DEPARTMENT OF STATE HEALTH SERVICES

OUTREACH, SCREENING, ASSESSMENT, REFERRAL

OSAR QUESTIONS AND ANSWERS

BHIPS OPERATION QUESTIONS

1. Wait list management: **The OSAR now has a centralized waitlist that is different from the traditional wait list for treatment providers. Not only can OSARs see clients they place on their wait list, they can also see clients a provider has put on its wait list when the clients have given the OSAR consent to see.**

2. A provider asked "when you click on the response button on a referral (in BHIPS), where does it go?" **Clicking the Response button on a Referral takes you to the Referral Response screen. After completing the referral response, the responder may need to save a consent form for the business entity receiving the response. Once a consent form is saved and the response is sent, the Referral Response can be accessed one of two ways. The response receiver may go to the client's Activity List and see the response, or if the user is designated as an Intake Coordinator for their business entity, they can look up responses (and referrals) on the new Referral List screen located in the Business Office. Please note: the user must have the Intake Coordinator role to access the Referral List. There may be one or more Intake Coordinators assigned to a single business entity.**

3. When looking for a client; why will the entity numbers not cross reference? I was under the understanding that our entity numbers would roll over to the next fiscal year? **Assumption: The question is about non-treatment programs (clinics).**

For the past two years there has been functionality in the BHIPS to attach (or group) like programs into one business entity. This is so clients and programs are accessible across fiscal years. You must use the Attach Program functionality to add new program years to a program group or create another program group for new program types and attach programs to it.

4. Spell check does not work. **It is possible that spell check was not connected to the training system at the time of training. However, it should be connected to the production system at all times. If it is not, please call the Help Line pagers and report the problem.**

5. How many characters can be typed in justification areas? **The number of characters is unlimited for most text fields. However, there are a few text fields limited to 255 characters.**

6. What do you want us to do if we had to leave an assessment incomplete? **Whenever possible, the expectation is that OSARs will complete assessments on clients to determine the appropriate level of service. There is a field on the General section of the assessment called Reason Incomplete. The assessment must be completed before a referral (other than detox or other crises services) can be made.**

7. What if we discover that a client has two entries in BHIPS? **Currently the only way to repair this is to print out all documents pertaining to the client's record that you do not want to use, delete all of the activities you can and re-enter them under the correct client record. This may include deleting some transactions that are associated with claims that may have been submitted. Before you can re-enter these claims on the appropriate client record, they will have to process through the claim reversal procedure that runs overnight.**

8. Is there a specific order that we should take in BHIPS when we first see a client (at initial contact) i.e. client profile, screening, assessment, financial eligibility form? **You must save a client profile first; it is the anchor of the client's record. BHIPS does not set the order in which you perform the rest of the activities mentioned in your question; however, since the score from the screening indicates whether there is a potential substance abuse problem, it is logical that it be done before the assessment.**

9. Progress note or clinician note? **Assumption: The question is asking about the order in which to fill out forms. Progress Notes should be used when a service is provided (i.e. individual session, group process, crisis intervention, motivational interviewing, etc.). Clinician's Notes should be used to document other activities that are not accounted for in BHIPS (etc. Unsuccessful follow-up, saw client in hall, was smiling for a change, QCC Approval, etc.)**

10. Are we required to use the BHIPS hard copy consent or can we use the agency consent? **All DSHS funded providers are required to use the BHIPS consent.**

11. Will the screening tool for HIV, STD, and TB be included in BHIPS? **There are plans to add these data items to the Screening in the future; however, a date has not been set for delivery.**

12. Is BHIPS set for OSAR to maintain and manage a centralized wait list for their treatment service area? **This functionality is available in BHIPS now and OSAR providers are required to fully implement use of the centralized waiting list on November 1st 2004. OSAR providers need to develop policies and procedures to ensure priority populations are being served. (Also see the related answer #1 of BHIPS Operation Questions.)**

13. Number of Days Approved for the requested service type? **This field displayed in BHIPS describes the number of days the OSAR is approving residential care only. The OSAR must enter a number in this field only if the Requested Service Type is approved and the number of days the OSAR is approving is different from the**

Requested Number of Days. You cannot enter a number less than one or greater than 14. For example, the provider requested 14 days of Intensive Residential for the client. The OSAR recommends only 7 days of treatment. In this example, the OSAR would enter 7 in this field. If the OSAR Response to Request for Approval field is not set to Approved Adjusted, BHIPS displays an error message when you enter a value in this field.

14. What does the amount of frequency and duration mean? **Refer to the explanation of amount, frequency and duration on BHIPS online help.**

15. Strategy detail should be for treatment providers doing the treatment plan not OSAR. **The language in the strategy detail is designed for treatment providers. OSAR providers are required to use the strategy to explain the types of services that need to be provided for the client to achieve the objective in the service plan.**

16. Can anyone put in a client profile? **Yes, any staff member may fill out the client profile.**

CLINICAL ISSUE

1. Can the Length of Stay (LOS) extend beyond 30 days if it includes clinical justification? How much longer? **Appropriate clinical justification following the TDI guidelines may result in a length of stay beyond 30 days.**

2. Clarification: Is service coordination only for those in residential (inpatient) treatment? **Service coordination is for high severity clients (use the placement guidelines) in residential treatment.**

3. Our training on BHIPS contradicts what our contract states: We will only serve high severity clients; the training indicates moderate/medium to high severity clients? **Dr. Wanser sent a letter to all OSAR providers that supersedes the contract content regarding service coordination. OSAR providers may access this letter from the DSHS/TCADA website**.

4. Does the service coordinator manage only high severity client or both high and medium severity clients? **See answer to question #2 above.**

5. If a client goes through a screening and meets criteria for outpatient services, do we have to do an assessment? **Yes. If the screening score indicates clinical need, the OSAR will complete an assessment.**

6. Do we need to conduct assessments on clients who may go to outpatient? A**ssessments need to be completed on every client whose screening score indicates there is a substance abuse/dependence issue. See answer to # 5 in Clinical Issues.**

7. DSHS should clarify who should schedule the initial appointment with the referral source i.e. OSAR or the client? **If the client presents to the OSAR and the OSAR assesses the client as High Severity in need of residential treatment then the OSAR will initiate the referral via BHIPS, and with appropriate release, schedule the intake appointment. If the client is put on a waiting list, the OSAR will provide the interim services. Interim services include: Motivational interviewing; referrals to community services such as housing, TANF, Medicaid, SSDI, TB, STD, HIV counseling, etc. with corresponding follow-ups, regular telephone contact to check on status of client while waiting for treatment services. A client referred to any treatment setting does not constitute interim services. Outpatient or Detox treatment services may be rendered to a client that is on a waiting list for residential care. When that type of treatment service is delivered to a client, the client will be receiving case management services from the treatment provider.**

When the OSAR arranges for outpatient or detox treatment services for a client that is waiting for a bed in a residential setting, it is best practice for the OSAR to obtain a consent to communicate with the treatment provider to ensure that treatment on the continuum of care is appropriately coordinated. Life circumstances change when a client is engaged in treatment and the need for the residential bed may or may not cease to exist. When the OSAR is communicating with the treatment provider about the client's needs, this type of information may assist the OSAR in determining whether or not to remove the client from the waitlist.

8. Who constitutes a priority population and is it addressed in BHIPS? **147.701 (2) states: The program shall establish criteria that place members of the priority populations at the top of the waiting list. Priority populations listed in order of priority are: Pregnant injecting drug user; pregnant substance abuser; injecting drug user; parents with children in foster care; honorably discharged veterans; all other substance abusers.**

9. Can a person stay or choose to stay on a waiting list in order to get a bed at a different facility? **Consider using Motivational Interviewing to appropriately address the issues. This needs to be documented in the client file and the client needs to have interim services while continuing on the waitlist. Client self-determination is clinically appropriate and needs to be addressed.**

TREATMENT

1. Clarify if all treatment contractors will report treatment capacity or will the OSAR also report treatment capacity? **The funded treatment provider will report treatment capacity to both DSHS and the OSAR.**

2. Treatment plan discharge? **There is no admission, discharge or treatment plan discharge for OSAR providers serving any clients. There is an aftercare plan for OSARs to complete in the service plan for high severity clients only in conjunction**

with residential treatment providers.

3. Responsibility of completing the discharge plan. **Treatment providers are responsible for writing and completing the discharge plan. OSAR service coordinators are to participate with the treatment providers in the development of the discharge/transfer plan.**

4. Detox: If someone presents in withdrawal; what is the OSAR's responsibility? **When a client presents in withdrawal, the OSAR is to refer the client to Detox when clinically appropriate—and if necessary assist with the client's transportation to that facility.**

5. When a client presents to OSAR and needs detox, do we do a profile & screening and assessment. .etc (service coordination) /and use level I**. See answer #4 of Treatment Issues. To adequately document situations such as this, the OSAR would need to do a client profile in BHIPS. The referral function can then be used to document that the client was referred to Detox. Then the OSAR completes a follow-up to the referral. If the person is unable to answer the questions in the screening and assessment, the QCC can answer the obvious questions, save the document with <u>incomplete information</u> and provide an explanation in the comment sections. (See answer #2 in Clinical issues for the question regarding service coordination.)**

6. Do we need to assess an outpatient client? **See answer in # 5 Clinical issues.**

7. How many residential treatment episodes per year? **The number of treatment episodes per year is determined by the clinical needs of the client. See #1 of Clinical Issues.**

8. Interim Services: Is ambulatory detox considered supportive interim services? Treatment? **Ambulatory detox is treatment, not interim services. Interim services include: Motivational interviewing; referrals to community services such as housing, TANF, Medicaid, SSDI, TB, STD, HIV counseling, etc. with corresponding follow-ups, regular telephone contact to check on status of client while waiting for treatment services. A client referred to any treatment setting does not constitute interim services.**

9. Will a client's sobriety, while on the waiting list, prohibit admission to inpatient treatment? **No.**

10. What if a client cannot put the deductible down and DSHS is the payor of last resort and I just had a treatment program say, "we are having problems recouping from private insurance" but what was not said but implied is they did not want to accept this woman, how can we address this? **This is not an OSAR issue, this is a treatment issue. Treatment providers should have policies and procedures to address this issue. When OSAR providers encounter a residential provider that denies access to clients, the OSAR needs to notify DSHS service coordination of the problem.**

DOCUMENTATION

1. What documentation, besides profile & screening on BHIPS, do we need to have on hand for telephone screenings? **Profile and screening documentation for telephone screening is all the documentation needed. The screening process should be conducted face to face when possible. When it is not possible, there should be a comment in the Comment section of the Screening tool explaining why it was necessary to do the telephone screening.**

2. Service plan update? **Progress on goals, objectives and strategies need to be updated on the client's service plan when problems are resolved or changed. Information for the changes in the service plan would come from the OSAR follow-ups on referrals. *(Remember, BHIPS labels the function of the service plan as treatment plan. Access to the service plan for OSAR providers happens automatically through the OSAR BHIPS access to the system.)***

3. Assessments: Not on Performance Measures – need to rely on counselor discretion? Level of uncertainty? Or will you give us requirements on when to complete assessments? **If the screening score indicates clinical need, the OSAR will complete an assessment. Screening and Post Screening Crisis Intervention/Motivational Interviewing numbers are in the performance measures, not the number of people assessed.**

4. How should we go back and do service plans for past clients? Do we need signatures on the service plans? **Service plan requirements begin November 1, 2004. All high severity clients seen after November 1, 2004 who need service coordination must have a service plan created and signed by the client. (If the client is assessed as high severity at a provider away from the OSAR, then the residential provider can print out the service plan created by the OSAR and have the client sign the service plan while at the treatment facility. A clinician's note reflecting that this has occurred will provide the documentation to substantiate the client has signed the service plan.)**

5. Recommend DSHS develop monitoring processes and reports that the OSARs will need to complete the LOS requirement. **OSAR specific reports will be developed based upon needs determined by providers in conjunction with DSHS staff.**

6. Clarification needs to be made between screening and assessment. **The screening tool in BHIPS is a DSM-IV based instrument which prompts OSAR providers to assess further for Substance related issues. The assessment in BHIPS is a tool used to determine the client's diagnostic issues and potential treatment needs in 9 areas.**

7. Do we have to have the original consent in our file(s)? What I mean is, can I send/fax a professional who will witness the signature and the professional will fax it back to me? **The majority of fax transmissions are not encrypted; therefore, can be intercepted**

and read without the permission of the client. The same goes for un-encrypted email messages. These forms of transmission should not be used.

OSARs that initiate a consent need to have the original printed, signed by the client, and retained in a file at the OSAR office.

FINANCIAL ISSUES

1. Can a client be placed on the wait list if financial is pending? **Adult clients may be put on the centralized waitlist if the financial documentation is in a pending status. There are no rules or guidelines for length of stay on a waiting list or length of time to determine financial status. Operationally, the fact is this—no admission, no billing by a treatment provider can occur until the financial eligibility has been determined on a client.**

2. Financial Eligibility – Attestation form – does it have to be signed by a QCC or can any staff member sign it? **The witness signature may be any staff person.**

3. BHIPS – Financial Eligibility – Documentation Pending. If the client's bed date comes up before the client has provided proof of income to the OSAR, can they give that documentation to the provider when they present for treatment & have the provider change the BHIPS income documentation screen? **The Financial Eligibility form may not be edited by the receiving provider; however, the provider may add another financial eligibility form with the correct information. It is important to remember that billing for services provided prior to the current date requires that the financial eligibility form be back dated so those services will be covered at billing time.**

4. Is there a financial grid that can be printed for use in the field? i.e. X – Amount of income; Y – Number of members in family; Z = Amount of services (%) Financial. **The sliding fee scale used in the financial eligibility calculation is posted on the On-line HELP in BHIPS.**

5. Total extraordinary expenses cannot exceed annual income. What if client has medical bills and "0" income? **Do not enter the medical expenses if there is no annual income. The client already qualifies for services because they have no annual income.**

6. What do you do if client is unable to pay after you establish the 10%? **This is not relevant to OSAR providers. It is up to treatment providers to address this issue.**

7. When completing the financial eligibility, how do you arrive at the treatment cost? Are provider's fees for treatment different? **Contact the treatment provider to which you are referring the client and get an estimate cost for treatment.**

OSAR SERVICES

1. Referral & follow-up: If we put a referral in the client's activity list is that the flag for

the treatment center to report to OSAR that the client showed up? **No, when the treatment provider responds to the referral then the OSAR will discover whether or not the client showed up if the treatment provider documented it in the response. If the information in the response is not adequate, the OSAR provider needs to contact the treatment provider or the client to obtain the answer for the follow-up measure.** The referral follow-up measure is different from the treatment follow-up measure treatment providers are required to report.

2. Referral & follow-up: Follow-ups on referrals within 60 hours. Currently BHIPS only allows you to do a follow-up on treatment referrals that were referred on BHIPS. What about referrals to educations, preventions, etc? **Follow-up for all referrals is 48 hours. All referrals should be completed in BHIPS. The follow-up function is in the referral document on the activity list.** ***OSAR providers will receive further written information about this change in the timeline for follow-ups.***

3. Can an OSAR in one region refer to a treatment provider in another region? **OSARs need to contact the OSAR responsible for the waiting list of residential providers in a region other than their own. Referrals to treatment providers in regions other than the region the client lives in is allowed and the referrals are completed through the OSAR responsible for that region.**

4. Is it the OSAR's responsibility to obtain the correct clinic number for each referral made to TCADA funded treatment providers? **It is the responsibility of the OSAR to *contact* the treatment providers and find out specifically which clinic numbers are associated with the services to which the client is being referred.**

5. Some outpatient programs in our region state that since they are not going to be paid for assessments they are going to refer them all to OSAR. (Unless they can tell over the phone that "they are a slam-dunk.") How do you suggest we respond to them? **Screenings and assessments are services for which DSHS is paying all contracted OSAR and treatment providers. (R 22 of 74 of the Alternative Solicitation RFP – FFY 2005) If the client first presents at a treatment program, the treatment program will determine financial eligibility and conduct the clinical screening/assessment.**

6. What does "co-ordinate transportation mean? Exactly? **Assist the client in finding transportation, i.e. mass transit, cab service, family, friends, etc.**

7. Our Probation Department frequently sends clients for screening and some will screen positive; however, the client and the Probation Department are not interested in inpatient treatment so why should we waste our time on an assessment? **OSARs are required to develop Memorandums of Understanding (MOU) with local referral sources. Issues like this can be handled between agencies. DSHS expectations are that OSAR providers will complete screenings on people who present. If the screening score indicates there is a clinical issue, then the OSAR provider needs to complete the assessment.**

8. ARCADA – HIV process for admission requires us to put money in the proposal for transportation. Is it still OK to use that money for that purpose or shall we transfer money to mileage money? **Funds awarded through a contract for HIV services has to be spent on the population served by that contract. HIV funds are not to be used by OSAR providers for any reason. HIV funds are limited to the clients receiving services through an HIV program.**

9. What is the definition of available? **OSAR providers submitted a proposal on how the QCC would be available to conduct screening and assessment. The method the agency submitted in the RFP process is the method that the agency is contracted to provide.**

10. How will coordination be done with other treatment facilities outside the regions? **Coordination with treatment options in "outside regions" should be done through contact with the OSAR in the region to which there is a need to refer a client.**

11. Please explain our relationship with detox services? **OSARs refer clients to detox when it is clinically appropriate. Detox facilities may refer clients to OSARs during the discharge planning process. There are no approvals for admission to Detox. OSAR service coordination is not required for Detox clients until or unless the client is admitted to residential treatment.**

12. What should we do if we have a priority population client and our region has no place for them and other regions within the state refuse to take the client? **Coordination with treatment options in "outside regions" should be done through contact with the OSAR in the region to which there is a need to refer a client.**
When OSAR providers encounter a residential provider that denies access to priority population clients, the OSAR needs to notify DSHS service coordination of the problem.

13. If a treatment provider refuses to accept an OSAR referral, what happens? **When OSAR providers encounter a residential provider that denies access to clients, the OSAR needs to notify DSHS service coordination of the problem.**

14. A provider expressed concern that some residential programs may receive preferential treatment from the OSAR. How will this be addressed? **(R 23 of 74 of the Alternative Solicitation RFP – FFY 2005) OSARs are expected to develop service coordination agreements with all DSHS funded treatment, and prevention providers within the service area.**

15. How will waitlist management work when there are two OSAR's in the same region? **OSARs in the region with 2 OSARs need to discuss these issues and decide how this will be handled.**

16. Please explain how the waitlist and capacity management will work when there are 2

OSARs in the Region? We both have to provide services in Harris County per our contracts. What if we both have a priority patient and there is one slot available? How will we coordinate the client on both of our waitlists? **See answer #15 of OSAR Services**.

17. If there are 2 OSARs in the same region, is the wait list going to be shared, and is the capacity management going to be shared? **See answer #15 of OSAR Services.**

18. Does the OSAR only refer to their region? **Coordination with treatment options in "outside regions" should be done through contact with the OSAR in the region to which there is a need to refer a client.**

19. When OSAR approves extended days for residential treatment, is it always another 14 days or less than that? **The provider can ask for less than 14 days, the OSAR can authorize less than 14 days. Clinical justification is necessary for any adjustment of length of stay.**

20. How long do you anticipate it will take for the staff to do the profile, screening, assessment and financial so that we can determine the length of time for the client's appointment? **Proficiency of the clinical staff with interview techniques and use of BHIPS will determine the length of time it takes to complete the tasks required.**

21. How many appointments should be made daily per service coordinator? **The number of daily appointments per service coordinator is an agency determination.**

22. Suggestion: Talking among ourselves, we felt it would be nice if questions from the field could be posted. Providers in the field would add in-put to how they deal with the situation in question. TCADA could then take the comments and view them as input from the field in practical application of our new OSAR treatment plan. TCADA would then put a reply and guidance for OSAR/treatment providers on web-site. **Thank you for this suggestion, DSHS will work with this suggestion, among others, internally and provide further information for the OSAR providers. This item is on the OSAR Work Group agenda.**

23. After a client completes residential how long do we have to link him with outpatient services? **30 days**.

24. When we are monitoring a client in residential, does it need to be face to face? **Refer to your agency's RFP response which is now a contract agreement.**

APPEAL PROCESS

1. Talk in length about the appeal process? Within the 24 hours of the request? **There is a 24 hour turnaround for appeal responses. The OSAR has 24 hours to respond to the initiated appeal. The provider has 24 hours to respond to the response by the OSAR.**

2. Who is the AE for 2nd level appeal? DSHS? OSAR? **If the provider is not in a network, there is no Administrative Entity for a 2nd level appeal. OSARs were required to develop an appeal process for the proposal response to the RFP. Each OSAR will be required to follow the plan for which the OSAR is contracted. DSHS expects that OSAR providers will notify all treatment providers for which they authorize services about the appeal process.**

3. If an OSAR and a treatment provider cannot agree on length of stay issues, how is this resolved? **The appeal process is designed to resolve these disagreements. See answer to #2 of Appeal Process and #1 in the Rules section.**

4. Recommend DSHS develop guidance on the appeals process to eliminate inconsistency among OSARs in authorizing length of stay. **See answer to #2 of Appeal Process.**

RULES

1. Is TDI still being used as Client Placement Criteria? **Texas Department of Insurance (TDI) placement guidelines are still being used as Client Placement Criteria. The Placement Guidelines developed by DSHS for determining severity of client symptoms is designed to assist providers in making these determinations with the information obtained using the BHIPS assessment. The placement guidelines can be accessed on the BHIPS HelpPage.**

2. What takes precedence, DSHS standards or TDI criteria, since TCADA will pay for abuse and TDI require dependence? **See answer #1 of Rules.**

3. Will performance measures be modified/changed due to OSAR's just now getting the information at this stage or will OSAR's have to petition the State to change these numbers? **OSAR measures are not being modified or changed due to the information provided in October. Contact your project officer after November and/or prior to March if you need to change the measures you contracted to accomplish.**

4. Does a QCC staff have to do the follow-up or can a Receptionist? **At minimum, the OSAR service coordinator must meet the definition of a counselor as defined by DSHS rules.**

TRAINING

1. Where do we find trainings for Motivational Interviewing? **Coordinated Training Services (CTS) provides Motivational Interviewing, (1 ½ day course). Contact Trish Larwood (tlarwood@hivconnection.org) by e-mail for detailed information regarding training in your area. Check the website for the other training information. TIP 35 from CSAT is an excellent reference and can be ordered through the CSAT publications website.**

2. Will all questions sent to Judy Brow be posted on the website so OSAR can access? **No. Contact Judy (judy.brow@dshs.state.tx.us) with any questions you have about CPS memorandum of understanding.**

3. Will any of these training Power Points be available to us (by email) to use to train staff "back home?" **See DSHS/TCADA website for the slide shows. The multi-media presentations related to BHIPS are accessible through the website.**

4. Where can I get the TDI criteria? **TDI criteria are accessible through a link on the DSHS/TCADA website under contractor resources "links".**

5. Is DSHS having training for treatment centers? **The multi-media presentations are being sent to all the treatment providers and are available on the DSHS/TCADA website.**

6. Can we receive a power point presentation on examples/specifics on:
   Problem
   Goal
   Objective
   Strategy
   How to maneuver through each category? **No power point is available on these maneuvers. Detailed information is available through the BHIPS Help Screen.**