Utilization Management Utilization Review and Care Management

PBH 3-1-10

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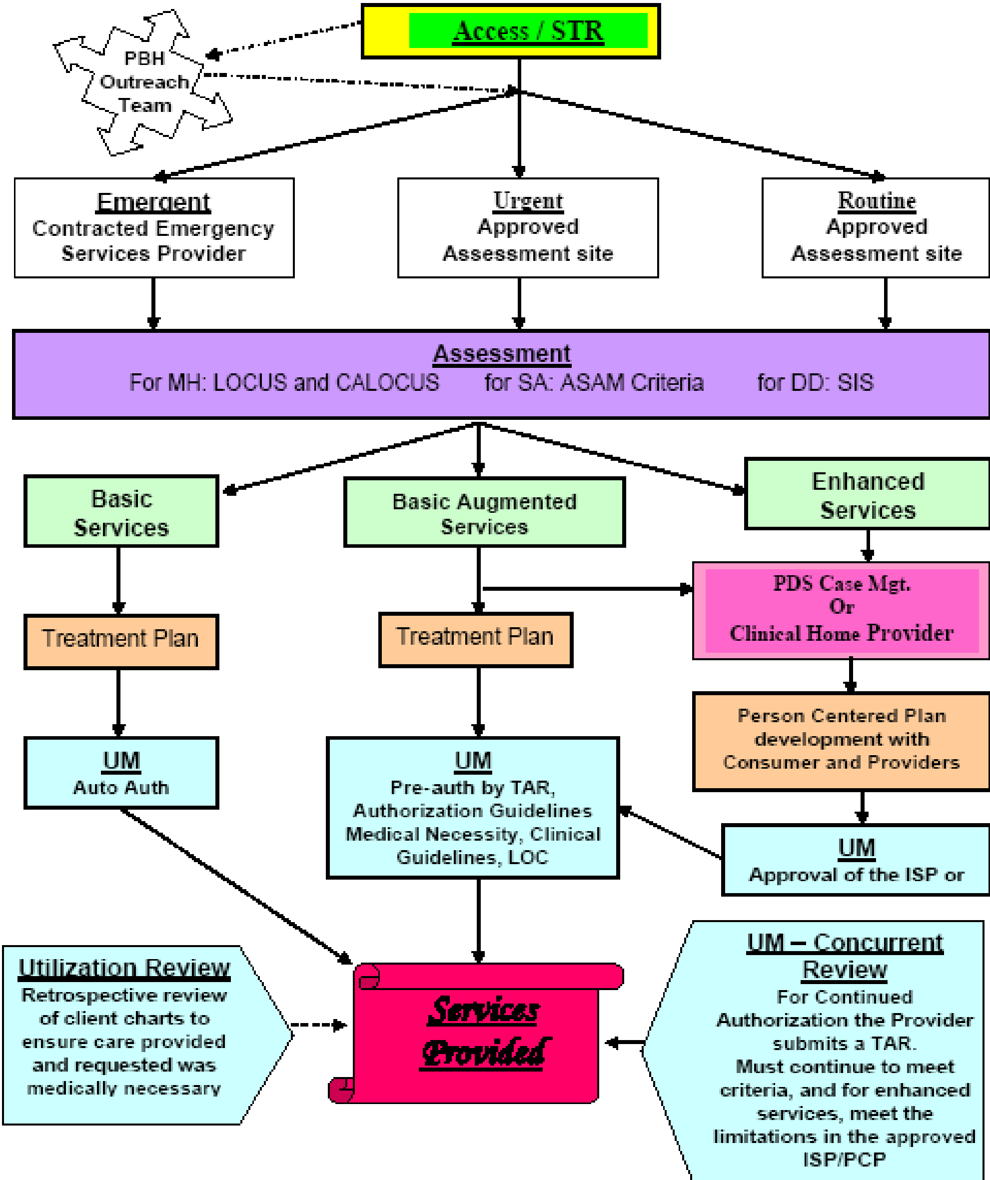
In the Beginning…

- The PBH Model emerged through intensive collaboration with DMA and the Division MHDDSAS, our local consumers, providers and stakeholders and consultation with National experts on design and re-design of our LME processes.
- The PBH Clinical Design Plan covers our structure, benefit plans and procedures in UM, UR and Care management.
- An Annual Utilization Management Plan guides PBH clinical direction and utilization goals

Implementation of the Clinical Framework



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PBH Care Management

Utilization Management / Utilization Review:

- The Care Management Unit of the LME will determine whether a consumer meets and continues to meet medical necessity criteria and target population requirements for the frequency, intensity and duration of requested services.
- Our goal is to ensure that consumers receive the right service; at the right time; at the right level; creating the most effective and efficient treatment possible.

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- This work is accomplished through consistent and uniform application of PBH's Clinical Criteria for each consumer's *individual* clinical needs to determine the appropriate type of care, service, frequency of services, and intensity of services, in the appropriate clinical setting.

- UM Care Managers assist the provider in managing a consumer's care needs and identification of appropriate services .

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- Utilization Management
  - The primary function is to make authorization decisions by conducting initial, continuing, discharge and retrospective reviews of services based on meeting Medical Necessity criteria for the frequency, intensity and duration of the service request.
- Utilization Review
  - The primary function is to monitor the utilization of services and review utilization data to evaluate and ensure that services are being provided appropriately within established benchmarks and clinical guidelines and that penetration goals are maintained. This will be accomplished using both Targeted Utilization Review and a sampling process across Network providers.
    - *Targeted Utilization Review* will be based on the results of the various Monitoring Reports and cases that are brought up in our Clinical Operations Committees monitoring reports that identify outliers as compared to established service levels or through specific cases identified in the PBH clinical staffing process.

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When we started…

- PBH had
  - 4 MHSA UM Care Managers
  - 4 DD UM Care Managers
  - A Call Center that covered 8am – 5pm Monday through Friday
  - A Behavioral Healthcare specific computer system that was not linked to our network of providers
  - A bunch of Fax machines…
  - Many late hours

Efficient?

How Did PBH Address the Issues?

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DATA, DATA and MORE DATA…

- The ability to have accurate, timely data on all aspects of your Clinical functions is critical.
- Without data there is no way to actively manage Utilization on a timely basis.
  - If your agency has no data, there is no way to know where you stand or how you can shape the clinical process.
  - If it is not timely, you may be too late to adjust your care management processes to be most effective.

How Did PBH Address the Issues?

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Process Mapping

- PBH Process Mapped all of our clinical procedures which allowed us to identify care management target points across the entire system from Access, Access Outreach, and Care Management.

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And Now…

- Currently PBH has
  - 11 MHSA UM Care Managers
  - 10 DD Care Managers
  - A 24/7 Call Center with Emergency Authorization, consumer placement processes, and referral follow up capabilities
  - Face-to-face Outreach capacity in all counties that provides STR functions performed by Licensed Clinical Staff
  - An integrated computer system that has a provider interface and EDI (Electronic Data Interface) capacity
  - Multiple LME and Provider collaboration committees
  - Internal PBH committee and workgroup structures that support the care management process.

Medical Director

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The Medical Director has an integral role in the Utilization Management Plan. The Medical Director focuses more on a systems level oversight of the entire LME with significant roles in Quality Management, Network Operations, Consumer Affairs and Community Relations. In regard to Clinical Operations departments, the Medical Director:

- Presides as Chair of the Care Management Team which has macro oversight for utilization management processes and outcomes including utilization review.
- Approves Clinical Operational Procedures that define the criteria and processes for approval and denial of care, including specifying the processes for the implementation of Medical Necessity.
- Hears and makes determinations on appeals.
- Ensures proper credentialing of PBH staff conducting reviews through the Credentialing Process.
- Chairs the Clinical Advisory Committee. This committee is comprised of clinical practitioners and consumer/family stakeholders. The Committee is responsible for review of practice guidelines.
- Approves all practice guidelines.

Clinical Director

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The Clinical Director also provides a critical role in the Utilization Management process of PBH. The Clinical Director's responsibilities are more focused towards the individual client level in the oversight and monitoring of the clinical processes. The Clinical Director:

- Reviews and determines need for services or denials of individual authorization requests for services for consumers, based on utilization review criteria.
- Provides Clinical leadership, including case consultation, and guide the development of clinical protocols for treatment.
- Provides consultation in the development of new services based on best practices and local needs. Consultation as related to service design and implementation of new services.
- Co-leads the design, implementation and monitoring of the Utilization Review process.

Clinical Director

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Continued:

- Assists in evaluating, and recommending annual utilization benchmarks and quality improvement strategies. Assist in evaluating utilization data, trends, consumer demographics related to services for children.
- Promotes the development of best practices through the quality improvement process, through involvement with the medical community and through consultation, training and other educational activities.
- Provides training and consultation to LME staff and network providers as related to clinical protocols, new clinical technologies and utilization review.
- Provides oversight of clinical and clinically related services in a manner that is consistent with NCQA standards for accreditation and with Medicaid, state and other federal regulations.
- Collaborates with the various management units of the LME in order to facilitate cross-functional evaluation, planning, and cooperative activities.

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The Care Management Team

- A PBH Internal team comprised of staff from all clinical disabilities as well as representation from all other PBH units (Network, QM, Finance, etc)
  - Chaired by the Medical Director
  - Identifies Best Practices to include Clinical Guidelines
  - Identifies gaps in clinical needs and formulate plans to meet those needs
  - Reviews data and makes recommendations on changes in Clinical operations to manage care

Care Management Team Macro Management

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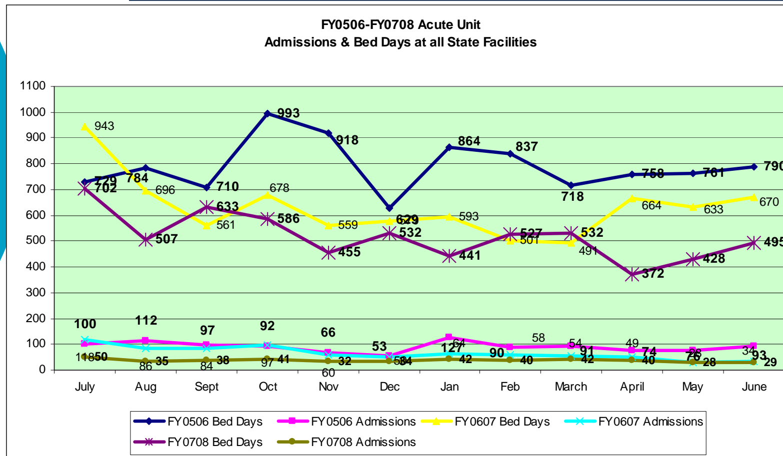
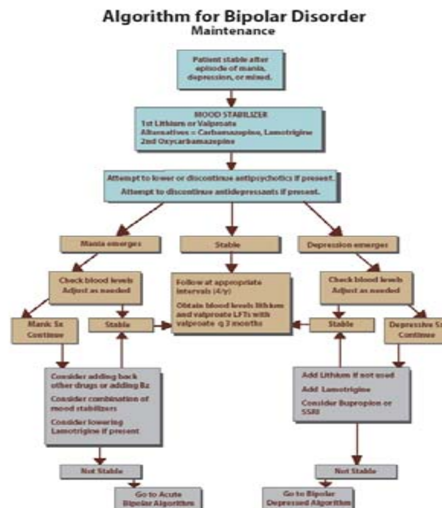


State Facility Readmission Measures	Within 0-30 Days	Within 0-180 Days	Total Admits FY0607
PBH #	56	123	847
PBH Rates	**6.6%**	**14.5%**	
North Carolina	12%	21.8%	**From 2006 CMHS Uniform Reporting System Output Table from SAMSHA.
US Average	9.1%	19.3%	



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Care Management Team

- Data Monitoring examples:
  - Access to Care
  - Under/Over Utilization
  - Service utilization rates; such as hospital use
  - Numbers (%) of denials/approval
  - Medicaid Appeals; including
    - # upheld/overturned, resolution levels
  - UR activities; by Provider, Dx, other specific issues
  - Registry of Unmet Needs; MH, DD, SA Services needs
  - Utilization Plan performance

The Clinical Advisory Committee

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Comprised of clinicians from inside PBH, Providers from our Network, and consumers / family members

- Chaired by the Medical Director
- Advises on clinical guidelines and protocols
- Advises on UM and Clinical Plan
- Advises on new clinical programs
- Advises on other clinical issues as needed

UM CQI Committee

- Committee is responsible for the implementation and oversight of the Clinical Operations CQI plan
  - UM/UR
  - Access
  - Outreach
- Monitoring of Performance Indicators
- Monitor and review adverse events and make recommendations for improvement
- Monitor Performance Improvement Projects (PIPs)
- Monitor individual department CQI activities

Quality in Care Management

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Inter-Rater Reliability (IRR)

- Results are shared with the care management team.
- As improvements are identified, they are incorporated into the IRR system
- Added a review of Person Centered Plans to evaluate uniformity across the staff in decision making around what a complete plan is.
- Materials administered are: Person Centered Plan Treatment Authorization Requests and Person Centered Plan Checklist.

The UR Committee Micromanagement

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- An internal UR team meets at least once per week
- Reviews groups of patients that have become outliers re: Inpatient referrals, High Community Support, Long term residential, etc.
  - Focus is determined using Data.
- Reviews and coordinates care management of individual patients that fall into outlier groups
- Reviews clinical performance indicators such – 7 day follow up, emergent, urgent, routine referral timelines.
- Strategize and implement plans to correct outliers via care management

State Hospital Acute Unit Admission and Utilization

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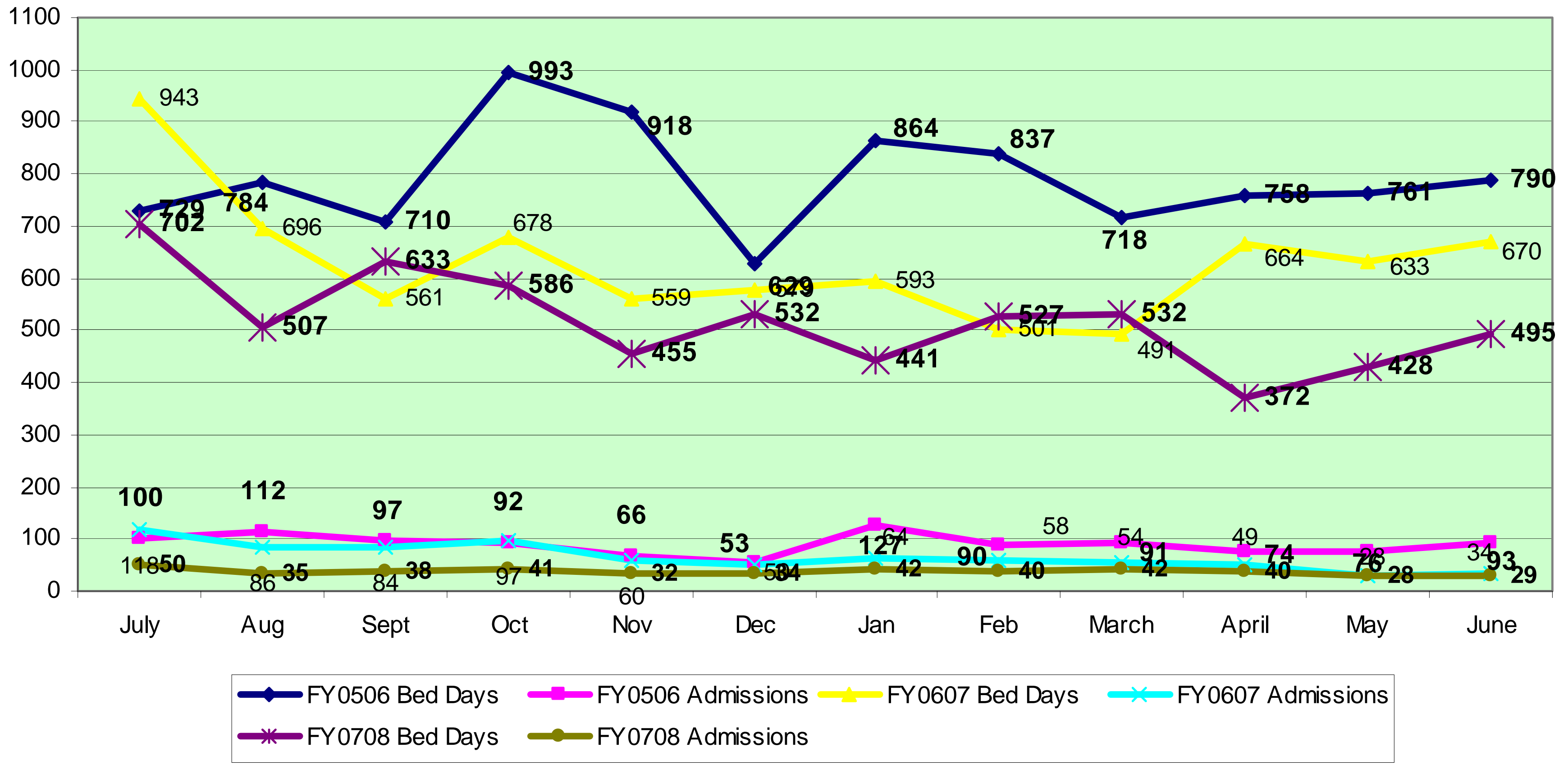

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Case staffings

- Scheduled case staffing daily. (8:30 AM)
- Reason for staffing:
  - complex clinical cases, appeal issues, EPSDT, state funding
- Ad hoc staffings on difficult cases with the providers and consumers
- Reconsiderations (Denials, Appeals)
- Focus on clinical care and clinical decision making
  - Presentation of problem and goals for the consumers using a standardized Clinical Staffing form
  - Questions on use of medication, dosage, medical issues
  - Service definitions as it relates to medical necessity
  - Step down planning and discharge planning identifying community resources.
  - Etc.

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PBH Access Outreach

Unit Purpose:

- Eyes and ears of the Access and UM departments
- Increase consumer utilization of appropriate community supports/wraparound services vs. higher levels of care (as clinically indicated)
- Ease consumer access to care
- Track consumer movement through the continuum of care
- Collaborate with internal/external providers to identify system barriers and offer solutions to identified problems
- Provide a TEAM approach to identified needs within the Access and UM units
- Obtain and disseminate information gathered on all service levels (consumer, provider, community stakeholder, state)

Utilization Management Tracking

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PBH UM Processed 51,043 Treatment Authorization Requests (TARs) in FY0809

Attained with a 94.2% overall rate for timeliness without extending the processing of requests

- Electronic tracking and correspondence with providers on TAR submission issues through a send back function with comments
  - ✓ **assists in efficient and effective clinical review of requests for services**
  - ✓ **affords timely entry into the treatment system for consumers**

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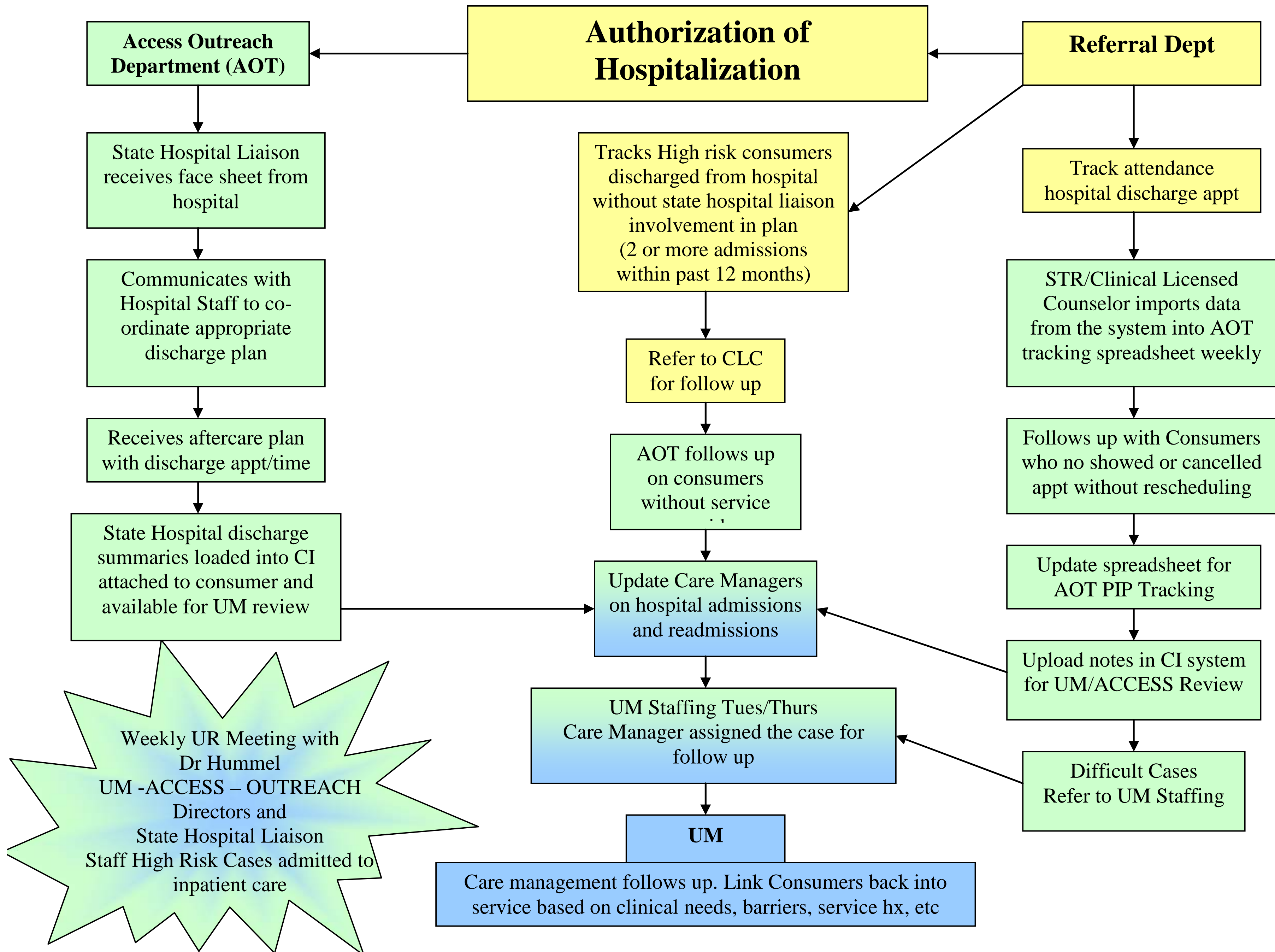
Technology to Streamline

- **Assignment of TAR cases and tracking of submission timeframes**
  - ✓ **Enables coordination of services and timely authorization by placing clinical comments on the Treatment authorization requests to better understand nature of request and also the needs of the consumers**
  - ✓ **Enables timely clinical response to needs of the consumer**

- **Electronic Clinical Documentation Upload to Consumer**
  - ✓ **Enables Care Management to review information necessary for authorization of services and also begin to place all information in one location for care management function**

- **Electronic submission and tracking of Crisis Plans**
  - ✓ **Assists in link*ing co*nsumers for crisis services and also avert hospitalizations**
  - ✓ **Allows care management to build review process targeted at specialty populations in need of additional care management**


Authorization of Hospitalization
Access Outreach Department (AOT)
Referral Dept
State Hospital Liaison receives face sheet from hospital
Tracks High risk consumers discharged from hospital without state hospital liaison involvement in plan (2 or more admissions within past 12 months)
Track attendance hospital discharge appt
Communicates with Hospital Staff to co-ordinate appropriate discharge plan
STR/Clinical Licensed Counselor imports data from the system into AOT tracking spreadsheet weekly
Refer to CLC for follow up
Receives aftercare plan with discharge appt/time
AOT follows up on consumers without service
Follows up with Consumers who no showed or cancelled appt without rescheduling
State Hospital discharge summaries loaded into CI attached to consumer and available for UM review
Update Care Managers on hospital admissions and readmissions
Update spreadsheet for AOT PIP Tracking
Upload notes in CI system for UM/ACCESS Review
UM Staffing Tues/Thurs Care Manager assigned the case for follow up
Difficult Cases Refer to UM Staffing
Weekly UR Meeting with Dr Hummel UM -ACCESS – OUTREACH Directors and State Hospital Liaison Staff High Risk Cases admitted to inpatient care
UM
Care management follows up. Link Consumers back into service based on clinical needs, barriers, service hx, etc

What We Learned…

Knowledge, Experience, Processes

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PBH learned several lessons along the way:

- You need sufficient staffing to manage and maintain within your Performance Indicator goals (e.g., Service request turn around time, Appeals time lines etc)
  - Manage through consistent monitoring of accurate data.

- You need a computer system that works with your business process…Not one that you have to design your business processes around.

- Internal LME collaboration is KEY.
  - Not only within the clinical functions, but throughout the whole LME
    - Example: Network, Finance, and UM Authorization.

What We Learned…

Knowledge, Experience, Processes

PBH learned several lessons along the way: – Continued

- Beginning with strong Utilization Management will help to shape your provider network and utilization patterns along the best practices lines. After shaping is evident, you can shift focus to more Utilization Review and ultimately to more Care Management of the system.

- Seek continual and meaningful feedback from your provider network, stakeholders and consumers.
  - Without collaboration you will hit roadblock after roadblock.
  - It has to be a team effort.

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Questions?

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