

# Provider Profiling

Evaluators

10/1/09 to 9/30/10



## **Evaluators**

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 October 1, 2009 to September 30, 2010.

Evaluators who were considered high volume based on the total number of initial evaluations completed and submitted during the period were profiled. The high volume criterion for evaluators was seventy or more initial evaluations submitted. These criteria resulted in nineteen profiled evaluators.

### **Profiled Providers**

1. Barbara Kettering
2. Bonnie Whipple
3. Brian Andrews
4. Bruce Anderson
5. Cynthia Stauffer
6. Haley Huba-Gaster
7. Hugh Smith
8. Karen McClure-Snodgrass
9. Laurie Keiper
10. Mark Zengerle
11. Matthew Smith
12. Michael Boerger
13. Nicholas Pappas
14. Pamela Machamer-Peechatka
15. Rebecca Murray
16. Richard Petroski
17. Richard Sleber
18. Robert S. Lambert
19. Theresa Scott

Profiled indicators include utilization, service delivery, quality and administrative compliance.

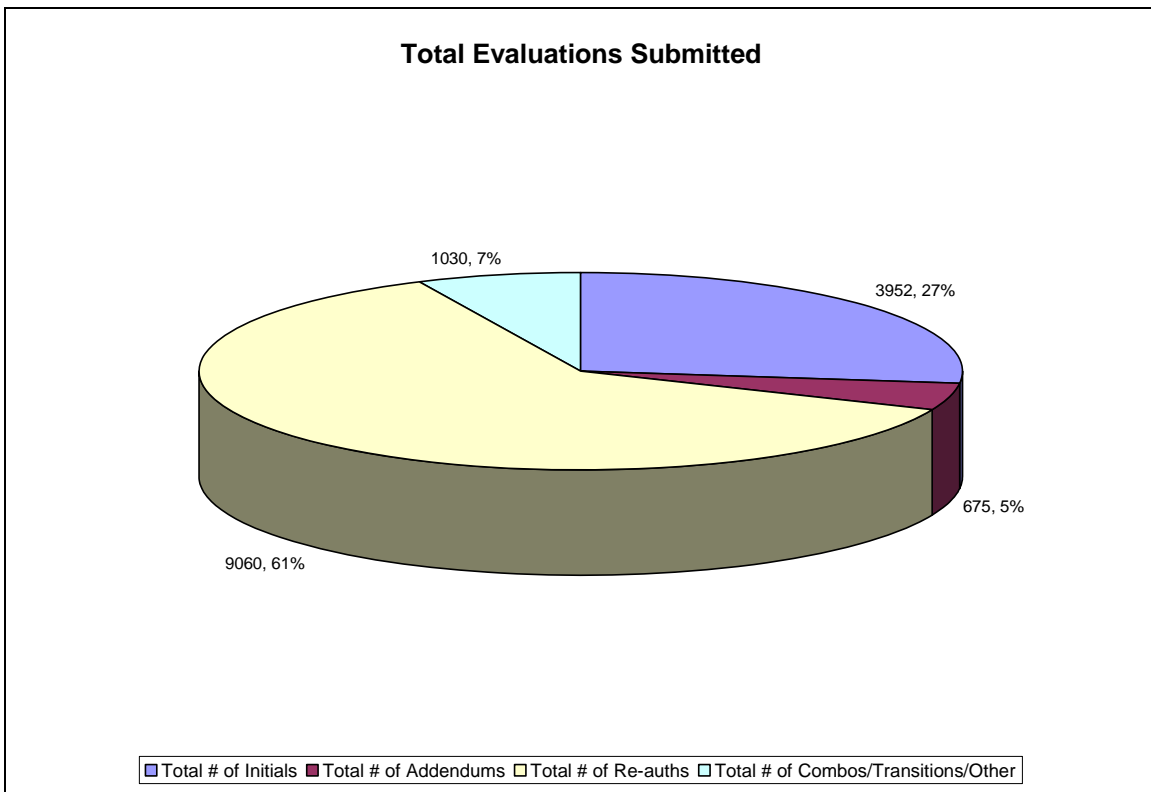
### **Utilization**

Across the Network there were a total of 14,717 evaluations submitted, up from the total of 12,950 submitted in 2008-2009. The total number of initial evaluations submitted was 3,952, which is twenty-seven percent of the total submissions, resulting in an average of 329 initial evaluations per month. In 2008-2009, twenty-six percent of the total submissions were initial evaluations, resulting in an average of 276 initial evaluations per month.

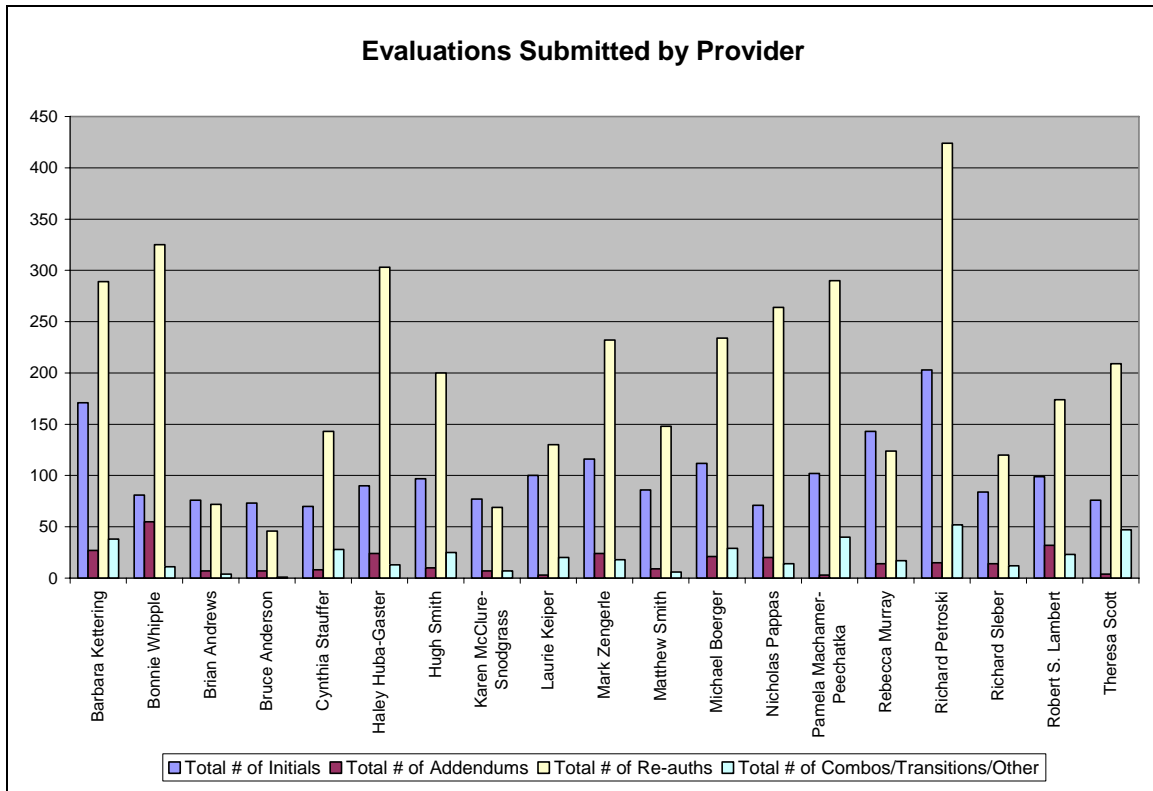
Of the 14,717 evaluations submitted, 9,060, or sixty-two percent, were re-authorization evaluations, resulting in an average of 755 re-authorization evaluations per month. In 2008-2009, sixty-one percent of the total submissions were re-authorization evaluations.

In addition, 675 addendums and 1,030 combo/transition/other evaluations were submitted for the period, which is greater than 2008-2009 in which 607 and 977 were submitted respectively.

An initial evaluation is one that recommends the initiation or start of a service, and a reauthorization evaluation recommends the continuation of a previously authorized service. An addendum is submitted when there is a correction or revision to the original evaluation. A combo evaluation is one that recommends an initial service, in addition to a continuation of at least one other service. A transition is an evaluation that recommends a change from one service to another. Evaluations that are categorized as “other” are those recommending special extensions or unit increases for specific services.

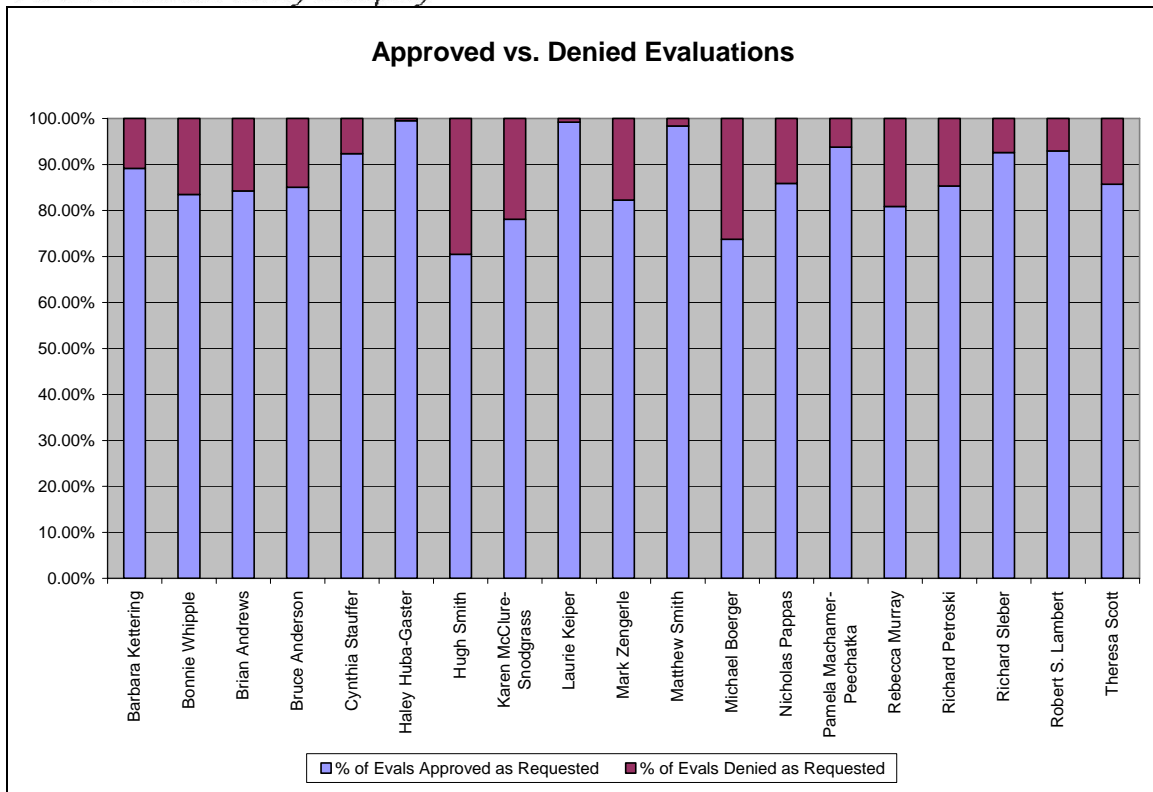


The total number of initial evaluations submitted for each profiled provider ranged from seventy-one to 171 for the period. The total number of addendums ranged from three to fifty-five. The total number of re-authorizations ranged from fifty-one to 466. The total number of combos/transitions/other evaluations ranged from one to fifty-two.

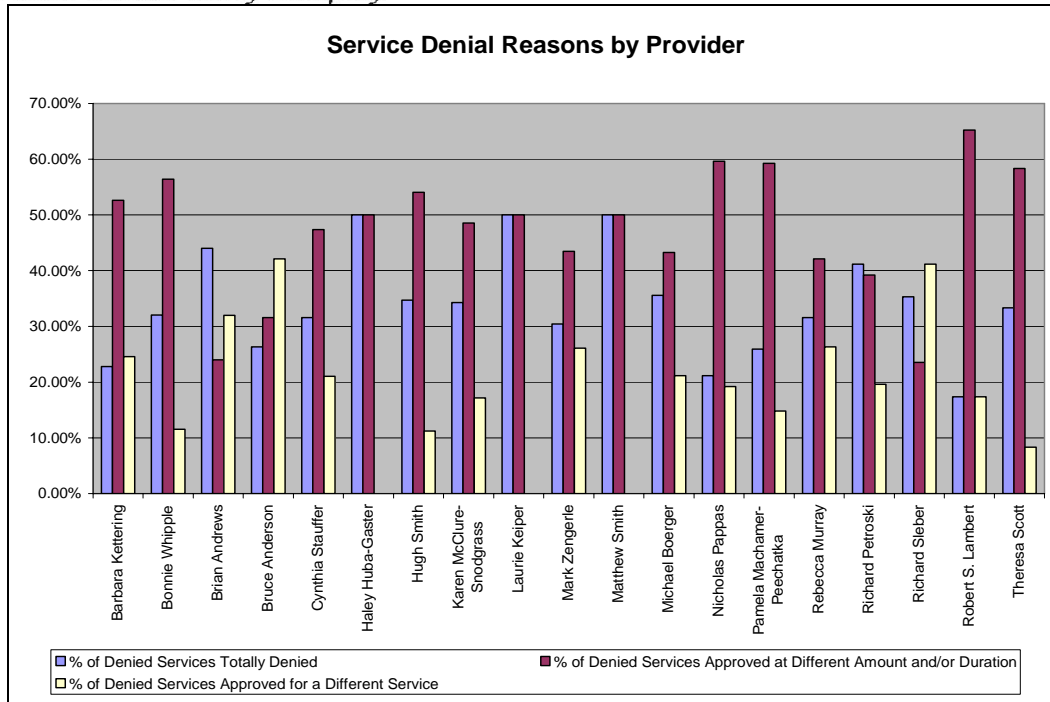


**Service Delivery**

Service delivery was measured using indicators of percentage of evaluations approved versus denied, and was further broken down by denial reasons for each service requested within an evaluation. Overall, 78.78% of evaluations were approved as requested across the Network, leaving 21.22% denied as requested. In 2008-2009, 50.44% were approved as requested and 49.56% were denied as requested. This significant improvement in denials is likely due to the multipronged interventions that CBHNP initiated. These include increased evaluator feedback, increased case management efforts, individual outreach provided to targeted providers and evaluators, as well as significant educational outreach and education regarding CASSP principles.

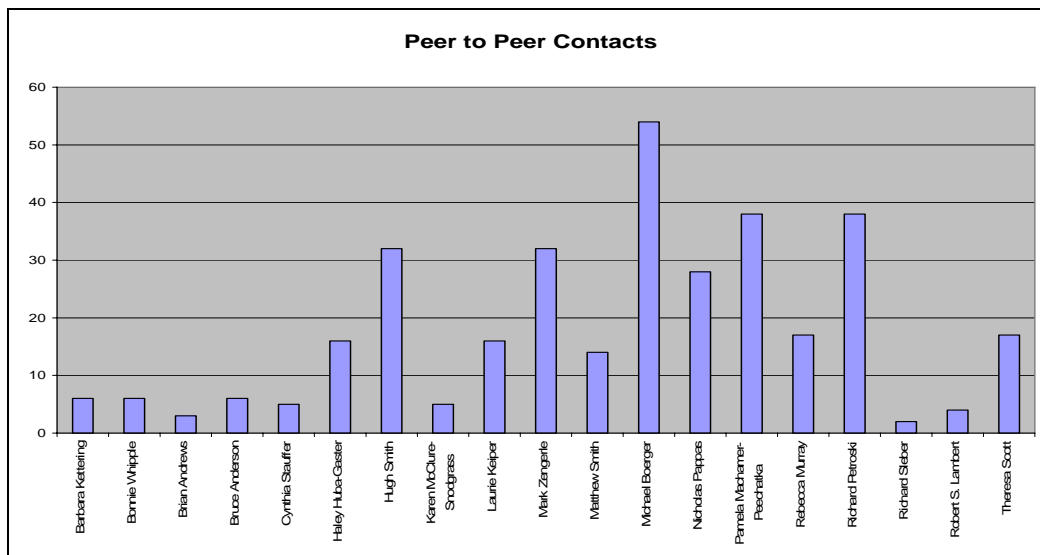


Of the denied evaluations, 31.80% of the requested services were totally denied, 36.41% were denied services that were approved at a different amount and/or duration, and 31.80% were denied services that were approved for a different service. These percentages are very similar to the data from 2008-2009, which reported 28.22%, 50.75% and 21.03% respectively.



## Quality Indicators

Quality indicators were measured using the total number of peer to peer contacts made by a CBHNP Psychologist Advisor to an evaluator regarding concerns with prescribing practices. The total number of peer to peer contacts ranged from two to fifty-four, with a total of 1,187 contacts across the Network.



## Administrative Compliance

Administrative compliance was measured by each evaluator's attendance at trainings and/or meetings. It should be noted that although attendance is not mandatory, providers are encouraged to attend all available trainings and meetings.

<b>Providers</b>	<b>Training/Meeting Attendance</b>
Barbara Kettering	100%
Bonnie Whipple	0%
Brian Andrews	0%
Bruce Anderson	0%
Cynthia Stauffer	100%
Haley Huba-Gaster	0%
Hugh Smith	0%
Karen McClure-Snodgrass	0%
Laurie Keiper	0%
Mark Zengerle	0%
Matthew Smith	0%
Michael Boerger	100%
Nicholas Pappas	50%
Pamela Machamer-Peechatka	0%
Rebecca Murray	0%
Richard Petroski	0%
Richard Sleber	50%
Robert S. Lambert	50%
Theresa Scott	0%

### **Network Recommendations**

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

- Encourage provider and evaluator agencies to Implement more structured training and supervision including CASSP, Life Domain format, Best Practice guidelines, and use of lead clinician for most initial evaluations
- Establish an active treatment culture and focus whereby recommendations are continually assessed and adjusted
- Encourage evaluators to consider utilizing a lead clinician upon initiation of services to provide mental health treatment, attempt to positively impact the presenting symptomatology, as well as gather additional clinical data
- Consider evaluator incentives for adherence to CASSP principles
- Encourage evaluators to discuss discharge planning at each encounter
- Encourage evaluators to estimate and document length of treatment
- Facilitate and support evaluator attendance at ISPT meetings
- Develop a philosophy that involves active evaluator input, especially when Members are progressing in treatment goals (e.g., recommendation should not remain stagnant)

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- Encourage evaluators to disseminate (to treatment teams and Members) empirically based treatment recommendations
- Evaluators should consider developing alternative mental health treatments that are targeted to symptom reduction, and are less intrusive than BHRS treatment.
- Distribute CBHNP resource guide to all internal staff in order to fully develop natural and community supports
- Develop a consortium of evaluators in order to share information and collectively address evaluator difficulties
- Develop procedures that will assist evaluators in submitting completed evaluations in a timely manner
- Encourage evaluators to closely match the symptoms and behaviors that are presented in the assessment with the recommendation offered
- Critically assess the ongoing impact that continued stay in the current LOC may have (e.g., diminishing return; offer alternative treatments)
- Actively offer reduction plans based on Member need