




United Behavioral Health

<b>Care Manager Inter-Rater Reliability Audits</b>			<b>Policy Identifier/Number:</b> QA-11
<b>Annual Review Completed Date:</b> February 2018			
<b>Policy Category:</b> Government – Pierce Regional Support Network	<b>Applicable Lines of Business:</b> Medicaid	<b>Entity/Plan:</b> Optum Pierce Behavioral Health Organization	<b>State:</b> Pierce County, Washington
<b>Approved by:</b> Bea Dixon, Executive Director		<b>Signature:</b> 	

#### Policy Statement and Purpose

Optum Pierce Behavioral Health Organization (BHO) provides quality oversight of the clinical decisions made by all Care Management staff.

To provide quality oversight of clinical decision making by all Optum Pierce BHO Care Management staff.

#### Policy Audience and Applicability

This policy is applicable to the Optum Pierce BHO and benefits administered through the Washington State Department of Social and Health Services (DSHS) current Prepaid Inpatient Health Plan (PIHP).

#### Policy Definitions

N/A

#### Policy Provisions

1. Monitoring Mechanisms
  - 1.1. Consistency in decision-making (inter-rater reliability), excellent communication and documentation skills, and appropriate consultation with clinical supervisors throughout the Care Management process are critical to ensuring that consumers access the most appropriate and effective treatment.
  - 1.2. A variety of mechanisms are used to provide inter-rater reliability oversight of clinical staff. These mechanisms include:
    - 1.2.1. Mentoring During the Initial Six Months
      - 1.2.1.1. Every Care Manager receives a more intensive level of oversight and support during his/her first 6 months of employment.
      - 1.2.1.2. As part of their pre-service training and prior to serving consumers, Care Managers are required to obtain an initial inter-rater reliability

Optum is responsible for adhering to all applicable state and/or federal laws governing activities within the scope of this policy, including the Mental Health Parity and Addiction Equity Act (MHPAEA) and the Health Insurance Portability and Accountability Act (HIPAA) privacy requirements, as well as the applicable requirements, standards and regulations as set forth by the Employee Retirement Income Security Act (ERISA), the Center for Medicare and Medicaid Services (CMS), the Department of Labor (DoL), and any applicable accrediting organizations.

score of 85% or higher on the correct application of Level of Care Guidelines.

1.2.1.2.1. Pre-service training includes frequent call observation and inter-rater reliability testing.

1.2.1.3. Each Care Manager is assigned a mentor who is either the Clinical Manager or a more experienced Care Manager.

#### 1.2.2. Monthly UM Record Inter-Rater Reliability Audits

1.2.2.1. As part of professional supervision, the Clinical Manager or a designee conducts UM record audits on all Care Management staff at least monthly.

1.2.2.2. These audits determine whether clinical decisions follow *Level of Care Guidelines* and Access to Care standards (inter-rater reliability).

1.2.2.3. Timeliness of decision-making and completeness of documentation are also reviewed.

#### 1.2.3. Silent Call Monitoring

1.2.3.1. The Clinical Manager conducts and documents results of silent monitoring on 2 inbound and 2 outbound calls for each clinical staff member who answers the Care Management lines within the first 6 months of employment.

1.2.3.2. The Clinical Manager uses a standardized evaluation tool that rates the clinical staff in several domains including:

1.2.3.2.1. Customer service skills;

1.2.3.2.2. Accuracy of responses to requests for information;

1.2.3.2.3. Accuracy of level-of-care determination; and

1.2.3.2.4. Appropriateness of responses to situations such as requests to file a grievance.

#### 1.2.4. Case Review

1.2.4.1. Case Reviews are scheduled weekly to provide Care Management staff the opportunity to present complex cases, including:

1.2.4.1.1. Consumers with co-morbid medical or substance abuse diagnoses;

1.2.4.1.2. Consumers who lack natural support systems; and

1.2.4.1.3. Consumers at high risk for utilization of high intensity and crisis services.

1.2.4.2. Case Reviews are designed to present an additional opportunity for the Medical Director and Clinical Manager to monitor the authorization decisions made by Care Management staff and to give staff feedback to help improve performance.

1.2.4.3. At their request, providers who are working with a case being discussed in a case review are to be included in the review.

## 2. Improvement Actions Based on Monitoring Results

2.1. When staff do not meet the 90% agreement performance standard for inter-rater reliability audits, or are shown through silent call monitoring or case reviews to be in need of additional training, the Clinical Manager is to immediately:

- 2.1.1. Arrange for additional training; and
- 2.1.2. Increase monitoring of the staff member until audits, silent call monitoring and case reviews show the staff member is appropriate to return to routine monitoring and oversight.
  - 2.1.2.1. In some instances, the level of supervision provided to new Care Managers may be reinstated.
  - 2.1.2.2. In general, 1 to 3 months of more intensive monitoring and training is all that is needed to restore the staff member's skills to appropriate performance levels.
- 2.2. The *QA/PI Work Plan* monitors a variety of indicators related to Care Management oversight and inter-rater reliability on a monthly, quarterly, and annual basis.
  - 2.2.1. Indicators include, but are not limited to:
    - 2.2.1.1. Aggregate monthly inter-rater reliability audits;
    - 2.2.1.2. Aggregate silent call monitoring results; and
    - 2.2.1.3. Trends in grievances related to level-of-care decisions.
- 3. Corrective Action Plans
  - 3.1. When data show that goals or benchmarks are not met, the Continuous Quality Improvement process is to be invoked and a *Corrective Action Plan* is required. In addition, if the Quality Assurance/Performance Improvement Committee or subcommittees see a concerning trend, they may recommend corrective actions to address this trend which may include training, system or policy changes, or other interventions.
  - 3.2. *Corrective Action Plans* are to include:
    - 3.2.1. A root cause analysis to locate the barriers to achieving the goal or benchmark;
    - 3.2.2. Implementation of actions designed to improve performance; and
    - 3.2.3. More frequent monitoring of performance to determine if the corrective actions are having the desired effect.
  - 3.3. Once performance is maintained at or reaches a level better than the goal or benchmark, the quality improvement activity is to be continued for 180 days to ensure that systemic changes remain in use and continue to be effective. Once the maintenance or improved level has been maintained for 180 days, the performance monitoring is to return to routine oversight.

**Related Policies, Procedures & Materials**

- Pierce Behavioral Health Organization Policy: QA-10 - *Customer Service Call Monitoring*
- Pierce Behavioral Health Organization Policy: CM-05 - *Utilization Management Resource Management Plan*
- Pierce Behavioral Health Organization Policy: CM-10 – *UM Authorization and Concurrent Reviews*

**Attachments**

N/A

**Approval History**

- Policy created and effective: 07/2009

- Policy and Procedure Committee review and approval: 10/26/2009
- Policy and Procedure Committee review and approval: 08/23/2010
- Policy and Procedure Committee review and approval: 09/26/2011
- Policy and Procedure Committee review and approval: 08/27/2012
- Policy and Procedure Committee review and approval: 12/02/2013
- Policy and Procedure Committee review and approval: 12/15/2014
- Operational Procedures and Standards Committee reviewed and accepted: 12/28/2016
- Optum Pierce BHO reviewed and accepted: February 2018