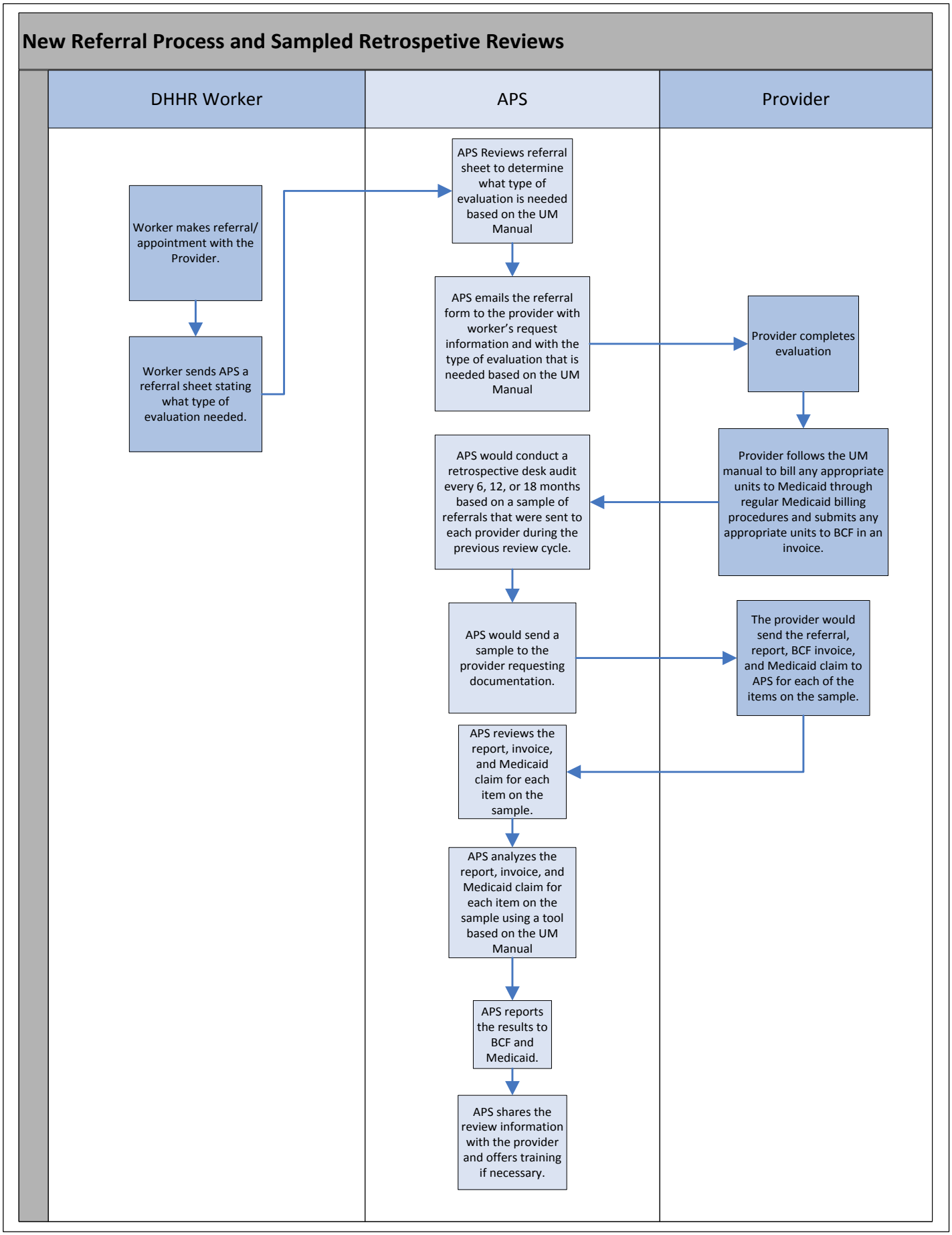
New Referral Process and Sampled Retrospetive Reviews
DHHR Worker
APS
Provider
Worker makes referral/ appointment with the Provider.
Worker sends APS a referral sheet stating what type of evaluation needed.
APS Reviews referral sheet to determine what type of evaluation is needed based on the UM Manual
APS emails the referral form to the provider with worker's request information and with the type of evaluation that is needed based on the UM Manual
Provider completes evaluation
Provider follows the UM manual to bill any appropriate units to Medicaid through regular Medicaid billing procedures and submits any appropriate units to BCF in an invoice.
APS would conduct a retrospective desk audit every 6, 12, or 18 months based on a sample of referrals that were sent to each provider during the previous review cycle.
APS would send a sample to the provider requesting documentation.
The provider would send the referral, report, BCF invoice, and Medicaid claim to APS for each of the items on the sample.
APS reviews the report, invoice, and Medicaid claim for each item on the sample.
APS analyzes the report, invoice, and Medicaid claim for each item on the sample using a tool based on the UM Manual
APS reports the results to BCF and Medicaid.
APS shares the review information with the provider and offers training if necessary.

APS Healthcare

Special Evaluations

The Special Evaluation Process encompasses many types of assessments in which the Bureau for Children and Families has an open case for either Child Protective Services or Youth Services.

Child Protective Services:

The primary goal of the child welfare services is to provide safety, permanency and well-being. In order to meet that goal, "reasonable efforts" must be made to ensure families have access to needed services to prevent removal and/or enable reunification to occur except when aggravated circumstances have been determined. Reasonable efforts include ensuring access to mental health assessment and treatment if needed. "Reasonable efforts" are a requirement of the Adoption and Safe Families Act of 1997 (ASFA).

WV DHHR Bureau for Children and Families Child Protective Services policy section 7.2 defines reasonable efforts as those actions which are taken prior to the placement of a child in substitute care in order to prevent or eliminate the need for removing the child from the child's home; and, those actions necessary to insure that the safety of the child will be maintained if the child is returned home.

Reasonable efforts are not required if the court determines the parent has subjected the child to aggravated circumstances which include but are not limited to abandonment, torture, chronic abuse and sexual abuse (Section 7.3). Other instances when reasonable efforts are not required are when the parent has:

- Committed murder of the child's other parent, guardian or custodian, another child of the parent, or any other child residing in the same household or under the temporary or permanent custody of the parent;
- Committed voluntary manslaughter of the child's other parent, another child of the parent, or any other child residing in the same household or under the temporary or permanent custody of the parent;
- Attempted or conspired to commit such a murder or voluntary manslaughter or been an accessory before or after the fact to either such crime; or,
- Committed a felonious assault that results in serious bodily injury to the child, the child's other parent, to another child of the parent, or any other child residing in the same household or under the temporary or permanent custody of the parent;
- Committed sexual assault or sexual abuse of the child, the child's other parent, guardian, or custodian, another child of the parent, or any other child residing in the same household or under the temporary or permanent custody of the parent;
- Has been required by state or federal law to register with a sex offender registry; or
- The parental rights of the parent to another child have been terminated involuntarily.

For this population the following types of assessments/evaluations are covered under the Special Evaluation Process:

Standard Psychiatric and/or Psychological evaluations when the purpose is to determine:

- If there is a behavioral health condition present
- If yes, what functional difficulties is it causing and to what extent is their functioning

impacted by the behavioral health condition?
- Is there a connection between the symptoms of the behavioral health disorder and the maladaptive behavior the youth has displayed?
- What behavioral health treatment is recommended?
- What is the prognosis?

These evaluations are reimbursable through CPT codes 90791 or 90792 and/or 96101. If the individual does not have funding for the evaluation the BCF case worker may issue a time limited "Special Medical Card" to cover these services. These treatment evaluations are processed through the standard prior authorization procedure, must meet Medicaid/CPT documentation requirements regardless of type of medical coverage/ultimate payer source and are paid by the Department's contracted claims payer.

Parental Fitness-

Behavioral Health Related- comprehensive assessment that is requested by Child Protective Services to answer specific questions regarding

- If there is a behavioral health condition present
- If yes, what functional difficulties is it causing and to what extent is their functioning impacted by the behavioral health condition?
- Is there a connection between the symptoms of the behavioral health disorder and the maladaptive behavior the adult has displayed?
- What is the prognosis?
- What behavioral health treatment is recommended (i.e. individual therapy, family therapy, pharmacologic management, etc.)?
- What community or Socially Necessary Services are recommended (i.e. parenting, adult life skills, domestic violence shelter, BIPPS, payee etc.)?
- Specifically, is the behavioral health condition the only factor affecting the individual's ability to parent?

These evaluations generally have the potential of being reimbursed by two different payer sources- WV Medicaid as well as the Bureau for Children and Families (BCF) due to the dual nature of the assessments (i.e. answering two distinct referral questions).

Parental Capacity regarding Capacity to Care, Capacity to Protect, and Capacity to Change – comprehensive assessment when there is no known or suspected mental health condition identified and/or when a finding of "aggravated circumstances" is in question by the MDT. This type of evaluation is reimbursed by BCF only.

Termination of Parental Rights- assessment/evaluation requested by Child Protective Services when the Department believes that reasonable efforts have been made, or an aggravated circumstance is discovered and a third party evaluation of progress in treatment or parental capacity is required. This area would also apply when a sex offender risk assessment is requested to assist in terminating the parental rights of an individual who has not been adjudicated of a sexual offense yet. This type of evaluation is reimbursed by BCF only.

Right to Visitation- an assessment of whether visitation should occur between certain individuals in a CPS case when the DHHR has determined supervised visitation cannot be

provided safely to the child. This includes physical and/or mental safety of the child. This area would also apply when a sex offender risk assessment is requested when the individual desiring visitation has not been adjudicated of a sexual offense yet. This type of evaluation is reimbursed by BCF only.

Competency of a child to be a witness- an evaluation/assessment requested by Child Protective Services to determine if a child who has been a victim of abuse or neglect is mentally capable of providing testimony in court. This type of evaluation is reimbursed by BCF only.

Competency of a child to know the difference between the truth and a lie- an evaluation/assessment requested by Child Protective Services to determine if a child knows the difference between the truth and a lie in order to testify in court, and to determine if the child's disclosure is accurate. This type of evaluation is reimbursed by BCF only.

Non-covered Evaluations:

The following evaluations/assessments are not covered for Child Protective Services:
Competency to stand trial-BHHF
Educational evaluations to determine school placement
Evaluation requested by the defense attorney

Youth Services:

Youth Services stems from both a social concern for the care of children and from a legal concern for the rights of children. Although state statute (Chapter 49 of the Code of West Virginia) does not contain the term Youth Services, it is clear from the statutes that the Department has a legal obligation to provide assistance to children and families involved with the Juvenile justice system. The Department has chosen the term Youth Services as the designation for the services provided to meet their obligations under the Juvenile justice statutes. (Youth Services Policy 1.6)

The target population for Youth Services includes Juveniles under the age of eighteen (18) years or between the ages of 18 and 21 if under the jurisdiction of the court beyond age eighteen, and one of the following applies (Youth Services Policy 1.8):

- The youth/juvenile is experiencing problems in the home, school, and/or the community to such an extent that the resulting behavior has the potential to become the basis for status offense or delinquency proceedings and intervention has been requested by the parent(s), guardian(s), custodian(s) or by the court to resolve the problem(s) without formal involvement in the Juvenile justice system.
- The youth/juvenile is under the auspices of the Juvenile justice system (i.e. awaiting adjudication as a status offender or delinquent, adjudicated as a status offender, awaiting disposition as a delinquent, on probation, etc.) and has been referred to the Department for services.

The Youth Services policy (Section 1.1) "sets forth the philosophical, legal, practice, and procedural issues which currently apply to Youth services in West Virginia. This material is based upon a combination of requirements from various sources including but not limited to: social work standards of practice; accepted theories and principles of practice relating to services for troubled children; Chapter 49 of the Code of West Virginia; case decisions made by the West

Virginia Supreme Court; and, the Adoption and Safe Families Act. Youth Services is a specialized program which is part of a broader public system of services to children and families."

As in Child Protective Services Policy, the requirement of reasonable efforts found in ASFA applies to the Youth Services program. Therefore, reasonable efforts in a youth services case include ensuring access to mental health assessment and treatment if needed.

For this population the following types of assessments/evaluations are covered under the Special Evaluation Process:

Standard Psychiatric and/or Psychological evaluations when the purpose is to determine

1. If there is a behavioral health condition present
2. If yes, what functional difficulties is it causing and to what extent is the youth's functioning is impacted by the behavioral health condition?
3. Is there a connection between the symptoms of the behavioral health disorder and the maladaptive behavior the youth has displayed?
4. What behavioral health treatment is recommended?
5. What is the prognosis?

These evaluations are reimbursable through CPT codes 90791 or 90792 and/or 96101. If the youth does not have funding for the evaluation, the BCF case worker may issue a time limited "Special Medical Card" to cover these services. These treatment evaluations are processed through the standard prior authorization procedure, must meet Medicaid/CPT documentation requirements regardless of type of medical coverage/ultimate payer source and are paid by the Department's contracted claims payer.

Risk Assessments for Pre- Adjudicated Delinquents that are requested by only the DHHR case worker for a youth whose alleged crime caused danger to the community and an evaluation is needed to determine appropriate level of treatment that can be provided in the least restrictive manner. This evaluation is a combination of a psychological evaluation and a risk assessment. The risk assessment component is funded through BCF and the psychological evaluation is funded through Medicaid.

Non-covered Evaluations:

Competency to Stand Trial
Status Offender Risk Assessments
Non-violent Adjudicated Delinquent Risk Assessments
Evaluations to determine solely the youth's educational level
Evaluations requested by the court, probation or defense attorneys
Custody Evaluation of potential relatives that may be a placement
Juvenile Sex Offender Risk Assessment Updates
Risk Assessments for Post-Adjudicated Delinquents

All Evaluations:

For all evaluation types and payer sources the CPT code definitions will be utilized. When medical necessity is met, Medicaid should be billed with the following codes: 90791 (psychologist), 90792 (psychiatrist) and 96101. When medical necessity is not met, BCF should

be billed using the same codes.

Medical Necessity Definition:

Services and supplies that are:
(1) appropriate and necessary for the symptoms, diagnosis or treatment of an illness;
(2) provided for the diagnosis or direct care of an illness;
(3) within the standards of good practice;
(4) not primarily for the convenience of the plan member or provider; and
(5) the most appropriate level of care that can be safely provided

CPT Code Definition: 90791—event code

An integrated bio-psychosocial assessment, including history, mental status, and recommendations. The evaluation may include communication with family or other sources and review and ordering of diagnostic studies.

CPT Code Definition: 90792—event code

An integrated bio-psychosocial and medical assessment, including history, mental status, other physical examination elements as indicated, and recommendations. The evaluation may include communication with family or other sources, prescription of medications, and review and ordering of diagnostic studies.

CPT Code Definition: 96101—4 units (unit=1 hour)

Psychological Testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, eg, MMPI, Rorschach, WAIS), per hour of the psychologist or physicians time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report.
Academic assessment and assessment required to determine the needs, strengths, functioning level(s), mental status and/or social history of an individual are also included. Documentation requires scoring and interpretation of testing and a written report including findings and recommendations. 96101 is also used in those circumstances when additional time is necessary to integrate other sources of clinical data, including previously completed and reported technician-and computer-administered tests.

Special Evaluation	
90791/90792 Includes: Interview, Collateral Contacts Record Review, Analysis, and Report Writing	One event of 90791/90792 may be requested for the medically necessary portion of the evaluation and one event may be requested for the BCF/YS concern. The event of the 90791/90792 includes all portions of the clinical/diagnostic interview, collateral interview, record review, analysis, and report writing.
96101 Includes: Test Administration, Test Scoring, Test Interpretation,	Direct, face-to-face administration, scoring and interpretation of psychological evaluations/tests. • Tests administered are necessary, congruent, and sufficient to the purpose/referral question as well as additional information that may have been discovered during interview or record review process.

Analysis, and Report Writing	○ Standard batteries may not be congruent to all consumers. • Tests administered are congruent to the manufacturer's standardizations including reading comprehension level. ○ If documentation does not demonstrate that the consumer possessed minimum reading comprehension threshold established by the manufacturer, the test does not meet medical necessity and should not be administered. • Documentation within the report substantiates the units/time claimed. ○ Units claimed should reflect the actual face to face administration time and is based upon manufacturer's standards related to normal and customary. ▪ A consumer with cognitive limitations may not take the total amount of administration time on the WAIS as a consumer that is in the above average range. ○ Self-administered assessments/tests (such as MMPI, PAI, PSI, SASSI, BDI, BAI, etc.) ▪ No administration time can be claimed due to the clinician not directly administering assessment. ▪ Monitoring of client completing self-administered tests is not reimbursable under this process. ○ Interpretation involves relating/synthesizing the score obtained to the referral question rather than only indicating score or category (i.e. the simple indication that a score is invalid does not substantiate any interpretation time). ○ Computer scored assessments/tests (i.e. MMPI, PAI, PSI, SASSI, etc.) ▪ Entering of the scores into the computer is an administrative function and does not require a clinician's credential; therefore, scoring time is not allowed. ▪ Computer generated interpretations (i.e. MMPI, PAI, PSI, SASSI, etc.) that are included within the report that are not synthesized (substantially modified from the computer printout) based upon other supporting information does not substantiate total interpretation time allowed by manufacturer. • Report should cite the sources when computer interpretation or other interpretation guides were utilized even when substantially modified information is included. ○ If individuals other than the approved clinician (i.e. BA

	level psychometrician) administers, scores or interprets any of the tests, this time is not allowed. Prior approval must be obtained prior to the clinician exceeding the unit benefit.
Provider Credential Information	
Provider Credential Information	• Psychiatrist—may utilize 90791/90792 for WV Medicaid as well as BCF • Licensed Psychologist or Supervised Psychologist—may utilize WV Medicaid codes 90791 & 96101 as well as BCF • Master's Degree clinician with Master's Level License—BCF only • Psychometrician activities are not reimbursable
Documentation Requirements	
Documentation Requirements	Documentation shall consist of the following: • A completed evaluation report signed with credentials by the staff member(s) who provided the service including the date(s) of the service • The report should contain an indication as to the location where the assessment occurred. • The report should contain an indication of time spent. • The report should contain all of the following components of the clinical interview as outlined within the 90791/90792 CPT code: o Description of the presenting problem—both the behavioral health concern and/or the parenting concern. o Description of the history of the presenting problem—how long presenting problem has occurred including intensity and duration. o Past treatment/services—related to both the behavioral health concern and/or the parenting concern. o History of the member's involvement with CPS/YS, services, and outcomes. o Pertinent medical history. o Mental Status Examination related to presenting problem. o Diagnosis rendered within DSM format and rationale. o Recommendations for future services—related to the behavioral health condition as well as parenting concern o Prognosis including rationale—related to the behavioral health condition as well as parenting concern. o 90792 – Must indicate a physical examination/review and ordering of diagnostic tests Collateral interview must be summarized within the report and include: • Name and title (If applicable) of person. • Their relationship to the case. • The date of the contact documented. • A summary of the information • The mode of the contact- face to face interview, e-mail, phone, etc.

	Records reviewed related to the case and referral question. Records reviewed should be listed and summarized within the report. Each record reviewed must be documented in the report with: • Title of Document and date • Date of record review • Number of pages per document • How the records were obtained • Brief Summarization of documents reviewed The report should contain the following components of the psychological testing as outlined within the 96101 CPT code: ○ Results (Scores and Categories) of the administered tests ○ Interpretation of the administered tests
Service Exclusions	
Service Exclusions	Special Evaluations do not include the following: • Travel time to a location such as the DHHR office to conduct the evaluation. • MDT attendance or preparation of summaries for MDTs • Court Testimony • Observation of parent/child interaction (i.e. observation of supervised visit between parent and child) ○ Time spent observing interactions should be billed under supervised visitation. Supervised Visitation is authorized through the Socially Necessary Services Program. ○ Enrolment and service information are available at http://www.wvdhhr.org/bcf. Collateral information may also be obtained via the DHHR worker when another entity is authorized to provide the service. • Administrative time
Reimbursement Process	
Reimbursement Process	• Providers will be reimbursed based on the current WV Medicaid rate. • Services reimbursed via WV Medicaid will be done through the usual CareConnection® authorization process and billing process. • Services reimbursed via BCF will be done via an invoice to BCF.
Attachments	
Attachments	• CPS/YS referral form • KEPRO retrospective review tool • KEPRO retrospective Review procedure • Provider requirements for the invoice for BCF

Additional Service Information:

1. These assessments are designed to be comprehensive in nature and one assessment per consumer per year is considered the standard. If the consumer situation dramatically changes within the course of a year, special consideration may be made.
2. Clinicians should not be providing treatment services (i.e. therapy sessions) to those consumers whom they have provided a "Special Evaluation" or vice versa.

3. The assessments are evaluative or standardized testing instruments.
4. The assessments are administered by qualified staff and are necessary to make determinations concerning the mental, physical, and functional status of the member or as required to determine medical necessity.
5. In the evaluations in which recommendations related to restricting parental visitation, termination of rights, etc., all individuals (i.e. the children) should be interviewed, whenever possible given age of child(ren), related to the referral question/aggravated circumstance. An explanation why each individual was not interviewed must be documented within the report.

Attachments

- CPS/YS referral form
- KEPRO retrospective review tool
- Process for completing special evaluations
- KEPRO retrospective Review procedure
- Provider requirements for the invoice for BCF

APS Healthcare

SPECIAL EVALUATION REQUEST FORM

REFERRING DHHR WORKER

Name: _____
County: _____E-mail_____Phone_____

Client Information

Name: _____ **Consumer D.O.B.:** _____
FACTS Client ID:_____ **FACTS Case Number:**_____

PROVIDER INFORMATION

Name: _____ **Phone Number:** _____
Practice Name: _____

REFERRAL REASON

Case Type

◯ Child Protective Services
◯ Youth Services

What is the purpose/reason for the evaluation? What information do you need the evaluation to contain?

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Send completed form to KEPRO by fax at: 1-866-473-2354 or by email to: wvspecialeval@kepro.com .

APS Healthcare

SPECIAL EVALUATION REPORT

Provider:		**SE Number:**	
Review Date:		**Reviewer Name:**	

1.	Does the purpose of the report document all facets of the referral question?	3	1.5	0	
2.	Does the documentation reflect that the client was present for the evaluation? **(NOTE: If Question #2 is scored 0, then all remaining questions will be scored 0.)**	1	0		
3.	Does the report contain the documentation of the client's presenting problem, history of the client's presenting illness, duration and frequency of the symptoms?	3	2	1	0
4.	Does the report contain documentation of the client's current and past medications including efficacy?	3	2	1	0
5.	Does the report contain documentation of the client's past treatment/service history (i.e. behavioral health treatment, CPS/YS services) up to the present day?	3	2	1	0
6.	Does the report contain documentation of the client's pertinent medical history as related to the presenting problem(s)?	3	1.5	0	
7.	Is there sufficient testing administered that was related to the presenting problem(s)? **(Note: If Question #7 receives a score of 0, then questions 8-10 receive a score of 0.)**	3	2	1	0
8.	Were the administered tests/assessments congruent and necessary to the purpose of the evaluation?	3	2	1	0
9.	Does the report contain the results (scores and category) of the administered tests/assessments?	3	2	1	0
10.	Does the report contain the interpretation of the administered tests/assessments related to referral question/presenting problem(s)?	3	2	1	0
11.	Does the report contain documentation of a comprehensive mental status examination congruent with the presenting problem as well as the findings of the evaluation?	3	2	1	0
12.	Does the report contain documentation of the rendering of the client's diagnosis as per DSM or ICD methodology?	3	2	1	0
13.	Does the report contain the client's prognosis for treatment including the rationale?	3	1.5	0	
14.	Does the report demonstrate a rationale for the diagnosis?	3	1.5	0	

15.	Does the report contain appropriate recommendations consistent with the findings of the report?	3	2	1	0
16.	Was the appropriate payor source(s) billed for the report?	3	1.5	0	
17.	Does the report contain the following: • Date(s) of the service • Location of the service • Time Spent • Clinician's signature with appropriate credentials?	3	1.5	0	
18.	Does the report support the time claimed by the clinician for 90791/90792 (i.e. interview, collateral sources, record review, report writing) for all payor sources?	1	0		
19.	Does the report support the time by the clinician for the 96101 (i.e. administration, scoring, interpretation, report writing) of the tests/assessments utilized for all payor sources?	1	0		

Total Score _____ [Possible 51]

Testing Time Breakdown

Tests Administered	Time Allowed		Comments	Adjusted Time
Total Reimbursable Time:				

Process for Completing Special Evaluations

1. Worker makes appointment/referral.

2. Worker sends KEPRO a referral sheet stating what type of evaluation they need.

3. KEPRO reviews referral sheet to determine what type of evaluation is needed based on the UM manual.

4. KEPRO emails the referral form to the provider with worker's request information and with the type of evaluation that is needed based on the UM manual.

5. Provider completes evaluation.

6. Provider follows the UM manual to bill any appropriate units to Medicaid through the regular Medicaid billing procedures and submits any appropriate units to BCF in an invoice.

7. KEPRO would conduct a retrospective desk audit every 6, 12,or 18 months based on a sample of referrals that were sent to each provider during the previous review cycle.

8. KEPRO would send the sample to the provider requesting documentation.

9. The provider would send the referral, report, BCF invoice, and Medicaid claim to KEPRO for each of the items on the sample.

10. KEPRO reviews the report, invoice, and Medicaid claim for each item on the sample.

11. KEPRO analyzes the report, invoice, and Medicaid claim for each item on the sample using a tool based on the UM manual.

12. KEPRO reports the results to BCF and Medicaid.

13. KEPRO shares the review information with the provider and offers training if necessary.

APS Healthcare

Special Evaluation Retrospective Reviews

KEPRO trainer/consultants provide ongoing and specific feedback to providers in order to assist them in meeting documentation requirements as directed with in the Special Evaluation Utilization Management Guidelines. Providers receive on-site technical assistance/trainings, feedback from clinical chart reviews, and precise consultative reports that may be utilized as tools to enhance provider performance. As program data are analyzed over time, providers are educated on the results and may attend or request training to improve their overall performance.

The consultation process is guided by a thorough set of treatment record review procedures, and supported by a number of treatment record review tools and provider treatment record review scoring protocol. All Special Evaluation consultation tools are approved by DHHR and available on our website.

At the completion of the consultation review, an Exit Interview will be conducted with designated provider staff personnel. Specific case examples are included to aide in discussing areas of strength and those requiring additional focus. The Bureau for Children and Families, Bureau for Medical Services and providers will receive a copy of the Consultation report which will contain all findings during the site visit within 30 business days of the exit. KEPRO trainer/consultants are accessible by phone and e-mail for providers to contact regarding questions or issues about the program and will contact the provider within ten (10) business days to ensure the consultation report was received. In addition, in an effort to assist providers in addressing specific concerns and improving performance, KEPRO also offers extensive technical assistance.

Consultation Procedures

Clinical Records Sample

A twenty percent (20%) random sample of records of members receiving approval for a Special Evaluation will be requested for review. These samples are intended to reflect a representation of the individuals receiving services by a provider Providers must maintain a copy of each completed report, and related invoices within their service record to facilitate a retrospective review.

Schedule/Notification to Providers

Consultations will be scheduled in advance by the trainer/consultant designated for a specific provider. Providers will be contacted by phone in advance of a site visit or desk review. A list of charts for potential review will be provided by fax or electronically in advance of the scheduled visit, generally allowing three days' notice to allow time to pull the requested charts. If a desk review is scheduled, the requested charts will need

to be forwarded to KEPRO via secure email or fax. All site visits or office reviews will occur as scheduled. In the event that a scheduling conflict arises, the consultation will be rescheduled for the earliest possible date agreeable to all parties and a new sample issued.

On-site or Desk Reviews

Consultants will conduct on-site or desk reviews with participating providers every six months. As agents of the Bureau for Medical Services/Bureau for Children and Families, consultants will explain the purpose of the consultation activities that will include the review of specific charts and may encompass interviews with key staff. The consultants will maintain confidentiality and providers are asked to provide an area for record review at their facility that is conducive to preserving confidentiality.

Exit Interview

Upon completion of the consultation review, the consultant will conduct an exit interview with provider staff. A summary of the initial findings will be discussed. Consultants will also offer training on identified areas of need.

Provider Trainings and Technical Assistance

KEPRO offers training in venues and formats designed to meet the needs of providers. Training topics are identified through periodic provider needs surveys, consultation score results, and provider input. Training modules are developed through research and consultation to address the targeted areas. Training events may include lecture, panel discussion, question and answer sessions, webinar, and/or small group discussions or may be individualized for a specific provider.

KEPRO trainings may be statewide, regional, or provider specific. To accommodate the needs of our wide range of providers, trainings on some topics may be open to all interested parties (subject to facility limitations), while others may be offered by invitation only. While every effort will be made to provide adequate advance notice to providers, some trainings may require a short planning time frame to address pressing concerns and meet the needs of providers. Training announcements include the training topic, learning objectives, target population, dates, time, location, and continuing education information. Training information may be provided through phone calls, mailings, email, fax and/or website posting. A training module or topic objective will be established for all trainings, along with a roster of participants and completed evaluations.

New Special Evaluation Provider Orientation

The special evaluation provider orientation program is recommended because it is KEPRO Healthcare's first step in the development of long-lasting partnerships with

providers. Orientation activities are provided in the form of focused training or technical assistance, depending upon the needs of the provider.