

Employer Contracts Effective January 2002

Quest welcomes the following new employers:

- Glatfelter Insurance Group, York, PA
- York City School District, York, PA
- Shipley Energy, York, PA
- Summit Health, Chambersburg, PA
 - Cumberland Valley Medical Services (new)
 - Summit Surgery Center (new)

Authorization requests for all levels of care and claims for these groups are to be sent to Quest Behavioral Health. Please be aware that employees have been provided separate Quest identification cards, but Quest may not be listed on their general ID card.

Quality Management Program

The purpose of Quest's QM Program is to improve the quality of care and service for members. Our accomplishments in 2001 include:

- Maintaining the rate of abandoned telephone calls at 5% or less.
- Maintaining the average speed of telephone answer under 30 seconds.
- Increasing the rate of ambulatory follow-up within 30 days after hospital discharge.
- Increasing the rate of family visits within 60 days for members newly diagnosed with ADHD.

Reminder: Please complete a family session within 60 days for a child or adolescent newly diagnosed with ADHD. The family session is automatically authorized to complement individual treatment.

Member Satisfaction

Quest completed its annual member satisfaction survey using the ECHO survey endorsed by NCQA.

Following are the results of responses to questions about provider issues. Respondents told us that they:

- Saw someone as soon as needed - 75%.
- Got an appointment as soon as wanted - 82% .
- Got professional help or advice over the phone – 70%.
- Saw provider within 15 minutes of the appointment time – 90%.

They said that they were:

- Told about side effects of medications – 81%.
- Given information about different kinds of counseling available – 52%.
- Given information about rights as a patient – 80%.
- Helped by treatment - 91%.

They also said that their provider:

- Listened carefully – 98%
- Explained things – 98%.
- Showed respect for what they said – 98%.
- Made them feel safe – 98%.
- Spent enough time with them – 94%.

The QM Committee will analyze the results further to identify opportunities for improvement. We welcome your suggestions about how to increase patient satisfaction in the above areas or any other areas. Next year Quest will be able to compare its results to other companies that use this survey.

Access and Availability

Our study of access and availability indicates a sufficient number of providers close to members in driving time to meet needs, and that appointments are available to meet Quest's standards. We continually add providers to the network as a need is identified and new business is acquired. Please let us know if you have difficulty offering appointments within:

- 6 hours for members with non-life-threatening emergencies.
- 48 hours for members with urgent needs.
- 10 business days for members with routine needs.

Provider Satisfaction

All of our providers were sent a satisfaction survey in January 2002. Thank you for your responses. We value your opinion. Satisfaction was 90% or higher in all areas except appropriateness of denials, claims payment timeliness and reimbursement rates. You told us you were 99% satisfied overall with our UM services.

Satisfaction with the appropriateness of denials was slightly less than 90%. Quest strives to work with providers to reach consensus and avert denials and will continue to do so. Satisfaction with the precertification

and recertification processes including the required paperwork is 93%. This is higher than our last survey and after revision of the recertification form which was shortened to one page.

89% of respondents were satisfied with claims payment timeliness. We consistently meet our claims payment time standard of within 45 days for a clean claim. Our average for clean claim payment is 21 days. However, Quest does not pay claims for all products. Please be sure to provide complete and accurate information so your claim can be processed quickly.

The area of lowest satisfaction was reimbursement rates. In response to your rating we again reviewed our reimbursement rates. They are competitive with other companies. We review our rates annually to remain competitive. Remember that benefits may be limited and rates set by some employers.

Complaints

Quest's Quality Management Committee reviews complaints. Our standard for resolving urgent complaints within two business days or less, and routine complaints within 30 days or less has been continually met.

Preventive Behavioral Health Programs

Attention Deficit Hyperactivity Disorder

Our ADHD preventive behavioral health program is designed to:

- Improve clinical outcomes for children and their parents.
- Complement your assessment and treatment of ADHD.
- Educate parents about ADHD and how they can work more effectively with their child by:
 - Recognizing the impact of ADHD on the family.
 - Teaching parents how to foster communication.
 - Describing ways to help modify problem behaviors at school and at home.
 - Providing ways to reduce the stress that they and other family members may experience.

Fifty-One (51) families were identified for the program in 2001. Fifty (50) participated. Parents of a child newly diagnosed with ADHD receive a series of three educational modules and a follow-up survey to assess their perception of the program's usefulness. Response to the program has been very positive. Thirty-four percent (34%) of participants responded to the survey. They reported that suggestions in the modules were helpful in providing ways to:

- Discipline a child with ADHD.
- Deal with the child's anger and frustration.
- Decrease the parent's own level of stress.

Major Depressive Disorder

Our MDD preventive behavioral health program is designed to:

- Improve clinical outcomes for members diagnosed with MDD.
- Complement your assessment and treatment of MDD.
- Educate members about depression and its symptoms, available treatments, the course of recovery, and their own role in the treatment process.
- Help members understand the importance of communicating with providers.
- Increase treatment compliance.

Three hundred and thirty seven (337) members were identified for the program. 318 participated. Members who are diagnosed with MDD receive a series of three educational modules over consecutive months, and a follow-up survey to assess their perception of the usefulness of program.

Response has been very positive. Thirty-one percent (31%) of participants responded to the survey. They reported that the modules overall were helpful. The modules helped them:

- Continue in treatment.
- Understand treatment.
- Make changes in their life.
- Cope better with their depression.
- Work more effectively in treatment.
- Feel less stressed and more supported.

Please Encourage Patient Participation.

Inform your patients about our preventive behavioral health programs and encourage them to participate. You or the patient may call us to receive more information about the ADHD Program or the MDD Program.

Clinical Practice Guidelines for Depression

Quest has adopted the APA's Practice Guideline for the Treatment of Patients with Major Depressive Disorder (Revision). This replaces the ICSI Health Care Guideline: Major Depression in Specialty Care in Adults. The APA's Guideline was adopted because it provides best practices for psychiatrists and other behavioral health clinicians whereas the ICSI Guideline targets only psychiatrists. The APA's Guideline was printed in the American Journal of Psychiatry 157:4, April 2000 Supplement and is available through the local library and at www.psych.org. If you would like a paper copy of the Guideline, please contact us.

Quest measures compliance with the following elements of the Guideline:

1. Evidence of a suicide risk assessment in the initial evaluation.
2. ECT treatment should be included in the treatment plan if chronic, moderate to severe depression: with or without a specific effective psychotherapy if patient prefers or severe depression and any of the following: psychotic features, patient prefers, previous preferential response, need of rapid antidepressant response, intolerance of medication.
3. Evidence that members have been informed of the potential side effects of medication.

Enclosed please find member information on the APA Depression Guideline. This information may be photocopied and distributed to appropriate members. You may also direct members to the Quest web site at www.questbehavioralhealth.com, under the member news section to obtain a copy of the member information.

You may request an exception to the Guideline by describing your reason(s) for the exception request in writing and sending it to our Medical Director, James Hegarty, MD.

Over Half of Depressed Patients Do Not Receive Recommended Duration of Antidepressant Therapy

James Hegarty, MD, Medical Director
Quest Behavioral Health

The medical treatment of depression has been conceptualized as consisting of three phases; acute, continuation, and maintenance antidepressant therapy. The acute phase is defined as the initial period of treatment with improvement until reaching a stable clinical plateau. The acute phase typically lasts anywhere from 1-3 months. The continuation phase is defined as treatment during a period of stable improvement up from 3-6 months after the end of the acute phase. Maintenance therapy, treatment beyond 9-12 months is reserved for patients with recurrent illness or other significant risk factors for recurrence. Clinical research has shown that if antidepressant treatment is terminated before completion of the continuation phase, there is a much higher risk for relapse. However, recent study results from HEDIS (Health Plans Employer Data and Information Set, 2000)¹ indicate that most patients in treatment for depression never complete treatment through the continuation phase.

Percent of patients not receiving 3 and 6 months of therapy	
Acute Phase (1-3 months)	41.2%
Continuation Phase (3-6 months)	57.8%

Frequency of appointments should be based on the individual clinical needs of each case, but a clinical rule-of-thumb may be *at least three visits in the first three months*. Relapse risk can be minimized by encouraging patients to comply with these minimum treatment durations.

¹ NCQA Health Plans Employer Data and Information Set. Available at: <http://www.ncqa.org/Programs/hedis/hedis2k.htm>

Patient Safety - The Use of Suicide Contracts

Scott D. Daubert, PhD, Clinical Director,
Quest Behavioral Health

Identifying and improving patient safety and clinical care remains a shared goal of Quest and our providers. Many behavioral health providers would agree that suicide risk management is the most common and complex patient safety issue that is routinely faced in clinical practice. The following information is summarized from the following sources as a starting point in this important topic area:

- Miller, C.M., Douglas, G.J., & Gutheil, T.G. (1998). Talisman or taboo: The controversy of the suicide-prevention contract. Harvard Review of Psychiatry, 6 (2), 78-87.
- DeAngelis, T. (2001). Surviving a patient's suicide. Monitor on Psychology, 32, (10), 70-75.

Safety contracts or suicide-prevention contracts are a patient's verbal or written promise of safety completed in response to suicidal or self-harm thoughts, impulses, or behaviors, and have become widely used clinical and risk management techniques. However, the literature review conducted by Miller et al. (1998) revealed both a lack of published research and a lack of formal training on the topic. They concluded that there is a tendency for clinicians to overvalue the effectiveness of "contracting", and that the process may actually detract from the completion of a thorough suicide assessment.

The following factors act to omit the applicability of suicide-prevention contracts:

- The low baseline rate of completed suicides and the unpredictability of suicide.
- The variety of risk factors and antecedents to completed suicides.
- The disparity between clinical usage (to enhance patient control and clarify emergency procedures) and legal usage (to protect from litigation) of the contract concept.

In summary, shorthand documentation such as "patient contracted for safety" in the absence of assessment of specific suicide risk factors and a plan for managing suicide risk likely does not enhance patient safety. Suicide-prevention contracts can play a useful role in

suicide risk management and patient safety when used in the context of informed consent and a thorough and ongoing suicide assessment.

Treatment Records

Your cooperation with the recent treatment record review in various offices is appreciated. Providers were sent their individual results and comparative data for all records reviewed. Quest's performance standard is 90% for each criterion. Performance did not meet expectations in all areas. Areas of concern relate to documenting:

- Consent to release information.
- Communication with PCPs at the time of admission, medication change and discharge.
- Measurable treatment goals.

The QM Committee identified areas of opportunity and several best practices from their analysis of the data.

They endorsed the best practices and made other recommendations to improve treatment records across the network. Quest's recommendations to improve treatment records are:

- Maintain a current consent to release information in each record.
- Ensure that the consent to release information is complete including the name of the clinician, organization, school, etc. intended to receive the information.
- Ensure that office policies are congruent with the time frames stated on the consent to release information form.
- Notify the patient's PCP at the time of admission to care, change in level of care, medication change and discharge from treatment. If the patient refuses permission to communicate with the PCP, document the refusal.
- Encourage patients to sign the consent to release information to the PCP and explain the inherent safety issues in not allowing communication.
- Document your communication with the PCP in the record.
- Consider use of a check box and date section in the record to document PCP communication.
- Document the date of the patient's last contact with the PCP or the date of the last physical examination.

- Do not use Quest's recertification form as a treatment plan.
- Include measurable goals in the treatment plan.
- Develop a memory jogger of items to be included in the mental status examination to be certain all items are included. The tool might be printed on a form or used by the individual completing the mental status examination.
- Following are several useful resources:
 - A model HIPAA compliant consent is available at <http://www.nhha.org/finance/hipaa-patientnotice.php>
 - Treatment plan guides include Leahy and Holland (2000); Treatment Plans for Depression available at www.guildford.com or Wiley/Jossg-Bass@www.wiley.com/practiceplanners.

Request For Information

For more information about Quest's QM Program, preventive behavioral health programs, clinical practice guidelines, medical necessity criteria, denial and appeals processes, confidentiality policies, members' rights and responsibilities statement, or other activities, or to request a paper copy of documents, please call the QM Department at 1-800-364-6352, or e-mail us at QBHQuality@aol.com. You may also visit us at: www.questbehavioralhealth.com/handbook.zip for more information about these topics and to view the Provider Handbook. If you would like to serve on our QM Committee, please let us know. We welcome your input and encourage suggestions about how to improve our services and our QM Program.

Announcements

Precertification may be obtained by calling 1-800-364-6352. Do not use Recertification forms as treatment plans. Recertification forms may be mailed or faxed. The Fax number is 717-851-1414. Recertification forms and claims should be mailed to:

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