Provider Profiling

Community Residential Rehabilitation – Host Home

01/01/12 to 12/31/12
CBHNP utilizes a provider profiling process that is an important provider-level quality improvement activity, as well as an opportunity to internally track and trend data over a set period of time to identify possible areas of improvement. It is also a tool to make meaningful comparisons based on a varied data set including claims data, authorization data, quality reports and demographic information. Provider profiling results have been compiled using data from January 1, 2012 to December 31, 2012.

Community Residential Rehabilitation – Host Home (CRR-HH) services are a twenty-four hour, seven day a week service that provides individual residential treatment in a home-like environment with maximum supervision, personal assistance and a full range of psycho-social rehabilitation services for psychiatrically disabled children who display severe interpersonal adjustment problems and who require an intensive, structured living situation.

All CRR-HH providers across the Network with Members in service were profiled during this period. The profiled providers for each Contract are as follows alphabetically:

Profiled Providers – Bedford/Somerset
  - Children’s Aid Home Programs of Somerset County
  - Family Care Services, Inc.
  - Northwestern Human Services of PA, Inc.
  - Pressley Ridge Schools

Profiled Providers – Blair
  - Adelphoi Village
  - Northwestern Human Services of PA, Inc.
  - Pressley Ridge Schools

Profiled Providers – Franklin/Fulton
  - Family Care Services, Inc.
  - Northwestern Human Services of PA, Inc.

Profiled Providers – Lycoming/Clinton
  - Community Services Group, Inc.
  - Diversified Treatment Alternatives, Inc.
  - Northwestern Human Services of PA, Inc.

Profiled Providers – Capital
  - Community Services Group, Inc.
  - Diversified Treatment Alternatives, Inc.
  - Keystone Service Systems, Inc.
Profiled indicators include demographics, utilization, quality, compliance and satisfaction.

**Demographics**

Demographic information available for Members receiving CRR-HH includes age, gender, race and diagnostic data. Demographic mix is consistent with previous years with no developing change in trend.

Overall, one percent of the Members receiving CRR-HH were between the ages of three and six, ten percent were between the ages of seven and ten, twenty-five percent were between the ages of eleven and fourteen, fifty-seven percent were between the ages of fifteen and eighteen, and seven percent were between the ages of nineteen and twenty-one.

Fifty-seven percent of Members receiving this service were male and forty-three percent were female.
Seventy-four percent of these Members were Caucasian, twelve percent were African American, eleven percent were categorized as Other, and three percent were Asian.

The most common diagnoses of Members receiving Community Residential Rehabilitation - Host Home services were Mood Disorder, Not Otherwise Specified – 296.90 at twenty-two percent, Oppositional Defiant Disorder – 313.81 at eleven percent, Attention-Deficit/Hyperactivity Disorder – 314.01 at eight percent, Bipolar Disorder, Not Otherwise Specified – 296.80 at eight percent, and Post Traumatic Stress Disorder – 309.81 at eight percent.
Utilization

Utilization information available for Members receiving CRR-HH services includes the number of unique Members treated, the total average length of stay, the average length of stay for ASD and Non-ASD Members, units paid and the number of Mental Health Inpatient and/or Residential Treatment Facility admissions that occurred during CRR-HH treatment.

The total number of unique Members served across the Network was 208 with the overwhelming majority of Members served being in the Capital Contract. In review of the number of Members served in comparison to contract enrollment, less than one percent of Members are served in this level of care.
The total average length of stay across the Network for CRR-HH services during the profiled period was 307 days. Providers that had a total average length of stay less than or equal to the Network average met one of the three target criteria for performance. The Blair, Franklin/Fulton and Lycoming/Clinton Contracts had average lengths of stay less than the Network average.

The average length of stay for ASD Members was 356 days versus Non-ASD Members with an average length of stay of 302 days.
The Network total number of units paid per Member was 35,581, with a corresponding number of units paid per unique Members of 171.06. The Franklin/Fulton and Capital Contracts had an average number of units paid per unique Member less than the Network average. It should be noted that units paid are based upon claims payment are not a representation of length of stay.

Across the Network there were fifty-four Mental Health Inpatient (IP) admissions during CRR-HH treatment, which is an average of 0.0201 admissions per 1000 Members. Providers that had zero IP admissions during treatment met the second target criteria for
The Lycoming/Clinton and Capital Contracts had averages less than the Network average.

Multi-Year Utilization Comparison

The total number of Members in CRR HH’s has decreased since 2009, as have the average units paid per Member and the number of IP or RTF admissions during CRR HH treatment. The average length of stay remains steady with 2009 and 2010, and has decreased since 2011, when the average length of stay showed a slight spike.
Quality

The quality indicators for CRR-HH were measured by the total number of complaints filed against each provider and the total number of critical incident reports submitted by the provider.

Across the Network, there were two complaints filed against CRR-HH providers. Additionally, there were 289 identified quality of care issues, resulting in an average of 0.1086 complaints and quality of care issues per 1000 Members. The Bedford/Somerset, Blair and Lycoming/Clinton Contracts had an average less than the Network.

There were a total of 170 Critical Incident Reports (CIR’s) filed across the Network, with fifty-one resulting in quality of care or safety concerns. The Network average of CIR’s resulting in quality of care or safety issues per 1000 Members was 0.0190.
Compliance

Compliance indicators were measured using the number of denied administrative appeals per provider, the number of provider performance issues reported for each provider, treatment record review scores and the percentage of trainings attended by each provider.

There were three denied administrative appeals across the Network for the profiled period, which is an average of 0.0011 denied appeals per 1000 Members. The Bedford/Somerset, Franklin/Fulton and Lycoming/Clinton Contracts had zero denied administrative appeals.
Across the Network there were 226 documented provider performance issues, resulting in an average of 0.0843 provider performance issues per 1000 Members.

The average treatment record review score for the Network was eighty-four percent. The Franklin/Fulton and Lycoming/Clinton Contracts did not have any providers that participated in the treatment record review process in 2012. However, in 2011 these Contracts scored seventy-seven percent and 100% respectively.
Providers have the opportunity to attend provider trainings offered by CBHNP throughout the year. Although these meetings are not mandatory, trainings include valuable information for providers, and attendance is encouraged. The Network average of provider training attendance was twenty-five percent. The Blair, Lycoming/Clinton and Capital Contracts did not offer any provider trainings in 2012.

![Provider Training Attendance](image)

**Satisfaction**

Member satisfaction was measured by the percentage of Members satisfied with the outcomes of complaints that were filed. There were only two complaints filed during the profiled period, and the outcomes of each complaint resulted in 100% satisfaction, which accounts for a 100% satisfaction rating across the Network for Community Residential Rehabilitation – Host Home providers.

**Target Criteria**

Although all aspects of performance are important, these specific targets of a total average length of stay less than the Network average, zero IP admissions during treatment and zero Credentialing Corrective actions since 01/01/12, are goals that all providers should strive to achieve. The CRR-HH preferred providers are as follows:

Bedford/Somerset
- Pressley Ridge Schools

Blair
- None
Network Recommendations

When summarizing the information contained above, several strategies for impacting CRR-HH performance can be identified.

- Actively work to decrease the length of time that Members reside within a CRR-HH; implementing more active discharge strategies to assist Members in transitioning to more natural settings.
- Develop enhanced strategies for the transfer of skills and skill generalization.
- Consolidate and renew efforts at identifying discharge resources earlier in treatment and actively involve these supports in treatment.
- Develop internal policies that address structured guidelines for when it is, and is not, appropriate to transition Members from Foster Care to CRR-HH, while remaining in the same host home.
- Develop internal policies which help guide host home families in the appropriate handling of Members based upon the appropriateness of each family member, their training, preparation and clearances to supervise Members in care.
- Review annually with Host Home parents the services which are included within per diem reimbursement and clarify procedures for scheduling necessary services.
- Develop an agency policy that incorporates discharge discussions upon admission, as well as on an ongoing basis.
- Adopt empirically based treatments that are diagnosis specific and have demonstrated efficacy for the most commonly occurring diagnoses (e.g., AD/HD; ODD).
- Consider developing alternative mental health treatments that are targeted toward symptom reduction, and may be less intrusive and more effective than treatment in a CRR-HH.
- Adopt empirically based treatment packages (e.g., ABA) for those Members affected by autism, as well as other diagnoses on the spectrum.
- Provide enhanced training to clinical staff in order to provide more active mental health treatment to our Members.
- Encourage clinical leads to disseminate (to treatment teams and Members) empirically based treatment recommendations.
- Establish an active treatment culture and focus whereby recommendations are continually assessed and adjusted.
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- Improve the level of trauma informed trainings and programs that are offered to CRR-HH staff.
- Improve the level of expertise of CRR-HH parents by providing training, support groups, and research based interventions based upon the specific diagnosis of the child.
- Actively involve the family or discharge resource in mental health treatment.
- Distribute and discuss CBHNP and other Best Practice guidelines in order to provide an educational resource to staff.
- Consider parent education, support groups, and trainings that can enhance CRR-HH treatment.
- Conduct an analysis of Members who required a more intensive level of treatment during CRR-HH and work to implement preventative components.
- Incorporate an objective measure (e.g. CANS) to determine symptom severity and most appropriate treatment.
- Member and Family (discharge resources) engagement is essential to the effectiveness of CRR Treatment, as well as active participation of the Member and family in weekly therapy sessions. Treatment needs to focus on individual therapy for Member in conjunction with family therapy.