Provider Profiling

Family-Based Mental Health Services

01/01/12 to 12/31/12
Family-Based Mental Health Services

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.

Family-Based Mental Health Services (FBMHS) are a comprehensive 24 hour, 7 day per week mental health treatment that is designed to be a 32-week, home-based, team-delivered, and comprehensive service package. The team concept involves the use of two therapists, a clinical supervisor, and representatives from the larger service system, when appropriate. FBMHS components include the following core services:

- therapeutic interventions that may include the Member and any combination of family members, and which will include individual or family therapy
- assessment, psychoeducation, and skill development
- family support services
- school-based consultation and intervention
- case management and service coordination
- 24-hour emergency coverage, crisis planning and crisis intervention
- transition and discharge planning
- outcomes evaluation planning
- fidelity to the FBMHS model

All FBMHS providers within the Network were profiled during this period. The profiled providers by Contract are as follows alphabetically:

Profiled Providers – Bedford/Somerset
  Alternative Community Resource Program
  Bedford Somerset MH-MR
  Blair Family Solutions
  Nulton Diagnostic and Treatment Center

Profiled Providers – Blair
  Altoona Regional Health Systems
  Blair Family Solutions, LLC
  Cen Clear Child Services, Inc.
  Jewish Family Services (OON)

Profiled Providers – Franklin/Fulton
Demographics

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

Overall, seven percent of the Members receiving FBMHS were between the ages of three and six, twenty-one percent were between the ages of seven and ten, thirty-four percent
were between the ages of eleven and fourteen, thirty-six percent were between the ages of fifteen and eighteen, and two percent were between the ages of nineteen and twenty-one.

Fifty-nine percent of Members receiving this service were male and forty-one percent were female.

Seventy-seven percent of these Members were Caucasian, twelve percent were categorized as Other, ten percent were African American and one percent were Asian.
The most common diagnoses of Members receiving Family Based Mental Health Services were Attention-Deficit/Hyperactivity Disorder – 314.01 at sixteen percent, Mood Disorder, Not Otherwise Specified – 296.90 at fifteen percent, Oppositional Defiant Disorder – 313.80 at twelve percent, Depressive Disorder, Not Otherwise – 311 at six percent, and Pervasive Developmental Disorder, Not Otherwise – 299.80 at six percent.
Utilization information available for Members receiving FBMHS services includes the number of unique Members, units authorized, units paid, units per Member per month, percent utilization and percent team delivered services.

The total number of unique Members served across the Network was 1,695. The Capital Contract had the greatest number of unique Members at 1,196, and the Bedford/Somerset Contract had the fewest at eighty.

Across the Network, there was an average of 63.01 units per Member per month. Providers that had units per Member per month less than or equal to the Network average met one of four target criteria for performance. All Contracts except Bedford/Somerset and Blair had an average below the Network.
Of the 1,281,651 units authorized, 638,416 were paid, representing an overall utilization average percentage of 49.81% across the Network. Providers that had a utilization percentage greater than or equal to the Network average met the second target criteria for performance. Both the Franklin/Fulton and Capital Contracts had a utilization percentage greater than the Network average.

The Network average of FBMHS team delivered services was 52.75% claims ratio. The claims ratio of forty-three percent is equivalent to the actual team delivered services of sixty-percent. Providers that had a percentage of team delivered services greater than
forty-three percent met the third target criteria for performance. The Bedford/Somerset, Blair and Franklin/Fulton Contracts scored above the Network average.

Across the Network there were 300 Mental Health Inpatient (IP) or Residential Treatment Facility (RTF) admissions during FBMHS treatment, which is an average of 0.1119 admissions per 1000 Members.

<table>
<thead>
<tr>
<th>Number of IP/RTF Admissions During Treatment</th>
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<tbody>
<tr>
<td>Bedford/Somerset</td>
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<tr>
<td>Blair</td>
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<tr>
<td>Franklin/Fulton</td>
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<td>Lycoming/Clinton</td>
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<td>Capital</td>
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Multi-Year Utilization Comparison

The total number of unique Members receiving FBMHS services has remained steady throughout 2009, 2010 and 2011, with the number of unique Members decreasing significantly in 2012. The utilization percentage and the percentage of team delivered services, based on claims payment, have shown an increase in 2012. Additionally the units per Member per month have shown an increase from 2011, but are still less than the numbers reported in 2009 and 2010. Another noted decrease was related to the number of IP or RTF admissions during FBMHS treatment. CBHNP will provide active care management in order to keep lines of communication open and effective and to ensure that FBMH services focus on discharge planning and development and utilization of natural supports/community resources with emphasis on establishing outpatient and/or medication management, as well as other less restrictive interventions. CBHNP has also established policies and procedures that provide more interaction with the CBHNP CCM, as well as clearly structure the nature of FBMHS treatment.
Quality

The quality indicators for FBMHS were measured by the total number of complaints filed against each provider, the total number of critical incident reports submitted by the provider, and each provider’s treatment record review score.

Across the Network, there were only three complaints filed, and all were against providers in the Capital Contract. Additionally, there were seventy-three quality of care issues across the Network. The number of complaints and quality of care issues per 1000 Members was 0.0284 for the Network. Due to the large number of Members served, the Capital Contract fell below the Network average, even though Capital had the greatest number of complaints and quality of care issues. The Blair Contract also fell below the Network average.

There were a total of 539 critical incident reports (CIR’s) filed across the Network, with four resulting in quality of care or safety concerns, one from the Franklin/Fulton Contract
and three from the Capital Contract. The Network average of critical incident reports resulting in a quality of care or safety issue per 1000 Members was 0.0015.

The Network average treatment record review score was seventy-seven percent. Only providers in Franklin/Fulton and Capital participated in the treatment record review process in 2012. However, in 2011 Bedford/Somerset scored eighty percent, Blair scored eighty-three percent and Lycoming/Clinton scored eighty-three percent. This was due to the restructuring of the Treatment Record Review in order to coordinate with the credentialing process.
Compliance

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

There were four denied administrative appeals for administrative issues and one denied administrative appeal for additional unit requests across the Network for the profiled period, which is an average of 0.0004 denied administrative appeals per 1000 Members. One denied appeal was from the Blair Contract, and the remaining four were from the Capital Contract.

The total number of provider performance issues across the Network was 1,168, with a corresponding average of 0.6037 issues per 1000 Members. All Contracts scored below the Network average except Franklin/Fulton.

Providers have the opportunity to attend provider trainings offered by CBHNP throughout the year. Although these meetings are not mandatory, they include valuable information for providers, and all providers are encouraged to attend. The Network average of provider training attendance was fifty percent. The Lycoming/Clinton and Capital Contracts did not offer any provider trainings during the profiled period.
Member satisfaction was measured by the percentage of Members satisfied with the outcomes of complaints that were filed. Overall satisfaction with FBMHS complaints across the Network was 100%.

Target Criteria

Although all aspects of performance are important, these specific targets of a units per Member per month, percent utilization greater than or equal to the Network average, percent team delivered services greater than forty-three percent (claims ratio – equivalent to 60% actual), and zero Credentialing Corrective actions since 01/01/12, are goals that all providers should strive to achieve. The FBMHS providers that met the target criteria are as follows:

- Bedford/Somerset
  - None

- Blair
  - None

- Franklin/Fulton
  - Franklin Family Services
  - Pennsylvania Counseling Services

- Lycoming/Clinton
  - None
Network Recommendations

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

- FBMHS teams should maintain open and regular communication with the CBHNP CCM.
- Extensions of FBMHS treatment, typically, are not an appropriate or accepted practice.
- FBMHS providers should provide training and clinical supervision to clinicians.
- FBMHS should strive to be the sole treatment provider for the family and should provide treatment to all members of the family, as well as work directly with schools.
- FBMHS should not, upon completion of treatment, begin treatment for another sibling in the same family as the identified patient for another authorization period of FBMHS.
- FBMHS should not provide treatment to Members who do not meet the criterion for inclusion in this type of treatment. A team meeting should be scheduled to discuss discharge planning in these cases.
- FBMHS should focus discharge planning on development and utilization of natural supports/community resources with emphasis on establishing outpatient and/or medication management, as well as other less restrictive interventions when the Member completes FBMHS.
- Notification should be given to CBHNP CCM regarding barriers that could negatively impact timely discharge to natural supports/community resources.
- Develop enhanced strategies for the transfer of skills and skill generalization.
- Develop an agency policy that incorporates discharge discussions upon admission, as well as on an ongoing basis, specifically as part of each 30 day review meeting.
- Adopt strategies for maintaining an internal commitment to fidelity to the FBMHS model.
- Adopt empirically based treatment packages (e.g., ABA) for those Members impacted by an ASD diagnosis, as well as other diagnoses.
- Distribute CBHNP resource guide to all internal staff in order to fully develop natural and community supports.
- Develop a consortium of providers in order to share information and collectively address provider difficulties.
- Establish an active treatment culture and focus, whereby treatment progress, or lack thereof, is continually assessed and adjusted.
FBMHS providers should explore enhancements to the model that best fit the diagnostic categories that comprise the current population.

FBMHS should work to improve diversionary strategies and techniques that will prevent more restrictive placements such as RTF or IP.