

Evaluator Quality Monitoring Program : Assessment of Best Practice Evaluations (BPE)

Training for Evaluators

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Training Agenda

1. Evaluator Quality Monitoring Program Background
2. Describe the evaluator orientation process
3. Introduce the QI-040 and new quality monitoring process
4. Describe quality improvement expectations associated with the new process
5. Provide item specific training on the Provider Performance Measurement Table

Background & Development of the Evaluator Quality Monitoring Program

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Evaluator Quality Monitoring Program

In collaboration with Pennsylvania Office of Mental Health & Substance Abuse Services, Behavioral Health Services of Somerset and Bedford Counties, Capital Area Behavioral Health Collaborative, & Tuscarora Managed Care Alliance, PerformCare is implementing an Evaluator Quality Monitoring Program.

The goal is to support evaluators in providing high quality evaluations and prescriptions.

Towards this end, PerformCare has multiple initiatives:

- An enhanced orientation process for new evaluators;
- A Quality Monitoring Program that provides feedback to evaluators on how their evaluations compare to standards and peers (Documented in PerformCare Policy QI-040 (in packet)).
- The use of CANS by evaluators for both assessing children and monitoring their treatment progress (Capital Area and Bedford-Somerset only);

These initiatives are impacting many things, including:

- How an evaluator gets started;
- The use of CANS during an evaluation (Capital area and Bedford and Somerset only);
- Quarterly reports to evaluators.

PerformCare's evaluator quality monitoring goals

- This program applies to both fully licensed psychologists working under their own license, as well as psychology associates working under the direct supervision of a fully licensed psychologist.
- Evaluations should be
 1. High quality
 - Factually accurate
 - Timely
 - Possessing all of the relevant and expected information
 2. Address consumer needs
 - Assess and refers appropriately
 3. Adherent to CASSP Principles
 - Child-centered
 - Family-focused
 - Community-based
 - Multi-system
 - Culturally competent
 - Least restrictive/least intrusive

The Evaluator Orientation Process and Steps to Take when Adding a New Evaluator

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New Evaluator Orientation

- Starting October 1, 2015 any qualified clinician who wishes to submit a Best Practice evaluation for authorization and reimbursement to PerformCare, must undergo an orientation with PerformCare before beginning.
 - Any new evaluators or associates must have the orientation prior to performing BPEs
- Any new evaluator must have an orientation prior to submitting BPEs
 - Completion of the orientation makes them eligible to perform BPEs
 - In order to initiate the orientation process the new evaluator must submit a resume to their AE
 - If it is an associate, their supervising psychologist must submit an attestation form and a copy of the associate's resume .

Steps to take when adding a new evaluator

- Evaluator submits appropriate form and resume to their AE
- The orientation will be completed within approximately two weeks of the PA receiving the application form and resume
 - This can be expedited if the email is current, the evaluator is responsive, and there is ample scheduling availability
 - The orientation lasts approximately ½ of an hour
- Once the orientation is complete, the evaluator will be entered into the PerformCare system as eligible to complete BPEs
- In the Capital Area and Bedford-Somerset, all evaluators also need to be (a) CANS certified, and (b) registered to input CANS into the online CANS tool before performing evaluations can begin.
 - To learn about becoming certified on PerformCare's CANS, as well as getting registered for the online CANS tool, contact Keven Cable at kcable@performcare.org.

Overview of New Quality Monitoring Process

The new process will be as follows:

1. Each quarter, every evaluator will have approximately 10% of their submitted Best Practice Evaluations audited against the Profiling Provider Performance Measurement Table (see handout)
2. Evaluators will be expected to achieve a 75% or higher on the aggregate of all scored evaluations in the quarter
3. Each quarter, reports will be shared with each evaluator on their performance
4. A score below 75% requires a written Quality Improvement Plan by the evaluator. The evaluator needs to attain scores above 75% for two consecutive quarters to come off the QIP

Disciplinary Action

In the event that the evaluator is unable to successfully achieve scores above 75% for two consecutive quarters, or fails to respond to complete the QIP, he or she would then be referred to the Credentialing Committee for further action and review.

- This recommendation will be made by PerformCare's Executive Director
- The PA who monitored the QIP will be the lead on making the referral to credentialing
- This referral could include recommendations up to, and including, termination of the evaluator from the network

Disciplinary Action - continued

- If at any point during the quality monitoring process an unaddressed member safety concern is found in a BPE, a referral to PerformCare's Quality of Care Counsel (QoCC) will occur in accordance with QI-040 Documentation Review and Follow-Up of Quality of Care Issues
- During the attestation process, it is agreed that all associates shall perform their duties under the full direction and control of the supervising psychologist. Therefore, if any one supervising psychologist has two or more associates who fail to successfully complete quality improvement steps, that psychologist will be referred to the Credentialing Committee, who will follow procedures in accordance with QI-003 Credentialing Progressive Disciplinary Actions for Providers
- A provider ineligible to perform BPEs through the Credentialing Committee, cannot resubmit for future eligibility options.

Ongoing Training and Education

- Annual training will be provided to evaluators and associates regarding quality expectations for BPEs and the monitoring process
- PerformCare will be continuously evaluating the helpfulness of this process for our network, as well as the usefulness of specific questions on the measurement tool and considering any needed changes annually. Please submit questions or comments to Jessica Umbrell, Psy.D. at jumbrell@performcare.org; or directly to your AE.
- PAs will respond to individual evaluator concerns within two business days to ensure technical assistance is readily available

Profiling Evaluator Performance Measurement Table

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Profiling Evaluator Performance Measurement Table

Evaluator Name: _____ Member ID: _____
 Evaluation Date: _____ Member Name: _____
 Assessment Date: CM Name:

Life Domain Format

- 1 Does the evaluation have sufficient information for all life domains (i.e. reason for referral, strengths, concerns, family, school, community, peer relationships, drug and alcohol, medical/developmental, trauma history, legal, service history, service update, clinical interview/assessment data, discussion, diagnosis, recommendations, mental status, and history of early intervention services)? Yes No

If no, what information was missing?

- Reason for Referral Community Legal Service Update
 Strengths Peer Relationships Service History Diagnosis
 Concerns Drug & Alcohol Discussion Clinical Interview/Assessment Data
 Family Medical/Developmental Recommendations History of Early Intervention Services
 School Trauma History Mental Status

- 2 Is information from the previous service provider(s) included? Yes No NA
 3 If sibling(s) are receiving behavioral health treatment, is this noted in the evaluation? Yes No NA
 4 Is the evaluation factually correct? (i.e. doesn't appear to have more than TWO significant factual errors - if there are more than TWO factual errors, please explain in the Comments Box below.) Yes No
 5 Is clinical information described in terms of frequency, intensity, & duration of behaviors and symptoms? (If No: please note missing clinical information in the Comment box below.) Yes No
 6 Are diagnoses sufficiently justified based upon the information contained within the evaluation? (If No: please note missing clinical information in the Comment box below.) Yes No
 7 Is there an overall discussion of the member's treatment experience, including progress, regression, barriers to treatment, or lack of progress? Yes No

Recommendations

- 8 If SI/Hi with a plan is relevant within recent history, immediate action is taken to ensure member safety and this is documented in the evaluation? Yes No NA
 9 If passive suicidal or homicidal ideation is expressed, appropriate follow-up is discussed with the member and team at the time of the evaluation? Yes No NA
 10 If substance abuse is identified, is proper follow up noted in the recommendations? Yes No NA
 11 If trauma is identified, is proper follow up noted in the recommendations? Yes No NA
 12 If eating disorders are identified, is proper follow-up noted in the recommendations? Yes No NA
 13 Do recommendations provide a rationale for services recommended? (If No: please note missing clinical information in the Comment box below.) Yes No

- 14 Treatment recommendations are consistent with CASSP Principles (If No: Please explain what is inconsistent, e.g., the correct treatment is recommended based on the information that is included in the evaluation; treatment recommendation is not too intense; treatment recommendation does not meet the need of the member)? Yes No
 15 If client is of appropriate age for EI services, and has appropriate concerns for EI intervention, was there a recommendation made to, or a documented discussion of, EI services? Yes No NA
 16 Does the evaluator consider (and include a rationale for) the most appropriate evidence-based match for the member based on the treatment options in the county? Yes No
 17 The evaluation has input from a qualified care giver in every domain (e.g. school, day care, home, community) that the service is prescribed? Yes No

Medications

- 18 Does the evaluator discuss or recommend a psychiatric consultation when medications are found to be not working, or to be having negative side effects? Yes No NA
 19 Does the evaluator discuss or recommend a psychiatric consultation after diagnosing a medication responsive disorder? (Discuss benefits/risk of medications and document if member/guardian is in agreement) Yes No NA

Diagnosis

- 20 If there is a rule out diagnosis, has it been clarified by the follow-up evaluation? Yes No NA
 21 When a diagnosis is removed, is there a clinical rationale documented? Yes No NA

CANS (Mark NA for 22-24, if member is from Franklin-Fulton)

- 22 Does the evaluation contain a CANS table, Severity Score, and the relevant EBSMs? Yes No NA
 23 Is the CANS scored correctly based on information found in the eval? Yes No NA
 24 Is the CANS completed within 10 days of the evaluation? Yes No NA

Substance Abuse Assessment

- 25 If the child is 10 years or older, was there a formal D&A screening performed (CANS, DAST, AUDIT)? Yes No NA

A Total	0
B Total Possible	25
Percentage (Calculate A/B)	0

* Note: If any of the Grey items are No (Items 8 or 9), then the evaluation instantly fails.

** Note: If an evaluator scores below the cutoff of 75% for the aggregate score for the quarter, a Quality Improvement Plan is required.

- Audit your BPE template and ensure that everything expected is in your template
- Notice that these standards are “lowest common denominator” standards

Profiling Provider Performance Measurement Table-Scoring

- **Item # 1.** *Life Domain Format (see handout)* – This item assesses whether all life domain information is included in the evaluation. PerformCare recommends that each of these items be clearly marked on the evaluation, to make it easier for the treatment team (and evaluation quality reviewer) to identify.
- **Item #2.** *Information from previous providers* – Credit is given for this question when it is apparent that the evaluator has received and reviewed, or made sufficient attempts to obtain, relevant clinical information from previous treatment providers. **N/A** will be marked when it is an initial evaluation and there was no treatment history.

- **Item #3.** *Treatment History for siblings* – Credit is given for this item when the evaluator has considered and documented the full range of services being delivered to the family. **N/A** would be marked when there are no siblings or no siblings are receiving services.
- **Item #4.** *Missing information*- Credit is given on this item when evaluations are up to date with regard to factual information, such as DOB, address, family constellation, etc.. Credit will not be given if significant information is missing in two or more domains.
- **Item #5.** *Frequency, Intensity, and Duration of clinical data* – Credit for this item will be given when the evaluator adequately describes the member’s behaviors. For example, if aggression is a behavior, indicate the setting, how often it occurs, how long aggressive episodes last and what the specific acts of aggression are. Use other relevant data to further indicate severity, such as if physical aggression caused injury to others or led to suspension, expulsion etc.

- **Item #6.** *Sufficient justification for diagnoses* – Credit for this item is given when the logic leading to an ultimate diagnosis is adequately explained and justified.
- **Item #7.** *Discussion of the member’s treatment experience* – The goal of this item is to ensure evaluations are capturing the member’s progress toward goals, any lack of progress or regression, and/or barriers to treatment.
- **Items #8 and 9.** *Assessing SI/HI-* The goal of this item is to ensure evaluators are adequately assessing and doing the appropriate follow-up when there is active or passive SI/HI. Recent history for this items is within 30 days. If either of these items are marked **NO** then an immediate referral to QOCC is made.

- **Items # 10, 11, and 12.** *Referral and follow-up for specialized services* – Credit is given for these items (substance abuse, trauma, eating disorders) when there is a significant issue in any of these areas, and an appropriate referral is made. N/A is marked when the member does not present with an issue requiring this follow-up.
- **Item 13.** *Rationale for the services prescribed* – Credit is given for this item when an evaluator clearly describes the reasoning behind the services they are prescribing. The analysis is not of the reasoning itself, just that there be a cogent rationale presented.
- **Item #14.** *Prescription Consistent with CASSP* – Credit is given for this item when the evaluator’s prescription is consistent with the intensity of the behaviors, and other CASSP principles are considered.

- **Item #15.** *Consideration for Early Intervention* – Credit for this item is given when the evaluator has considered EI for anyone 0-3 in place of, or in combination with, BHRS. **N/A** is scored when the child is older than 3.
- **Item #16** – *Consideration of Evidenced Based Programs* – Credit is given for this item when the evaluator has thought broadly about the services available to the member in the continuum of care and considered the most appropriate evidenced based service for the needs of the member. If the CANS yields an EBP, but evaluator prescribes something else, there should be sufficient justification for the difference in the prescription.
- **Item #17** – *Input from settings where services are prescribed* – Credit is given for this item when the evaluator has demonstrated receiving, reviewing, and considering feedback for each setting where services are being prescribed. This is most relevant for school/day care feedback.

Profiling Provider Performance Measurement Table-Scoring –cont-

- **Item #18.** *Psychiatric follow-up* – Credit is given for this item when the evaluator makes recommendations for appropriate follow-up when there are concerns about medication. **N/A** would be marked when there are no medications, or there are no issues with medications.
- **Item #19.** *Referring to psychiatry for medication responsive disorders* – Credit is given for this item when evaluators are making recommendations, or discussing the possible benefits of medications, when medication responsive disorders are being diagnosed. **N/A** would be marked when the disorder is not known to be responsive to medications (e.g., Adjustment disorder.)
- **Item #20.** *Clarifying diagnoses* – Credit for this item is given when evaluators are making sufficient efforts to confirm diagnoses that are being considered. These should be clarified within two re-authorizations except where there are limitations such as wait-lists for comprehensive evaluations or testing. Provisional diagnoses should be used verses rule-outs, per DSM standards. PLEASE NOTE: The term “rule-out” is not recognized in DSM-5. Instead use “provisional” diagnoses, as is stated in DSM-5 “The specifier ‘provisional’ can be used where there is a strong presumption that the full criteria will ultimately be met for a disorder but not enough information is available to make a firm diagnosis.

Profiling Provider Performance Measurement Table-Scoring –cont-

- **Item #21.** *Ensuring justification when diagnoses are removed* – Credit is given for this item when the evaluator has provided a clear rationale for changing diagnoses. N/A is marked when this does not apply
- **Items #22, 23, & 24 – CANS Items:**
 - (22) The CANS response screen must be included with the evaluation, including the Severity Score, Evidence-Based Service Matches, and the Needs Table;
 - (23) the CANS must be scored correctly; and
 - (24) the CANS must have been scored within 10 days of the evaluation.
 - **N/A** will be used when the member is from Franklin or Fulton counties, where there is no CANS expectation for the evaluation.
- **Item #25.** *Substance Abuse Screening* – Credit is given for this item when members 10 or above are screened for substance abuse concerns with an appropriate measure. The CANS counts as an adequate assessment of substance abuse. N/A would be marked when the member is below the age of 10.

Questions ????