



Clinical Operations

Focusing on Care Management

Utilization Management

Utilization Review

5-2-10

Decisions, Research, and Collaboration on Design

- The PBH Model emerged through intensive collaboration with DMA and the Division MHDDSAS; our local consumers, providers, and stakeholders; and through consultation with National experts on design and re-design of our LME processes.
- Many high level policy decisions were necessary to move forward with the design and implementation of the system to operate the Waivers.

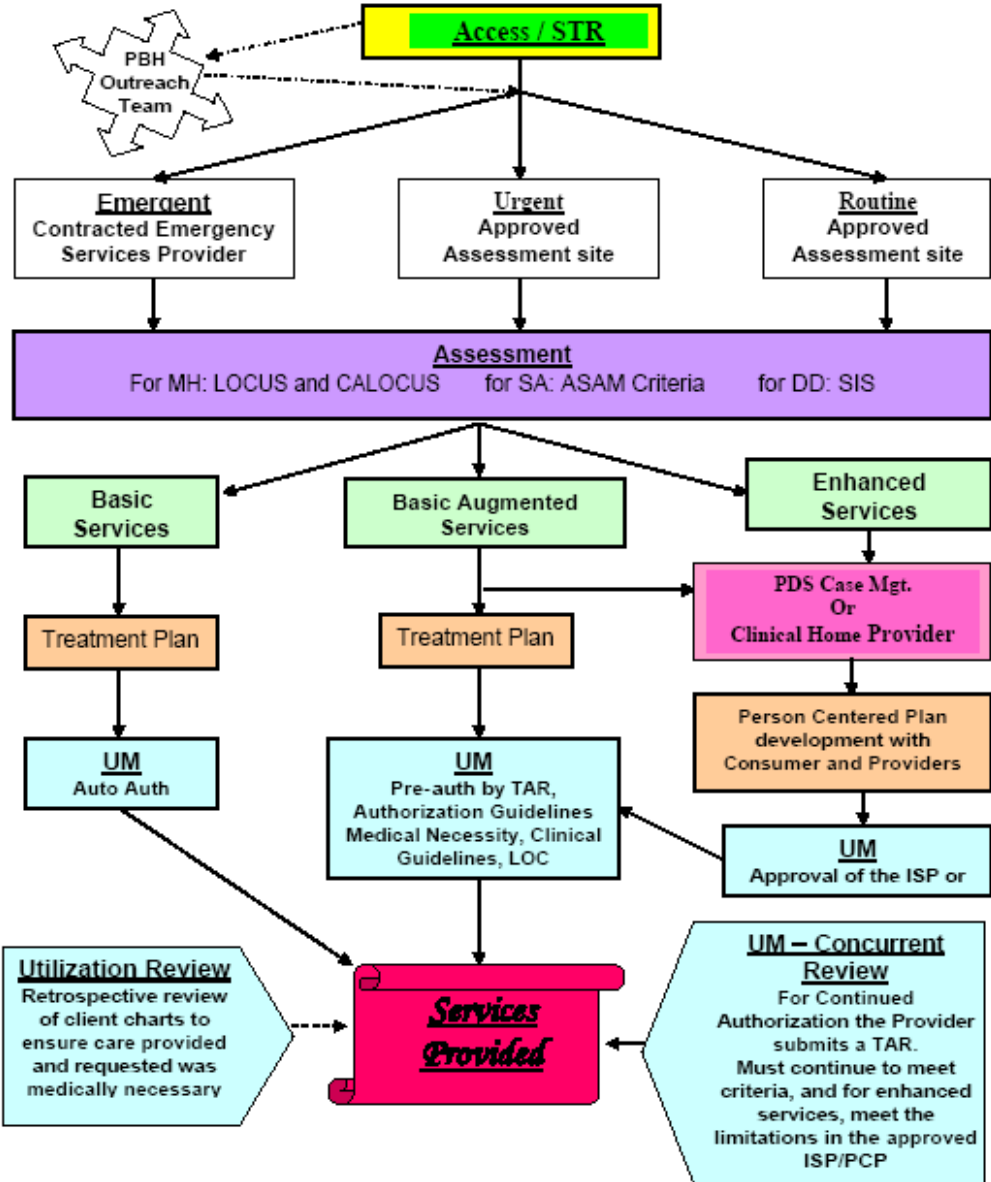
Decisions, Research, and Collaboration on Design

- Guiding Policy level documents:
 - 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

Clinical Design Plan

- The following are the sections of the Clinical Design Plan
 - **System Goals**
 - **A Self-Managed System**
 - **Recovery Focused System**
 - **The Clinical Plan**
 - **Clinical Framework**
 - **Access and Enrollment:**
 - **Assessment:**
 - **Treatment Planning:**
 - **Utilization Management:**
 - **Information Systems Infrastructure:**
 - **Continuum of Care**
 - **First Responders:**
 - **Crisis Services System**
 - **Mental Health**
 - **Child MH System of Care**
 - **Adult MH**
 - **Substance Abuse Services**
 - **Developmental Disabilities**
 - **Olmstead**
 - **Additional Services Based on the B-3 Section of the 1915 B Waiver**

Implementation of the Clinical Framework



Utilization Management Plan

- The following are the sections in the Utilization Management Plan
 - **Utilization Management:**
 - **Medical Director and Clinical Director:**
 - **Determining Medical Necessity**
 - **Prior and Continued Stay Authorizations:**
 - **Notices of Action**
 - **Utilization Management Activities**
 - **Care Management Team:**
 - **Review of Service Authorization and Utilization Trends:**
 - **Utilization Management Clinical Staffing:**
 - **Clinical Advisory Committee:**
 - **Written Utilization Management Criteria for each level of care authorized:**
 - **Coordination of Care Management Activities:**
 - **Utilization Review Process:**
 - **Routine Monitoring:**
 - **Utilization Management Plan General Goals:**
 - **Utilization Management Specific Goals:**

Benefits Design:

- A SIGNIFICANT amount of research on historic utilization data is required to gain an understanding of the clinical models present in your organization.
- After the models are apparent, policy decisions on acceptance of business as usual or a deliberate drive to change the models to match best practices can begin to be made.

But Remember...

- Initial Policy decisions on the benefits structure, levels, and models affected decisions made down the line.
 - For example: a policy decision on treating Medicaid and State funded services the same, affect the design and set up of the authorization system, as well as the claims system, IS structure and set up of underlying tables in the database, set up of the contract process, etc.

Benefits Design:

- Choice of a Level of Care program and tools are important early in program design.
- Merging the available service array with the chosen level of care protocol(s) is essential early in development of a system of care.
- The resulting design acts as the basis for Utilization Management guidelines and care authorization processes.
- Authorization Guidelines Example

Authorization Guidelines-Non-Secure 24 hour Services with Psychiatric- Level 6- Score Range (23-27)													
Non-Secure 24 hr Services with Psychiatric Monitoring Level 6 Score Range (23-27)	Procedure Code	MHSA/ODD Basic	MHSA/ODD Basic Augmented	MHSA/ODD Enhanced & Transitional Services	Prior Auth Required?	LME Response Time	Review Type	Initial Auth Guidelines	Re-auth Frequency Guideline	Re-Auth Guidelines	Medicaid Max / Min Limits	PCP Required	Other
RESIDENTIAL TREATMENT-LEVEL I TFC	H0046			X	Yes	14 calendar days	TAR	60 days	Every 60 days	Up to 60 days	Must be reviewed at least every 90 days	Yes	
RESIDENTIAL TREATMENT-LEVEL II Therapeutic Foster Care (TFC) Single Family	S5145			X	Yes	14 Calendar Days	TAR	60 days	60 days	Up to 60 days	Must be reviewed at least every 30 days (after initial 120 day auth)	Yes	
RESIDENTIAL TREATMENT-LEVEL II 1-4 Beds -	H0200			X	Yes	14 Calendar Days	TAR	60 days	Every 60 days	Up to 30 days	Must be reviewed at least every 30 days (after initial 120 day auth)	Yes	
RES. TREATMENT-LEVEL II (age <6 yrs.)	YA234			X	Yes	14 Calendar Days	TAR	30 days	30 days	Up to 30 days	Must be reviewed at least every 30 days (after initial 120 day auth)	Yes	
RES. TREATMENT-LEVEL II (age 6-12 yrs.)	YA235			X	Yes	14 Calendar Days	TAR	30 days	30 days	Up to 30 days	Must be reviewed at least every 30 days (after initial 120 day auth)	Yes	
RES. TREATMENT-LEVEL II (age 13+ yrs.)	YA236			X	Yes	14 Calendar Days	TAR	30 days	30 days	Up to 30 days	Must be reviewed at least every 30 days (after initial 120 day auth)	Yes	
RES. TREATMENT-LEVEL II TFC Therapeutic Leave	YA254			X	Yes	24 hours	TAR	Up to 5 days / month*	Every 30 days	Up to 5 days / month*	Up to 5 days / month*	Yes	
RES. TREATMENT-LEVEL II TFC Therapeutic Leave Room & Board (age <6 yrs.)	YA265			X	Yes	24 hours	TAR	Up to 5 days / month*	Every 30 days	Up to 5 days / month*	Up to 5 days / month*	Yes	
RES. TREATMENT-LEVEL II TFC Therapeutic Leave Room & Board (age 6-12 yrs.)	YA266			X	Yes	24 hours	TAR	Up to 5 days / month*	Every 30 days	Up to 5 days / month*	Up to 5 days / month*	Yes	

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.

PBH Care Management

- 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 .

PBH Care Management

- 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.

Improving Care Management Efficiency

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.

Improving Care Management Efficiency

Process Mapping

- o 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.

Improving Care Management Efficiency

- 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

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

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

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.

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 focuses on Macro Management

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

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

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

- 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

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.

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)

Care Management Statistics

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

94.2% overall rate for timeliness
(within 14 days) without extending
the processing of requests

Total Denial rate was less than 1%

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 *linking* consumers for crisis services and also avert hospitalizations
 - ✓ Allows care management to build review process targeted at specialty populations in need of additional care management

What We Learned...

Knowledge, Experience, Processes

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.

Questions?



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