

# **BEHAVIORAL HEALTH CONNECTICUT, LLC**

## **2003 Care Management Program**

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## **BEHAVIORAL HEALTH CONNECTICUT, LLC**

### **2003 CARE MANAGEMENT PROGRAM**

**I. PURPOSE:** The purpose of Behavioral Health Connecticut, LLC's (BHC) Care Management Program is to coordinate and facilitate access to quality care through the entire continuum by ensuring that medically necessary services are delivered by licensed professional providers in the most appropriate setting. BHC utilizes a dynamic process to continuously monitor, evaluate, improve, and promote quality behavioral healthcare services.

### **II. OBJECTIVES:**

1. To ensure compliance with care management and quality improvement policies and procedures, state and federal utilization review laws and regulations.
2. To demonstrate improvements in the care rendered by network providers through the oversight, monitoring and review of behavioral healthcare services delivered.
3. To facilitate positive clinical outcomes as a result of the management of care across the entire continuum and the integration of quality management activities.
4. To ensure continued current relevancy of clinical criteria, thereby eliminating the potential for under/over utilization.
5. To improve customer satisfaction by incorporating feedback from patients and providers.
6. To maintain the confidentiality of data relating to members and providers.
7. To ensure that compensation plans for individuals who provide utilization services and conduct reviews do not, directly or indirectly, contain incentives.

### **III. ORGANIZATIONAL STRUCTURE**

**A. Accountability of Governing Body: The Management Committee** is BHC's governing body and is comprised of representatives of the health care institutions and ambulatory provider organizations that own BHC. This committee meets on a quarterly basis in addition to special meetings, as necessary. The Management Committee delegates responsibility for clinical matters to the BHC Medical Director. The Medical Director, in collaboration with the Director of Clinical Operations and care management staff, ensures quality patient care.

The BHC clinical staff is compensated solely on a salaried basis with no incentives or individual bonuses. Care Management decision making is based solely on the appropriateness of care and service. BHC does not reward practitioners or other individuals conducting reviews for issuing denials of coverage or service.

**Performance Improvement/Utilization Management (PI/UM) Committee:** The Management Committee has established the PI/UM Committee to ensure the delivery of quality care and service to members. This committee is responsible for the ongoing development of a dynamic care management process, with specific goals and objectives designed to improve the quality of care. Membership is comprised of internal staff as follows: Medical Director, Director of Clinical Operations, Manager of Care

Management, and Quality Specialists, as well as, representatives from network facilities and ambulatory network providers. This committee meets on a quarterly basis with special ad hoc meetings, as necessary.

Performance Improvement/Utilization Management Committee carry out the following activities related to care management:

- *To review and advise on clinical issues including, but not limited to utilization of services, quality of care and service, quality improvement activities, practice guidelines, and medical necessity criteria.*
- *To review and advise on the annual Quality Improvement Work Plan, selected indicators, quality improvement, and preventive health activities.*
- *To review and advise on provider issues including, but not limited to profiling and communications.*
- *To review and advise on clinical policies.*

### **Roles and Responsibilities of Key Staff:**

#### **Medical Director**

- *Ensures that the continued development of the Care Management Program reflects the organization's goals and objectives.*
- *Oversees the quality and effectiveness of behavioral healthcare services provided.*
- *Responsible for the overall quality and effectiveness of the Care Management Program.*
- *Coordinates the process for upper level clinical reviews, assuring that denials are rendered by board certified psychiatrists or psychologists from appropriate specialty areas.*
- *Provides clinical supervision/consultation to the Director of Clinical Operations and the Care Managers.*

#### **Director of Clinical Operations**

- *Ensures compliance with all Care Management Program policies, procedures, and requirements.*
- *Ensures compliance with federal and state statutes and regulations governing managed care, utilization management, and related activities.*
- *Ensures compliance with care management and other related requirements of Managed Care Organizations (MCOs) with which BHC contracts.*
- *Supervises referral and triage processes, ensuring compliance with BHC policies, procedures, and standards.*
- *Directs implementation of NCQA Standards throughout all departments.*
- *Ensures that participation in QI activities is included in every staff member's job function.*
- *Responsible for coordinating and overseeing training of internal staff and network providers related to care management processes and requirements.*
- *Prepares all necessary documentation for annual audits for delegated arrangements.*
- *Produces annual Care Management Program Description and Evaluation documents.*

- *Responsible for the ongoing professional relations between BHC and providers.*

### **Manager of Care Management**

- *Monitors compliance by care managers with all Care Management Program policies, procedures, and requirements*
- *Monitors over and under utilization*
- *Monitors utilization trends*
- *Oversees the high risk case management program*
- *Oversees care management case load assignments*
- *Assists care managers to resolve UM issues*
- *Reviews all proposed denials*
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### **Quality Management Specialists**

- *Assist in the development of quality improvement programs including clinical and service quality improvement activities.*
- *Assist in the development of and monitor QI indicators.*
- *Coordinate reporting processes and follow-up among departments.*
- *Develop collaborative projects with MCOs related to the coordination of medical and behavioral healthcare.*
- *Responsible for ensuring the implementation and documentation of PI/UM committee meetings.*
- *Oversee BHC complaint system and follow-up.*

### **Care Managers**

- *Render level of care determinations to ensure that care is provided in the most appropriate and least restrictive setting.*
- *Ensure that cases are triaged to the appropriate provider according to triage protocols for level of urgency.*
- *Apply high-risk indicators for the determination of inclusion in the high-risk case management program.*
- *Refer all cases not meeting clinical criteria to the Medical Director or designee.*
- *Responsible for ensuring compliance with BHC Care Management policies and procedures, NCQA UM standards, HCFA requirements, Connecticut UR licensure standards, and all other regulatory agencies, as applicable.*

**D. Open Dialogue:** BHC does not place restrictions on open dialogue between providers and their patients. Providers are free to discuss all treatment options, regardless of costs or coverage and may advocate on behalf of their patients or file complaints with BHC, MCOs, or government agencies about practices, which are believed to affect the quality of care or services.

**E. Confidentiality:** Documents created as part of the UM process are confidential and are maintained in compliance with legal requirements and accrediting standards. All staff with access to these records are required to review the confidentiality policy and signify, in writing, an understanding of this policy.

**Confidential documents include but are not limited to:**

- *Data, reports, or other information (electronic, hard copy, or verbal) that identify an individual patient, provider or reviewer.*
- *Reports and recommendations relative to care management processes.*
- *Proprietary work product documents, data, and reports.*
- *Care management proceedings, including discussions and communications authorized by the PI/UM Committee (review notes and meeting minutes).*

**F. Policies and Procedures:** The Director of Clinical Operations, in consultation with the Medical Director and PI/UM Committee, is responsible for the development of written policies and procedures that govern daily operations. Final approval is the responsibility of the Management Committee to ensure that the Care Management process is fully integrated into the Quality Improvement Program.

**IV. PROGRAM SCOPE:**

**A. Telephone Access:** BHC maintains toll-free access lines, which link members and providers to clinical and administrative resources, services, and programs. The toll-free numbers are staffed 24 hours a day, seven days a week by clinical reviewers. Care managers are available during business hours for triage, referral and authorization of all clinical services, as well as after hours for emergent and urgent triage and authorization.

**B. Levels of Care:** BHC manages the medical necessity and appropriateness for all settings and levels within the behavioral health continuum of care. Clinical criteria are structured on levels of care and are utilized in all review determinations. BHC works with providers, as needed, to design tailored treatment plans for patients through the use of alternative levels of care and treatment modalities as provided under the member's health benefit plan. Levels of care include:

- *Acute Inpatient*
- *Observation/Holding Bed*
- *Residential*
- *Partial Hospitalization*
- *Intensive Outpatient*
- *ECT*
- *Office-Based Traditional Outpatient Services*

**C. Medical Necessity:** BHC determines the medical necessity of services requested and/or provided during the review process. Medical necessity is defined as services which are:

- *Intended to identify or treat a diagnosable disorder that causes pain or suffering, threatens life, or results in illness, as defined in the DSM IV, manifested by impairment in functioning.*
- *Consistent with nationally accepted standards of medical practice.*
- *Individualized, specific, and consistent with the individual's signs, symptoms, history, and diagnosis.*
- *Reasonably expected to help restore or maintain the individual's health or to improve or prevent deterioration in the individual's diagnosable disorder.*
- *Not primarily for the convenience of the individual, provider, or another party.*
- *Provided in the least restrictive setting that balances safety, effectiveness and efficiency.*

**D. Clinical Criteria:** BHC utilizes written clinical criteria to review and determine the appropriateness of the levels of care and the services requested for both psychiatric and chemical dependency cases. References include the Practice Guidelines developed by the American Psychiatric Association. For determinations of levels of care pertaining to chemical dependency services, BHC has adopted criteria from the American Society of Addiction Medicine Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition. The psychiatric criteria were developed internally after a literature search and consultation with the PI/UM Committee. These criteria are used in the determination of all review decisions unless otherwise directed by the MCO. The criteria are reviewed and updated annually to comply with current and accepted standards of care. Final authority for the approval and adoption of the clinical criteria is the responsibility of the Management Committee. Review criteria are made available to providers upon request and are also maintained on BHC's web site.

**E. Practice Guidelines:** BHC recognizes the need to promote best practices among its practitioners while at the same time partnering with them to create individually tailored treatment plans. BHC disseminates practice guidelines to providers based upon population needs, such as high risk and/or high volume diagnoses and services. Since depressive disorders rank as the highest volume diagnostic grouping, a guideline was adopted related to the management of these disorders. Guidelines are reviewed biennially by the PI/UM Committee. The Management Committee has final authority for the approval and adoption of practice guidelines.

**F. Care Management Review Process:** Early assessment and intervention at the most appropriate level of care, and the application of clinical criteria meeting current treatment standards, ensure that medically necessary care is delivered in the most appropriate setting. The review process encompasses the following elements resulting in reviews, which are consistent, objective, and utilize sound clinical judgement:

- *Reviews are conducted by licensed and experienced care managers and/or practitioners.*
- *Denials are rendered by board-certified psychiatrists.*

- *Review decisions are based on consistent relevant clinical information.*
- *Reviewers apply adopted clinical criteria.*
- *Reviewers document rationale and criteria application.*
- *Reviewers follow standards for review timeliness.*
- *Members are assisted with transition when benefits end.*

**G. Relevant Clinical Information:** Minimum requirements for the collection of the clinical information necessary to conduct a review at a specific level of care and setting are included in BHC’s policies and procedures. This information is captured in standardized screens or “Authorization Events” contained within eCura, BHC’s clinical software system. Care management determinations are made only when complete clinical information is available, unless BHC has communicated, in writing, the specific information needed to properly conduct the review. Providers are given a reasonable opportunity to submit the necessary information.

**H. Timeframes for Review Decisions:** BHC has implemented timeliness standards for review determinations that are in compliance with NCQA and state statutes and regulations. Response times are measured from receipt of all information necessary to conduct the review.

<i><b>Urgent Precertification</b></i>	1 Calendar Day
<i><b>Non-Urgent Precertification</b></i>	1 Business Day
<i><b>Continued Stay Review</b></i>	1 Business Day
<i><b>Expedited Continued Stay Review</b></i>	3 Hours (if received 8:00 a.m. – 6:00 p.m.)
<i><b>Outpatient Treatment Review</b></i>	2 Business Days
<i><b>Retrospective Review</b></i>	30 Calendar Days

**V. CARE MANAGEMENT ACTIVITIES:**

**A. Triage and Referral:** BHC maintains a toll-free member access telephone line available 24 hours/7 days a week. During normal business hours, Monday through Friday from 8:00 a.m. to 4:30 p.m., all calls to the access line are answered by intake personnel who are trained to answer administrative inquiries and refer clinical calls to a BHC Care Manager who assesses the level of urgency of caller’s needs and triages appropriately. After hour calls to the access telephone line are answered directly by on site Care Managers at the IOL Assessment Center, with clinical back up from the BHC Medical Director or designee. Callers with administrative questions (*e.g. claims payment, benefits*) receive a follow-up call during the next business day. BHC utilizes the following definitions for emergent, urgent and routine:

- ***Emergent** appointments occur in response to thoughts or feelings that are intolerable to the patient, or behavior that prompts urgent action by others, such as violent or self injurious behavior, threats of harm to self or others, failure to care for oneself, deterioration of mental status, bizarre or confused behavior or intense expression of distress.*

- ***Urgent** appointments are those in which the patient’s ability to contract for the safety of himself or others may be time-limited, when the severity or nature of presenting symptoms is intolerable, but not life threatening to the patient, or in response to a catastrophic life event.*
- ***Routine** appointments are those in which the patient presents in no immediate distress and can wait to schedule an appointment without any adverse outcomes.*

BHC uses the following appointment access standards in accordance with NCQA. Providers are expected to make best efforts to meet these appointment timeliness standards for all members.

<i><b>Life-threatening Emergency</b></i>	Member is seen <b>immediately</b>
<i><b>Non Life-threatening Emergency</b></i>	Member is seen <b>within 6 hours</b>
<i><b>Urgent Situation</b></i>	Member is seen <b>within 48 hours</b>
<i><b>Routine Situation</b></i>	Appointment is offered <b>within 10 days</b>

Intake staff determine the caller’s needs utilizing specific scripted questions related to the request for a referral. Any call requiring clinical judgment is immediately transferred to a Care Manager. The Care Manager conducts a risk assessment and utilizes the following criteria in facilitating a referral:

- *Nature and severity of presenting problem(s)*
- *History*
- *Patient preferences and special needs (e.g. bilingual)*
- *Geographic accessibility*
- *Provider’s clinical competency in a particular area*
- *Provider availability*
- *Provider’s cultural competency*

**B. Admission Review:** All admissions to inpatient, partial hospital, residential treatment facilities, respite, intensive outpatient programs, and ambulatory crisis services (*detoxification, ECT*) must be prior authorized and are subject to continued stay review. This process allows BHC the opportunity to identify possible high risk and/or chronic patients for focused case management and possibly redirect care when appropriate, to an alternative level.

All admission reviews are conducted telephonically by care managers. Written clinical criteria are utilized to evaluate the proposed treatment plan to determine if the requested services are customary for diagnosis and provided at the most appropriate level of care. Cases where clinical indications are unclear or where medical necessity is not met are referred to the Medical Director or designee. Providers and members are notified of review outcomes, within established timeframes, unless a sooner response is required by law. Written confirmation letters of all admission determinations are mailed to providers and members.

Emergent conditions requiring immediate hospitalization may be certified up to 24 hours following the admission/procedure (*or upon notification if mandated by statute*) and are eligible for continued stay review on a concurrent basis. A behavioral health emergency is defined as a condition that manifests suddenly with severe symptoms, poses imminent or serious harm to oneself or others, and is recognized by a prudent layperson as a condition that requires immediate medical attention. If the member's situation is a life-threatening emergency and the member is not already in an emergency room, he/she is referred to the nearest emergency room.

D. **C. Continued Stay Review:** Continued stay reviews are conducted telephonically or via facsimile by care managers at regular intervals throughout the period of hospitalization. Determinations are based on medical necessity criteria, consideration of the severity and complexity of the patient's symptoms, and progress in meeting treatment goals. Cases where clinical indications are unclear or where medical necessity is not met, are referred to the Medical Director or designee. Each review is concluded prior to the expiration of the current certification and the provider is informed of the review. Adverse determinations are confirmed, in writing, to the provider and the member, within established timeframes.

**D. Discharge Planning:** The care manager, provider and patient coordinate discharge planning after the initial treatment assessment is performed. Discharge planning focuses on establishing the next appropriate level of care that will enable the patient to return to his/her maximum level of functioning. The following areas are evaluated according the patient's situation: (1) Appropriateness of transition to a clinically appropriate, less intensive level of care; (2) Aftercare treatment plan, including record of first follow-up appointment; (3) Availability of social support network; and (4) Availability of community-based resources to adjunct social support network and aftercare treatment.

**E. Outpatient Treatment Review:** In-network and out-of-network providers are required to submit an Outpatient Treatment Report (OTR) in order to receive authorization for outpatient visits in excess of the number allowed at the time of initial registration. The OTR is reviewed for medical necessity and appropriateness of care according to clinical criteria by a care manager, who authorizes a specific number of sessions within a specified treatment period. If care cannot be authorized by the care manager, the case is referred to the Medical Director or designee. Determination letters are sent to the provider and member, within established timeframes. Additional sessions require submission of an updated OTR.

**F. Retrospective Review:** Retrospective reviews occur when BHC receives a request for authorization of care already rendered. Such reviews follow the same procedures used by BHC for prospective and concurrent reviews, except that determinations are made, in writing, to the provider and the member within 30 days of receipt of all necessary information.

**G. Out of Network Services:** Behavioral healthcare services provided by non-participating providers are subject to BHC's standard care management review process and UM standards, and are dependent on the member's plan of benefits. If the member's

plan of benefit does not include a provision for out-of-network care, an exception will be made in the following cases:

- *Emergent care.*
- *Services that are medically necessary, but are not currently or readily available in the existing network.*

The admission, concurrent review and/or outpatient treatment plan protocols will apply to all out-of-network care.

**H. High Risk Case Management:** BHC utilizes High Risk Case Management as a mechanism to facilitate the planning and coordination of care for individuals who have a complex or chronic illness and/or medical comorbidity. Close monitoring and appropriate perspective clinical interventions decrease the number of serious acute episodes of care.

Diversionary strategies and alternative levels of care are initiated while patient status and compliance are tracked during periods other than acute phases of illness. High-risk cases are defined by the following indicators:

- *Members hospitalized two or more times in one year.*
- *Dual diagnosis.*
- *Readmission to inpatient treatment within 30 days after an inpatient stay.*
- *Medical condition(s) which may impact treatment of a behavioral health diagnosis.*
- *History of violence for suicide attempts.*
- *History of treatment failure and/or non-compliance with D/C aftercare treatment recommendations.*
- *Inadequate support system to assist and sustain treatment at the least restrictive and most appropriate level of care.*

**I. Denials:** The Medical Director or designee reviews all potential denials of clinical services. For intensive levels of service, a telephone discussion of the case occurs between the BHC Medical Director or designee and the treating provider. In many cases, an alternative level of care arrangement is negotiated in lieu of a denial of care. All adverse determinations are communicated, in writing, to the provider and member within established timeframes and include denial reasons, clinical rationale, and appeal information. All denials are tracked, trended, and reported to the PI/UM Committee.

**J. Appeals:** In arrangement where BHC has not been delegated appeal processing by MCOs, BHC's role is to direct the member/provider back to the MCO for any information related to the appeals process. BHC forwards any information, related to the case, to the MCO and in some instances the BHC Medical Director or designee may be asked to conduct a review of additional information submitted to the MCO. Clinical determinations rendered by the MCO are reviewed and tracked by the BHC PI/UM Committee. In arrangements where BHC has been delegated the appeals process, established policies and procedures are followed.

**K. Coordination of Care:** BHC has established procedures to ensure that behavioral healthcare services, provided to its members, are coordinated and integrated with members' general medical care. BHC will assist members in obtaining necessary services and follow-up medical treatment as needed to provide continuity and coordination of care. BHC providers assess members for possible coexisting medical conditions, and with written patient consent, exchange information with members' primary care physicians. BHC audits treatment records for documentation of communication and coordination.

At the initial intake visit, the provider requests patient or guardian permission, in the form of written consent, to release information pertaining to the patient's mental health and/or substance abuse to the designated primary care physician in order to facilitate the coordination of care. With patient consent, the provider sends a form to the primary care physician with the following information:

- *Patient's diagnosis.*
- *Notice that the patient is receiving behavioral healthcare services.*
- *Name and telephone number of the primary therapist.*
- *Instructions on how to request additional information from the primary therapist.*
- *A request for communication of any pre-existing or co-existing medical conditions that may impact upon the patient's current course of treatment, including reactions to prescribed medication.*

Care management policies and procedures, for the coordination of behavioral and medical care, detail the collaboration among care managers within these domains. Process steps include assigning responsibility for initiating the coordination of care to the care manager who was initially involved with the case. If a transfer from medical to behavioral health, or vice versa occurs, the initial care manager does not close the case until the succeeding care manager has assumed responsibility for the patient, and the attending physician and patient/family are aware of the transfer. BHC audits authorization files for these cases to determine the documentation of this transfer of care between Care Managers.

**VI. INTERFACE WITH QUALITY IMPROVEMENT:** BHC's Performance Improvement Program facilitates the provision of quality, efficient behavioral health services to patients and providers through monitoring, evaluating, and influencing the

processes and behaviors which impact the delivery of care and services. Care Management functions are integrated with other functional areas through the Performance Improvement/Utilization Management (PI/UM) Committee. The PI/UM Committee is comprised of management and staff personnel drawn from each functional service area, as well as, multidisciplinary network providers. The PI/UM Committee is responsible for providing direction, support, and resources for all quality improvement projects.

Network practitioner and facility representation ensure that expert provider input is utilized in the design, implementation, and evaluation of all clinical activities. Key performance indicators are monitored in all operational areas. Indicator statements are prepared which clearly delineate how the organization measures performance for a particular service type. The statement includes: the type of data that is collected, method for measuring the data, frequency of the measurements, and why the measurements are relevant to the member population. Monitoring of performance indicators is incorporated into the annual work plan of quality improvement activities.

BHC supports the need for quality activities that measure outcomes. Each department or functional area selects outcome indicators and presents them to the PI/UM Committee for review and approval, along with an intended action plan, if needed. Subsequent reports include the data for that reporting cycle and also previous data for comparative purposes. Quality of service, within the care management department, is measured through an audit process, which measures reviewer consistency, quality of documentation and timeliness of the review. Other monitors include complaint tracking and information obtained from member and provider satisfaction surveys.

BHC conducts the following outcome studies through the HEDIS Behavioral Effectiveness of Care Measures:

- *Follow-up After Discharge for a Psychiatric Diagnosis:* This program supports the HEDIS effectiveness of care measure for follow-up visits after hospitalization. All patients hospitalized with a psychiatric disorder should have a follow-up visit within 7 days of discharge. BHC care managers work with participating facilities and practitioners to ensure that the patient has an appointment before he/she is discharged.
- *Depression Education Program/Antidepressant Medication Management:* This program supports the HEDIS effectiveness of care measure for antidepressant medication management. Patients newly diagnosed with depression should remain on the medication for a minimum of 6 months. In addition, these patients should be seen for at least 3 medication management visits during the acute treatment period. BHC works with the MCO in developing interventions to educate providers and members about the importance of adequate medication management for those patients diagnosed with depression and started on antidepressant medication.

Quality activities, regarding care management, include clinical reviewer audits, trending of utilization patterns, rates of provider and member satisfaction with the care

management process, and compliance with the goals of the various quality improvement initiatives.

**A. Care Manager Audits:** Audits of care manager activities are conducted quarterly for timeliness of reviews, consistency of decisions and adequacy of documentation. Cases are also discussed in weekly clinical rounds with the Medical Director and Director of Clinical Operations. An improvement plan is implemented for any care manager who does not meet the established standards.

**B. Treatment Record Reviews:** BHC has adopted the NCQA Treatment Record Review Guidelines and conducts treatment record reviews of high volume practitioners. Results from these reviews incorporated in to provider profiles and results shared with providers on an individual and on an aggregate basis.

Results from these reviews incorporated in to provider profiles and results shared with providers on an individual and on an aggregate basis.

**C. Provider Satisfaction Survey:** Provider satisfaction with BHC is measured on an annual basis and specifically measures various aspects of providers' satisfaction with the care management process. All results are reported to the PI/UM Committee and are used to incorporate changes into daily operations, as well as, more global programs and initiatives.

**D. Member Satisfaction Survey:** Member satisfaction surveys are conducted in coordination with the Management Care Organizations (MCOs). BHC will be implementing its first Member Satisfaction Survey during first quarter 2003 to those members who received services during 2002. Results will be analyzed, trended and reported to the PI/UM Improvement Committee where improvement activities are developed and initiated. The survey process will be repeated on an annual basis.

**VII. PROGRAM EVALUATION:** The Care Management Program will be reviewed and evaluated annually by the PI/UM Committee. Recommendations for revisions will be directed to the Management Committee for final approval. All other activities will be evaluated as they occur by the PI/UM Committee for relevancy and effectiveness. Changes will be made, as necessary. When operating under delegated UM from another contracted organization, the annual written evaluation of the above data will be reviewed by the delegating entity.