

GREATER COLUMBIA BEHAVIORAL HEALTH Policies and Procedures

Category: Clinical
Approved On: 09/21/06
Approved By: The Board of Directors
Revised: 00/00/00
Effective Date: 15 days from the last revision date

No: CL 338.00

Title: **Clinical Review**

I. Scope:

This policy applies to Greater Columbia Behavioral Health.

II. Purpose:

To verify by way of Primary Verification and Clinical Audits that enrollees are receiving timely and appropriate service.

III. Process/Procedures:

GCBH will conduct Primary Verification and Clinical Audits in compliance with the Mental Health Division PIHP and State contracts as follows:

1. Set a schedule that allows for the required number of charts to be reviewed within the contract year such that at least half are completed within the first 6 months, and the remainder completed within the last 6 months.
2. Gather and pull data 3 weeks prior to the site visit:
 - Random pull that represents demographics of consumer base of each agency;
 - A representative sample of new consumers of 6 months or less; and
 - A representative sample of consumers involved in 2 or more services.
3. Send out notification letter to provider 14 calendar days prior to the site visit, specifying the date audit is set for and enclosing checklist (see attached), and CRRT (see www.gcbh.org – under forms).
4. Interview/audit occurs and documentation provided is reviewed; staff is interviewed; charts are reviewed; checklists and rating tools are completed and exit interview is given.

5. GCBH drafts a Utilization Management report within 30 calendar days of completion of the audit.
6. Discussion of draft report with provider takes place via a conference call within 5 business days.
7. GCBH prepares a final report within 10 business days of discussion of the draft report unless the time frame is extended by GCBH Director (not to exceed 30 business days).
8. Submission of plans of corrective actions will occur within 30 calendar days of the final report.
9. Review of corrective actions will be periodic but will be completed within 90 calendar days of final report.

IV. Expected Outcome (s):

- A. To ensure quality care and service to all enrollees.
- B. To ensure compliance with the Mental Health Division PIHP and State contracts.

V. Scheduled Review of this Policy:

The review of the GCBH policies and procedures manual is on a two year cycle. The GCBH policy review and revision approval process is a three month process. This policy is scheduled to be reviewed every second year:

- A. by GCBH staff by September of even years,
- B. by the Regional Advisory Board (RAB) by October of even years,
- C. by the GCBH Board of Directors by November of even years, and
- D. outside of the schedule if required.

Approved:

Date:

/S/ William Wilson
William Wilson, DrPH
Interim Director

9/21/06

Attachment One: On-Site Provider Review Procedure

- 1) Review of Agency Clinical Policy and Procedures
- 2) Random review of clinical staff credentials (current license, certification, criminal background check).
- 3) Clinical records review focusing on:
 - a. Thorough Assessments demonstrating medical necessity
 - b. Consumer directed treatment planning-consumer and family voice
 - c. Treatment plan strengths based (service prescribed by treatment plan, etc)
 - d. Clear specification of observable, measurable outcomes
 - e. Use of formal and informal supports
 - f. Use of Mental Health Specialists
 - g. Use of consumer support network
 - h. Progress toward agreed upon outcomes
 - i. Planning for management of crisis
 - j. Children's Level II treatment planning, case coordination, and service delivery
 - k. LRA case management activities including planning and service delivery
- 4) Random sampling of reported services to verify documentation of:
 - a. Data integrity check (does reported data correspond with clinical records?)
 - b. Service provided was linked to the treatment plan
 - c. The service was medically necessary
 - d. The documentation was thorough, containing a statement on progress, intervention, and plan for next visit
- 5) Review a selection of charts for persons admitted for inpatient treatment within past six months:
 - a. Review selected charts of persons admitted to inpatient care for documentation of participation in inpatient treatment (clinical summary provided, attendance or participation in inpatient treatment and discharge planning, appointment of lead clinician for follow up)
 - b. Documentation indicates timely commencement of treatment after discharge (inpatient) to first service (outpatient)
 - c. Documentation that a lead staff person was designated to coordinate discharge planning and subsequent treatment
- 6) Outpatient to Outpatient Continuity of care:
 - a. Review random sample of shared cases
 - i. Lead agency-coordination of treatment
 - ii. Continuity of care
- 7) Crisis Provider
 - a. Has the crisis provider integrated a quality management process that ensures compliance with GCBH crisis standards (documentation of internal reviews and quality management interventions that improved performance, access time records, data analysis,)

- b. The provider has policies and procedures that ensure the safe keeping of detained persons' property in accordance with WAC 388-865-0245(3); that is, ensures that when a peace officer or county designated mental health professional escorts a consumer to a facility, the county designated mental health professional must take reasonable precautions to safeguard the consumer's property
 - c. Review of random selection of clinical records to:
 - i. Assess triage to mental health support services and/or allied services
- 8) Review of provider Quality Management system(s) QI
- a. Review of Performance Improvement Project(s) PIP's.
 - i. Access to Care (ATC) PIP
 - ii. Consumer Voice PIP
 - b. Review of provider internal process to detect under and over utilization



Greater Columbia Behavioral Health

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Kennewick, WA 99336-1958

Attachment Two: Utilization Management (UM) Outpatient Provider Review Plan

- 1) GCBH notifies Providers of Audit and copies notification to relevant Member Government (by means of GCBH advice of all audits)
- 2) UM sends letter to Provider:
 - a) Describing how UM will do review on site
 - b) Attaching Provider Check List to assist in preparing for the review, including the Quality Management Check List
 - c) Advising which charts have been selected for the review
- 3) UM On Site Review
 - a) Entry Interview
 - b) Review of Provider Documentation based on Provider Check List
 - c) Opportunity to interview staff who completed the Provider Check List or Quality Management Check List
 - d) Review of Charts
 - e) Exit Interview
- 4) Draft UM report of Provider Review (within 30 calendar days of completion of review)
- 5) Provider Response (within ten business days of mailing of Draft Report)
- 6) UM/Provider Discussion of Review and Provider's response by conference call (within five business days of Provider's response)
 - (1) UM Final Report (within ten business days of joint discussion of Draft Report, unless extended by GCBH Director, not to exceed 30 business days).
- 7) Submission of Plans of Corrective Actions (within 30 calendar days of Final Report)
- 8) Review of Corrective Actions (periodic and to be completed within 90 calendar days of Final Report)

**Attachment Three
Utilization Management
Provider On-site Review Check List**

Focus	Evidence	Supporting Documentation (describe)	Comments
1. The provider has an effective Quality Management system	<ul style="list-style-type: none"> • Provider has written and operational Quality Management process. 	Review of Policies & Procedures	
	<ul style="list-style-type: none"> ▪ Documentation of meetings (minutes) 	Minutes	
	<ul style="list-style-type: none"> • Membership and attendance 	Minutes	
	<ul style="list-style-type: none"> • Documentation of effective quality improvement projects/ Performance Improvement Project(s) (PIP's) implemented during past 6 months 	Local Performance Improvement Project (matches Plan, Do, Check, Act/Maintain procedure format)	
	<ul style="list-style-type: none"> • Agency QI Plan addresses and utilizes internal and external information to improve the effectiveness of consumer care. <ul style="list-style-type: none"> • External inputs • Agency internal inputs: 	QMOC data analysis, Utilization reports, outliers, satisfaction/complaints data QRT and Ombuds reports, QRT staff, consumer, and allied system survey results, UM data analysis and systemic reviews, GCBH Contract Audit Reports, GCBH QMOC report	
2. The Provider has policy and procedures to ensure timely access to treatment	<ul style="list-style-type: none"> • Performance standards are established and reviewed in relation to: • Time from initial request for services to Intake • Time from Intake to "next service" • Timely access is supported by appropriate resource allocation 	Examples of reports	

Focus	Evidence	Supporting Documentation (describe)	Comments
3. Provider has policy and procedures to detect and correct under and over utilization	<ul style="list-style-type: none"> • Clinical managers focus on ensuring medical necessity throughout duration of treatment through effective supervision of clinical staff • Reports from IS support clinical management: • Accumulation of services for each consumer • Efficiency by provision of reports such as: <ul style="list-style-type: none"> ○ Staff Direct Time • No-shows 	<p>Examples of procedure manuals, supervision reports, established agency supervisory standards, and training of supervisors</p> <p>Examples of types of information collected and used in analysis</p>	
4. Provider has Policy and Procedures relating to ensuring continuity of care	<ul style="list-style-type: none"> • Procedures relating to liaison with inpatient providers, participation in treatment planning and discharge planning • Procedures relating to the transfer of care from and to other community providers 	<p>Provider has a lead person to ensure continuity of care between inpatient and community providers</p> <p>Examples of cases</p>	
5. Data Integrity	<ul style="list-style-type: none"> • Reported duration matches clinical documentation. • Services are adequately documented demonstrating medical necessity • All service events reported to RSN are contained in the clinical record • Signatures are complete (date, title/position, degree) • Correct coding is used 	Review of Data	