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| CHELAN-DOUGLAS RSN/PHP POLICY AND PROCEDURE MANUAL | | Chapter: | 7.3.1 |
| Title: | QUALITY ASSURANCE AND UTILIZATION REVIEW | Page: | 1 of 6 |
| | | Date Effective: | October 25, 2005 |
| Subject: | INTER-RATER RELIABILITY AUDIT | Date Revised: | |
| | | Authorizing Signature: Formally Adopted | |

PURPOSE: To assess concurrence with admission decisions made by clinical staff and by peer reviewers for mental health cases.

PROCEDURE:

1. To provide consistency in utilization management decisions and to meet accrediting body standards (URAC and NCQA), CDRSN provides for Inner Rater Reliability Studies.
2. At least annually, the Medical Director and UM Director conduct an inter-rater reliability evaluation, auditing the consistency with which the UM staff (non-clinical, clinical utilization management specialists, and peer advisors) certify services, utilize criteria/protocols, and make UM Decisions. BHO utilizes vignettes for reviews by care managers, physicians and other UM decision-makers.
 - A. The goal for consistency is 90%. Individuals who do not meet established thresholds of performance will be counseled and corrective action will be initiated. All clinical decision-makers are provided BHO's criteria upon hire or contracting for peer review.
 - B. The following elements are reviewed:
 - i. Concurrence with admission decisions
 - ii. If justification for the decision was clearly documented and in accordance with the appropriate criteria
 - iii. If agreement with recommended length of stay or alternative treatment setting exists
3. Quarterly peer reviews are utilized to ensure consistency among reviewers. New employees are reviewed quarterly until they achieve a 90% consistency rate
4. As part of the Inter-Rater Reliability process, vignettes are reviewed by clinical staff, physicians, and other UM decision-makers. The vignettes are then scored for each participant and measured for consistency.

5. In addition, weekly conferences are held with the medical director to review care management decisions to insure consistency among reviewers.

Audit tool and sample case studies are attached.

Referral # _____
Peer Advisor _____

(circle one) Denial Appeal

Inter-rater Reliability Audits

1. Would you agree with the initial decision regarding the admission?

(Circle one)

YES

NO

2. If NO: What is your rationale for the decision?

Specific:

3. What Criteria would you base this decision on?

- BHO Mental Health Admitting; continued stay
- ASAM Admitting; continued stay
- TCADA Guidelines Admitting; continued stay

4. Would you agree with the length of stay or alternative level of care recommended by the peer advisor?

(Circle one)

YES

NO

5. If NO- What would your recommendation be?

Auditor Signature

Date

Inter-Rater Reliability Assessment

Case Study #1

1. Which guideline applies?

2. Does the admission meet ASAM or BHO Admission Care criteria? YES ___ NO ___

3. Review each Care Day (below) and determine if case meets continued stay criteria.

History SHL 47 Y/O Male had breakup of 4-year relationship and planned to drown himself in his pool. Patient's brother is an inpatient at the UMC facility so the patient drove himself to the hospital on 1/08/05. Patient informed staff that he was going to cut his wrists with a razor. The patient's depression was rated 8 on a 1-10 scale. The patient had been unable to work and was treated at this facility 4 years ago. Patient was admitted to the hospital and was placed on a unit that specializes in psychiatric problems.

| Meets Criteria? Yes/No – Why? | Care Day | Clinical Summary |
|--|-----------------|--|
| | 1 | Patient was depressed, crying, isolative, guarded and rating his anxiety at a 5 and 8. The patient was prescribed Remeron 15 mg h.s. He had poor eye contact, poor concentration, suicidal with no plan, less disorganized. Attending documents that he was not at risk for self-harm. |
| | 2 | 1.10.05 Remeron was discontinued and Lexpro 10 mg was begun. Patient rated his depression at 7, anxiety 5. He was well groomed but hostile, asking for more medication for his anxiety and depression. No SI. HI or psychosis. |
| | 3 | 1.12.05 Patient discharged and scheduled for follow-up Intensive Outpatient Program. |

Inter-Rater Reliability Assessment

Case Study #1

1. Which guideline applies?

2. Does the admission meet ASAM or BHO Admission Care criteria? YES ___ NO ___

3. Review each Care Day (below) and determine if case meets continued stay criteria.

History 25 Y/O Male was admitted via ED to Daniel Hospital on 3.04.05 with a diagnosis of Severe back pain and Reflex Sympathetic Dystrophy. Pt had a nerve block under anesthesia, PCA Dilaudid for pain control with some relief. Patient is now anxious and depressed with suicidal ideation. Patient UDS was positive for opiates and cocaine. Patient was also on IV Ativan for anxiety. The facility has no psychiatrist to perform consultation. BHO Medical director spoke with the facility attending and determined that patient was suicidal with a plan to overdose and admission to psychiatry was appropriate. Patient was transferred to UCLA 3.12.05.

| Meets Criteria? Yes/No – Why? | Care Day | Clinical Summary |
|----------------------------------|----------|---|
| | 1 | 3.13.05 Patient diagnosis is Opioid Dependence and Depression, Axis 2 None, Axis 3 Complex Regional Pain Syndrome and L/ S Disc Herniation, Axis 4 Psychosocial and environmental stressors Axis 5 40. Treatment plan: Discontinue Lexapro, start Remeron 15mg QD, Neurontin 800 mg TID for pain management and anxiety, Ativan 1 mg q8hours, Fentanyl Patch 75 mcg x 72 hours, Hydromorphone 2 q4 hours prn for break through pain. Patient is on a locked psychiatric unit. |
| | 2 | 3.14.05 Patient depressed and very anxious related to chronic pain. Patient denies SI OR HI. |
| | 3 | 3.15.05 Patient is medical stable denies SI or plan. Meds administered and consults obtained for various problems. Patient to be discharged today with recommendation for follow-up with regular outpatient treatment, condition improved. No SI or HI. Discharge meds: Gabopentin 800mg TID, Remeron 7.5 mg HS, Effexor 75 mg qd, Ativan 0.5 mg BID prn. |

Inter-Rater Reliability Assessment

Case Study #3

1. Which guideline applies?

2. Does the admission meet ASAM or BHO Admission Care criteria? YES ___ NO ___

3. Review each Care Day (below) and determine if case meets continued stay criteria.

History 14 y/o female flipped out last pm in her home, breaking windows, raging, shrieking out of control. Her mother and mother's brother in law brought her into the facility in law. The mother appeared to be intoxicated. The mother reported that her daughter had been oppositional and defiant since parents' divorce a year ago. The patient has been in counseling sporadically for the last 6 months with Dr. Lee. Patient presented with a flat affect, hopeless and helpless expressing thoughts of self-harm. Patient was reluctant to answer any questions. The mother shared that they were about to be evicted from their apartment because of the patients' behavior. Patient was admitted to the hospital with the following diagnosis: Depression, Cannabis abuse, Severe –primary support group, social environment, school failure, financial problems of mother, abandonment by father. Patient was admitted to the facility on 1/14/05.

| Meets Criteria? Yes/No – Why? | Care Day | Clinical Summary |
|--|-----------------|---|
| | 1 | 1/15/05 nurse reports patient was feeling happy and hopeful, denied any S I., stated her relationship with her family was better. The patient met her treatment goal for the day. |
| | 2 | 1/16/05 Patient was depressed with feeling of hopelessness, low energy, having difficulty addressing issues, low self esteem. Patient threw her clothes into the hall, and required redirection. Awaiting family meeting father can attend until 1/17/05. |

| | | |
|--|---|--|
| | 3 | <p>1/17/05 The attending physician stated that the patient was ready for discharge over the weekend but the mother informed staff that there was a history of sexual abuse by the father so the attending did not feel patient should go home without a family meeting. During the family session the staff found out that mother is drinking all the time and when the patient was 3 y/o she had a diaper rash and the father applied cream to the area and the mother whom the attending describes as "a personality disorder", called the police. There was an investigation and the father was cleared. Medications are Prozac 10mg QD. Axis I 296.23 MDD Single Episode Severe without Psychotic Features, II Deferred, III None, IV Primary Support, V25. Patient remains angry and does not like the food but denies SI Patient has a history of ODD. Discharge patient to home with recommendation for regular outpatient treatment.</p> |
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