care.

19. **Mental Health Practitioner:** An individual with current and appropriate licensure, certification, or accreditation in a mental health profession, which includes, but is not limited to: psychiatrists, psychologists, registered psychiatric nurses, Qualified Mental Health Associates, and Qualified Mental Health Professionals.
20. **Participating Provider:** An individual, facility, corporate entity, or other organization credentialed by JBH as a Provider of non-inpatient or inpatient mental health services and approved by JBH's Board of Directors as a sub-contractor to provide mental health services to JBH Members. Participating Providers must enter into a formal contract with JBH and agree to bill and/or submit encounter data in accordance with that contract.
 - For purposes of this policy, the responsibilities listed for Participating Providers shall also apply to the LMHA's in JBH's Service Area, to each of which JBH has delegated responsibility for managing non-inpatient mental health services for JBH Members in the LMHA's contractor and/or subcontractor. In this capacity, the LMHA may make service authorization and utilization management decisions that require issuance of a Notice of Action.
21. **Provider:** An organization, agency or individual licensed, certified and/or authorized by law to render professional health services to OHP Members.
22. **Quality Assessment (QA):** The measurement of both the technical and interpersonal aspects of care (process) and the outcomes of that care. As such, it is the first step in Quality Assurance and improvement. It does not move beyond problem detection and measurement (IOM 1990).
23. **Quality Assurance:** A full cycle of activities for measuring Quality of Care and maintaining it at acceptable levels.
24. **Quality Assessment/Performance Improvement (QA/PI) Plan:** A program that includes the basic elements as described in 42 CRF 438.240.
25. **Service Authorization Request:** A request from an OHP Member or Member Representative for provision of a service.

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26. Special Healthcare Needs: Those members categorized by State of Oregon Department of Human Services as Phase II as well as all foster children and those who reside in adoptive care.

27. Utilization Management: The process used to regulate the provision of services in relation to the overall Capacity of the organization and the needs of Consumers.

PART III: DELGATED ADMINSTRATIVE ACTIVITIES PROCEDURES

A. Clinical Background Checks and Credentialing checks

1. One month prior to Delegated Activities review: contractor and/or subcontractor will submit to JBH their internal policies and procedures regarding:
 - Background checks, including DHS background
 - Providers excluded from participating in Federal Healthcare Programs check.
 - Credentialing policy including primary source verification.
 - Non-discriminatory practices when hiring and compensating providers.
2. At time of delegated review: JBH staff will review personnel files of employees to ensure each file contains background checks including DHS checks, verification of employee checked against Excluded Federal Healthcare Program list and primary source verification. Contractor will also provide proof of their review of subcontractor staff, including out of area staff.

B. Encounter Data Collection and Submission

1. One month prior to Delegated Activities review: Third Party Administrator (TPA) namely PHtech will submit to JBH their internal policies and processes for quality management and quality assurance processes prior to contract renewal. Changes to policies will be sent to JBH for review as they occur.
2. At time of delegated review: JBH staff will audit TPA's FFS payments, refunds, denials, and encounter data submissions. TPA will share results of SAS 70 and other audit report with JBH along with associated actions plans. • Sub-capitated entities will reconcile capitated claims they have sent to the TPA with the response file received from the TPA. • The TPA will reconcile capitated claims received from sub-capitated entities with

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data transmitted to and received by the state. This policy will be an attachment to JBH's contract with its TPA.

C. Client Process Monitoring System (CPMS) and other required data collection systems

1. One month prior to Delegated Activities review: Contractor and/or subcontractor will submit to JBH their internal policies and procedures for ensuring timeliness of submission of CPMS data. Contractor and/or subcontractor will also be required to submit to JBH on a quarterly basis a summary report of their CPMS data submission.
2. At time of delegated review: JBH staff will audit CPMS processes against policies and review with staff quarterly CMPS reports. CPMS data will also be audited during clinical record review portion of audit.

D. Fraud and Abuse Monitoring and reporting system

1. One month prior to Delegated Activities review: Contractor and/or subcontractor will submit to JBH the following internal policies and procedures:
 - Policies that articulate JBH & Contractor's commitment to comply with all applicable Federal and state standards to guard against fraud and abuse.
 - A copy of their employee handbook with the Fraud and Abuse section for employee reference.
 - The name of the Compliance Officer and a roster of the Compliance Committee that is accountable to the senior management to monitor fraud and abuse activities.
2. At time of delegated review: JBH staff will interview the compliance officer and compliance committee that ensure that effective training and education is provided to the Compliance Officer, Compliance Committee and staff involved in the development and submission of claims. JBH will also audit a random sample of treatment records during the clinical record review, including a review of claims paid data. The purpose of this audit will be to ensure that delivery of services and payments of services align.

E. Member rights, Advance Directives and Mental Health Declaration Review

1. One month prior to Delegated Activities review: Contractor and/or subcontractor will submit to JBH their internal policies and procedures regarding:
 - Advance Directives, Mental Health Declarations and Member rights.
 - Contractor and/or subcontractor will also submit the documentation that they use as acknowledgement that the

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clients were informed of their clients' rights and offered the opportunity to complete an Advance Directive and a Mental Health Declaration. These documents must also be available in Spanish.

2. At time of delegated review: JBH staff during the chart audit will audit a random sample of treatment records to review the written acknowledgement that the client was informed of their rights and offered the opportunity to complete an Advance Directive and a Mental Health Declaration. JBH staff will also interview clinicians who provide this information to clients to gage their level of understanding of this process.

F. Provider and Staff Orientation, Education and Continuing Education review

1. One month prior to Delegated Activities review: Contractor and/or subcontractor will submit to JBH their internal policies and procedures regarding:
 - Provider staff orientation and training.
 - Contractor and/or subcontractor will also submit to JBH their employee handbook section that details how staff is trained on DHS mandatory reporting requirements including how this relates to HIPPA.
2. At time of delegated review: JBH staff will review completed staff training logs and ensure that training documentation is contained within staff personnel files.

G. Financial Data Review

1. One month prior to Delegated Activities review: Contractor and/or subcontractor will submit to JBH their internal policies and procedures regarding:
 - Submission and timeliness of financial data, including current OHP member 3rd party resources data, PEO data, quarterly statements of revenue, health care expenses by service type and annual financial analysis data.
2. At time of delegated review: JBH staff will interview financial staff members at contractor and/or subcontractor sites to review their process of providing financial data.

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H. Provision of alternate provider based on moral or religious objections of client.

1. One month prior to Delegated Activities review: Contractor and/or subcontractor will submit to JBH their internal policies and procedures regarding:
 - a. Clients' request of alternate providers based on moral or religious objections.
2. At time of delegated review: JBH staff will review a chart selected by contractor and/or subcontractor provider that documents process of a client request for provision of alternate provider.

I. Members with special healthcare needs

1. One month prior to Delegated Activities review: Contractor and/or subcontractor will submit to JBH their internal policies and procedures regarding: Phase II members, chart identifiers and documentation requirements.
2. At time of delegated review: JBH staff will review 2 charts selected by the contractor and /or subcontractor for evidence of identification of being a Phase II, contact information and communication with primary care physician or specialist. Also, documentation of allergies, physical condition and medications currently prescribed. The members' treatment plan must address the physical health care needs.

PART IV: SHARED ADMINSTRATIVE ACTIVITIES REVIEW PROCEDURES

A. QA/ QI and PIP activities review

1. One month prior to Delegated Activities review: contractor and/or subcontractor will submit to JBH their internal policies and procedures regarding:
 - QI/QA process and a roster of their QI committee
 - Also, including meeting notes for 2009.
2. At time of delegated review: JBH staff will interview designated QI representative from contractor and/or subcontractor agency to gain an understanding of the PIP process at the agency level, the internal QI process and agency specific internal QI initiatives. JBH members will also be reviewing any documentation that the QI representative that indicates their participation in the two annual PIP's.

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B. Access Data Review

1. One month prior to Delegated Activities review: contractor and/or subcontractor will submit to JBH their internal policies and procedures regarding:
 - Collection and submission of access data, including their process for the quarterly reports.
 - Contractor and/or subcontractor will also submit internal notice of action policy and will cc JBH on all notice of action letters sent to clients.
2. At time of delegated review: JBH staff will process in which this data is gathered and how contractor and/or subcontractor agencies are effectively tracking access. Also, JBH will interview staff to gage any problem areas that arise with access to services or collection of access data. JBH staff will also review log of notice of action or a log that indicates zero notice of action letters being sent.

C. Grievance System Management Review

1. One month prior to Delegated Activities review: contractor and/or subcontractor will submit to JBH their internal policies and procedures regarding:
 - Grievances and appeals.
 - Contractor and/or subcontractor will also submit the documentation that they use as acknowledgement that the clients were informed of their right to confidentially address concerns and/or denial of service, and the process for grievance procedures.
2. At time of delegated review: JBH staff will verify that copies of the information about the grievance process and related forms (OHP 3001, DMAP 3030, DHS 0443) is posted in prominent locations in each waiting room, satellite, part-time and practitioner's office. JBH staff will also view the grievance log maintained within the office JBH staff will interview designated staff that assist clients with grievances to gain an understanding of the grievance process within each office. These documents must also be available in Spanish.

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PART V: DELEGATED CLINICAL ACTIVITIES REVIEW PROCEDURES

A. Children's Services Array Activities Review

Community Mental Health Program (CMHP) Roles and Responsibilities

Community Mental Health providers may contract with certified providers to assist with any of the responsibilities listed below. Should the CMHP's use such providers, each child/adolescent authorization should note the coordinating entity.

- Authorize outpatient and intensive outpatient mental health services and communicate with JBH Children's UM staff regarding treatment.
- Conduct UM for outpatient and intensive outpatient services.
- Coordinate treatment with JBH Children's UM staff
- Provide Care Coordination to children, especially those receiving intensive outpatient or higher services, or ensure the provision of care coordination through a designated provider.
- Screen referrals and recommend to JBH Children's UM staff ICTS or higher level of care
- Meets with family to develop relationships and to identify strengths, needs, and treatment goals.
- Jointly coordinate and convene the Child and Family Team meetings with the family on an as needed basis.
- Coordinate with DHS/Child Welfare as appropriate
- Maintain case files and disseminate the Comprehensive Service Coordination Plan
- Maintain regular contact with the child, family, service providers, and representatives of other systems in which the child is involved.
- Provide or ensure appropriate case management services to include: assessing needs, identifying and coordinating services, monitoring services effectiveness, consultation, advocacy, crisis response, etc.
- Collaborate with the Child and Family team to adjust level or care to meet needs.
- Ensure the implementation of a transition plan to/from services and maintain involvement during transitions.
- Ensure the establishment of a Community Care Coordination Committee.
- Assurance of the delivery of 24/7 crisis care

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1. One month prior to Delegated Activities review: contractor and/or subcontractor will submit to JBH their internal policies and procedures regarding:
 - All of the above roles and responsibilities.
 - 7 days prior to delegated review JBH will provide to contractor and/or subcontractor a list of charts to be reviewed.
2. At time of delegated review: JBH staff will audit charts to ensure compliance with clinical delegated activities as well as OAR requirements.

B. Adult Services Array Review

Community Mental Health Program (CMHP) Roles and Responsibilities

Community Mental Health providers may contract with certified providers to assist with any of the responsibilities listed below. Should the CMHP's use such providers, each adult authorization should note the coordinating entity.

- Authorize outpatient mental health services and communicate with JBH
- Delivery of adult outpatient treatment and client case record management
- Adult UM staff regarding treatment.
- Conduct UM for outpatient services.
- Coordinate treatment with JBH Adult UM staff
- Provide Care Coordination to adults, especially the SPMI population or ensure the provision of care coordination through a designated provider.
- Ensuring clients' expectations for recovery and goals for treatment are identified as well as strengths, needs, and treatment goals are developed with client input.
- Collaboration between the Contractor and/or subcontractor providers, contracted providers, physical medicine providers, and social service providers.
- Maintain regular contact with the member, family, service providers, and representatives of other systems in which the member is involved.
- Provide or ensure appropriate case management services to include: assessing needs, identifying and coordinating services, monitoring services effectiveness, consultation, advocacy, crisis response, etc.
- Assurance of the delivery of 24/7 crisis care
- Pre-authorization of Acute Care and Sub-Acute care

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1. One month prior to Delegated Activities review: contractor and/or subcontractor will submit to JBH their internal policies and procedures regarding:
 - All of the above roles and responsibilities.
 - 7 days prior to delegated review JBH will provide to contractor and/or subcontractor a list of charts to be reviewed.
2. At time of delegated review: JBH staff will audit charts to ensure compliance with clinical delegated activities as well as OAR requirements.

C. Purpose of Audit:

1. Assure that utilization of mental health services is consistent with the treatment service needs of the Member.
2. Assure that community resources are consistently used to meet the treatment needs of the Member.
3. Assure that treatment services are provided in compliance with the Oregon Administrative Rule.
4. Assure that the services provided are in compliance with the Office of Medical Assistance Programs (OMAP) definitions.
5. Assure that services are provided in the least restrictive, most cost-effective setting addressing the clinical appropriateness and necessity of the level of care required by the Member.
6. Identify areas of training and/or technical support needed by the agency; and Identify areas of correction that an agency may need to provide a response.

D. PROCESS AND/OR PROCEDURE:

1. JBH will conduct audits at all contracted providers during delegated reviews. JBH Providers will be notified in writing 30-45 days in advance to schedule dates for the review.
2. The names of 5% or 30 Members, whichever is less, with a minimum of 20, will be selected for review. JBH will randomly select half of the Members for review and the agency will be responsible for identifying the other half. 15 of the charts must be adult (1 being a special healthcare member) 5 of the charts must be children (1 being a special healthcare member). The agency is responsible for providing their selections to JBH 7 working days prior to audit. The list of selected Members will be generated from the PH tech and may include all or any of the following:
 - Members who were enrolled within the agency prior to the current service year and are still in service;

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- Members who were enrolled after the current service year began;
- Members who have been closed/terminated by the agency during the current service year.

Once the review process is complete, JBH will follow the steps for oversight, monitoring and performance (Part VI)

PART VI: OVERSIGHT, MONITORING AND PERFORMANCE.

When a provider fails to meet a performance expectation, including but not limited to contract compliance issue, Quality Management Committee (QMC) requirement, and data submission:

PRINCIPLES:

JBH representatives requesting information need to make the process user friendly. Complex data requests should be designed with input from the people responsible for responding.

Notification to providers and an opportunity for problem solving and assistance to the provider should be incorporated at every stage of this process. All steps should be documented. Grievance procedures are outlined in the contract signed by the JBH and provider organizations.

STEP 1: The provider is contacted by someone authorized by JBH with responsibility for the specific task, who can explore with them what difficulty they are having, problem solve and offer technical assistance (TA), and set new timelines if needed. Information gathered can be used to improve the process.

STEP 2: An inadequate response from the provider results in a report to the Quality Management Coordinator who can review whether the problem is related to the request and is affecting a number of providers, or if it seems related to specific provider difficulties. If the latter, a written work plan details the expected corrective action. In either case, the Quality Management Coordinator takes a “provider relations”, technical assistance role in attempting to assist the provider in solving the difficulty.

STEP 3: The Quality Management Coordinator regularly reports such TA efforts and their results to the Executive Director, and documents unresolved problems. Problems specific to a particular provider which are to be so reported are documented in the provider's re-credentialing file and copied to the executive of the provider organization.

STEP 4: Non-compliance or failure to perform according to JBH standards is reported by QMC to the Advisory Council along with the Executive Director's recommendation for actions which may:

- Limit a provider's scope of practice,

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- Require timely compliance with standards with an accompanying monitoring plan, or
- Otherwise modify a provider's status.

STEP 5: Formal written notice with time frames for required action is given to the provider organization's governing body prior to Step 6.

STEP 6: A recommendation for termination of provider status would be made by the Quality Management Committee through the Executive Director. The Executive Director will coordinate recommendations and actions with the Board of Directors. Any termination process will follow the terms of the contract between the JBH and the provider organization.