

Executive Summary

The Quality Improvement / Utilization Management (QI/UM) Program of CBHNP systematically monitors and evaluates the quality and safety of clinical care and the quality of service by CBHNP and network providers. Quality of care is defined as the degree to which health care services are consistent with current professional knowledge. This approach looks both *outward* to the provider network and *inward* to the provision of services by CBHNP to Members and providers.

The CBHNP QI/UM Program has been organized around ten Strategic Clinical Quality Improvement (CQI) Initiatives. These are listed below with highlights of the activities from the Calendar Year 2011:

1. Access

- Expanded capacity by adding 1 SA ICM/RC Provider; 2 JCAHO RTF; 1 MH Outpatient; 1MH Inpatient; 1 SA Outpatient; 1 MH Partial Hospitalization Program; 1 IP Non Hospital Drug Free/Halfway House; and 1 CRR-HH Program to the network.
- Developed several alternative services for both adults and children such as Brief Treatment, Psychiatric Rehabilitation, Multidisciplinary Therapeutic Foster Care, Multisystemic Therapy-Problem Sexual Behavior, and Juvenile Firesetter Assessment Consultation Treatment Services.
- Expanded Peer Support and Telepsychiatry throughout the network.
- Continued development of school based outpatient clinic sites, including substance abuse sites.
- Developed a proposal for BHRS redesign of administrative processes which might improve access.

2. Appropriateness

- Closely monitored service denial and grievance trends, achieving sustained improvement.
- Worked with BHRS providers on a quarterly basis to monitor initial access and service delivery in comparison to service authorizations. Continued focus on improving communication between providers and evaluators and active adjustment in prescriptions as progress to goals is realized.
- Worked with FBMH providers to identify variations in service delivery in preparation for the development of a Best Practice Guideline on FBMH.
- Participated in root cause analysis of BHRS initial access.
- Finalized a Best Practice Guideline for clarification of BHRS Roles.
- Finalized a Best Practice Guidelines for conducting FBA's.

3. Competency

- Conducted over 1,400 peer to peer consultations to monitor the appropriate prescription of services supported by appropriate recommendations, incorporating the use of objective measures, Member strengths and identification of symptom free periods into recommendations.
- Conducted 16 QI orientations for all new psychologists coming into the network.

- Conducted nearly 100 on-site reviews and improved the network average for Quality Treatment Record Reviews for eight levels of care; and, expanded to include three additional levels of care.
 - Improved the network average Autism Competency Assessments scores of BHRS providers.
 - Completed the review of Co-occurring Competency Assessment scores for MH IP, CRR HH, RTF and PHP services.
 - Expanded the Enhanced Care Management (ECM) initiative for high-risk and high-utilizing Members by adding a second full time position to support.
 - Conducted Clinical documentation audits quarterly, providing aggregate trend analysis and individual feedback to be used in supervision.
 - Implemented a Physician Advisor documentation training and audit process.
 - Reviewed the content and quality of over 300 FBAs, giving feedback to providers on improvement.
 - Reviewed the content and quality of over 540 initial treatment plans for Members receiving BHR services, giving feedback to providers on improvement.
4. Consumer and Family Involvement
- Refined Consumer / Family Satisfaction Team (CFST) processes to accommodate the local needs of each county.
 - Reviewed regular reports of CFST as available by contract addressing areas of required action and identification of steps for improvement. As applicable, trend summaries were presented at QI/UM Committees and Credentialing Committee.
 - ECHO Member Satisfaction Surveys are administered annually and results incorporated into the QI/UM Program.
 - Participated in a host of local community outreach initiatives across contracts.
5. Continuity and Care Coordination
- Conducted a root cause analysis of follow up after hospitalization rates.
 - Implemented case conferencing for clinical care managers to facilitate more active care management of complex cases which often lead to readmission.
 - Repeated the MH IP Discharge Planning Audit, increasing the average network score from 58% to 74%.
 - Conducted almost 12,000 outreach calls to Members to verify follow up aftercare appointments to ensure proper transition from inpatient.
 - Maintained compliance with quarterly reporting requirements, as applicable and ongoing measurement of ambulatory follow-up rates after hospitalization, as well as conducting annual Barrier Analysis.
 - Completed performance improvement within required timeframes for all contracts on both mental health and substance abuse measures as defined, as well as conducting annual Barrier Analysis for BHRS access, Substance Abuse Follow up and Access, and MH IP Follow up and Readmission.
 - Expanded efforts to support statewide initiatives related to Domestic Violence, Childhood Obesity and Smoking Cessation.
6. Diversity and Cultural Competency
- Monitored penetration rates and treatment denials by race and county in order to prevent health disparities.
 - Monitored network capacity of Spanish-speaking providers, particularly in Lebanon,

- Lancaster and Dauphin counties where Member need exists.
 - Monitored provider cultural competency assessments completed during credentialing site visits.
 - Continued focused on the application of Recovery principles in all aspects of service delivery.
 - Supported the development of consensus documents in some areas of the network to enable more integrated, co-occurring treatment.
7. Outcomes and Efficacy
- Reviewed BHRS outcomes as a basis for annual Barrier Analysis.
 - Reviewed MH IP outcomes as a basis for annual Barrier Analysis.
 - Review Substance Abuse treatment outcomes as a basis for annual Barrier Analysis.
 - Completed the review of cost drivers identified for each contract to identify either best practices and/or opportunities for improvement.
 - Worked on the development of expanded outcomes reporting functionality across all levels of care.
8. Prevention and Community Outreach
- Continued two preventive behavioral health programs – Early Identification of ADHD and Improving Treatment Compliance for Adults with Depression
 - Implemented a process for review of individuals with higher than average use of Crisis Intervention services as a potential quality of care concern.
 - Refined a process for review of individuals with multiple inpatient admissions as a potential quality of care concern.
 - Expanded the Member section of the CBHNP website to provide educational materials to Members about both physical and behavioral health issues in a *Wellness Library*.
9. Safety
- Monitored the submission of Critical Incident reporting, inclusive of all seclusion and restraint incidents through continued support of alternate reporting methods to include paper reporting, adoption of HCSIS, provider initiated report formats, and ProviderConnect.
 - Implemented a Restraint Reduction toolkit to offer providers best practice recommendations to consider.
 - Quality of Care Council under the direction of the Medical Director, identified and investigated 827 issues. Incorporated a quarterly review of outliers such as high volume AWOL's and/or restraints in RTF and Community Residential Rehabilitation (CRR HH) and high volume peer to peer consultations.
 - Follow up with providers on Members receiving restraints above the benchmark, again offering educational resources related to restraint reduction.
 - Monitored Complaint Analyses to trend by provider, by contract and network-wide for use at QI/UM and Credentialing Committee.
10. Service Excellence
- Telephone service access continued to exceed stringent performance goals.
 - Continued to exceed the performance goal for timeliness of administrative appeal decision-making and notification.
 - Continued to offer the Member Handbook in Spanish, Braille, large print, and/or audiotape versions while reminding Members of interpretive / assistive services as

- needed when they are deaf or hard of hearing.
- Continued to support the functionality of e-Cura® ProviderConnect affording providers the opportunity to view authorizations and claims status, submit critical incident reports, capacity and FTE reporting on-line 24 hours a day, seven days a week.
 - Achieved full compliance with HIPAA 5010 transaction format updates implemented 1/1/12.
 - Established an Emdeon Payer ID, giving flexibility to providers for testing and submitting claims.
 - CBHNP began providing ePayment allowing for web-based registration and preference selection for electronic funds transfer (EFT) services, electronic remittance advice, and postable 835 format.

All stakeholders, including Members, providers, counties, the Pennsylvania Department of Public Welfare, and CBHNP employees are encouraged to reference this QI/UM Program Annual Evaluation. CBHNP strives for transparency in its HealthChoices managed care operations. All Quality Improvement documents including this evaluation and the QI/UM Program Description are available upon request to any stakeholder.

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