

Provider Profile Report Series

Update as of 6/4/2009

Partner with Stakeholders to Improve Quality of Services



Goals for the Provider Profiles

- Be a partner in helping us develop information that leads to positive change and quality improvement
- Share your thoughts, ideas, and expertise
- Opportunity to express concerns and develop solutions
- Understanding of Provider Profile Data
- Buy-in to Data as an advocacy tool
- Consistent Information Sharing
- Establishment of quality improvement initiatives

Profile Reports to aid:

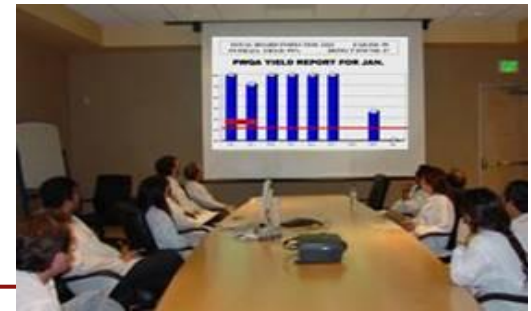


- Moving from a traditional service system to a recovery/resiliency oriented culture that embraces performance improvement, manages system change and promotes recovery in a **systemic, planned, measurable, continual, and collaborative way.**

Recommendations for Provider Profiles

- This PowerPoint highlights some of the recommendations that have been jointly developed by providers and DBH for the development of meaningful, feasible, and useful profiles.
- Please see accompanying posting for more details.

Recommendations from Providers



- Include indicators that capture the recovery concepts and are based on what will support quality improvement.
 - Use of the ROSI was discussed. More communication and information for providers is need around the ROSI.
- To support feasibility of measure development, **a gradual approach to implementation would be desirable**. Over time measures might be revised or discontinued based on information about measure utility.
 - DBH has begun development by level of care and each will include discussions with providers as template baseline reports as developed.

More Recommendations

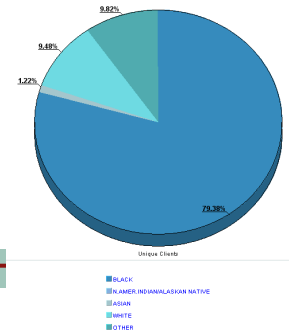


- Ensure that indicator definitions are clear and understandable, establishing baselines (set reasonable thresholds), and looking for changes over time. Take advantage of existing data to establish baselines and benchmarks. Where data currently exists, providers asked for baseline information for their agencies, in order to develop effective and timely plans for change.
 - **Operational definitions** were included for all data presented in the template report. Baseline data was presented, **with three-year trend-lines and blinded comparisons across providers** for purposes of benchmarking. Targets for post psychiatric hospitalizations and follow-up were listed as comparisons based **upon OMHSAS** recommendations; no other targets were set at this time.
- There is a need to be alert to potential unintended consequences of measures. To control for this, generally targets are not set at the extremes to allow for expected and individual variation. For example, recidivism (readmission) would not be set at 0% because this might discourage re-admission of individuals who need treatment.
 - **April 2nd discussions did highlight the need for reviewing trend information and clinical knowledge** of the levels of care to set **appropriate targets.**

Recommendations re Small Providers and Duplication with other Payors

- For providers that serve a small number of consumers, report might entail developing different benchmarks, since a generic percentage goal may not be meaningful when applied to a very small sample size.
 - A totally blinded comparison report was developed for providers that serve a small number of people in recovery, e.g. for **those with less than 30 inpatient discharges**. There was no discussion about how to use measures as yet.
- Measurement implementation would be strengthened by aligning the different measurement demands from various payors e.g., CBH, Magellan, and BDAP.
 - As templates are developed for a particular level of care, **providers will be asked for support/definition/impact of measures in comparison with other payors**.

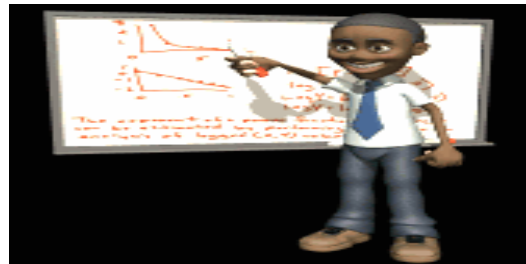
Reporting Slices



- Reporting quality in some cases might be facilitated by multiple “reporting slices.” Outcomes of clinical effectiveness may vary or have different norms for populations such as individuals with mental retardation, autism, and co-morbid medical conditions. Applicability across populations is a consideration in choice of indicators.
 - In each of the workgroups during the April 2nd meeting, we discussed severity and/or complications such as homelessness, co-occurring illnesses, those in multiple systems such as DHS, people who may be having acute episodes of high intensity services, etc.
 - As a next step, DBH is working on developing a **demographic profile** of those served by each provider for the next series of reports. While this is not a severity index, it will allow for better understanding of populations served.

Preferred provider Definition?

- Interpreting differences in quality as strictly a function of one indicator was a concern. Both consumers and agencies are complex and the use of multiple indicators for evaluation was seen as valuable, rather than an “all or none” approach.
 - **Multiple indicators were included** in the initial report with the goal of developing and changing these as quality gains are made and additional information can be developed
 - Discussion of preferred provider was not extensive at the April 2nd meeting; the intent is first to develop the baseline reports, and then during 2010 **to further discuss the definition of a preferred provider.**



New Areas of Discussion on 4/2



- Readmissions and continuity of care need **different operational definitions** for residential rehabilitation and for children's RTF.
- **Discharge status** would be helpful to explain service utilization and as an outcome.
- **Provider staff training, qualifications, retention of staff, and staffing ratios** affect quality and should be considered.
- Future reports need **trend-lines for incidents and complaints** and compliance in reporting.
- **Post-treatment monitoring** was noted as one way of capturing better outcomes; frequently successes are not known without this. Some providers indicated that they currently have a system for this type of monitoring.
- Monitoring of quality of assessments, implementation of evidenced-based treatment, family involvement, information from prior and other treatment episodes/agencies & effective discharge planning were components of quality that should be addressed over time from a qualitative review. **Chart audits** were briefly discussed as one way of determining these components.
- Providers indicated that they did want to continue to be involved in the process of creating, reviewing, developing, and using the profile reports. **Future meetings** were¹⁰ agreed to upon to more develop and discuss specific measures for each level of care.

Tentative Time-Lines; Review **Website** for **Updates and Schedule**

Next Steps in Development of Provider Profiles (tentative schedule)

- Invite in for discussion and review the following in Summer 2009
 - Children's Residential Treatment Providers
- Invite in for discussion and review in September through December 2009
 - Residential Rehabilitation Providers
 - Inpatient Psychiatric Providers to revisit format and targets using 2008 data
 - Day (Transformed) Program Providers
- To be scheduled for Discussion in 2010
 - BHRS, Targeted Case Management, Access to Alternative Services Housing (AAS), Outpatient Mental Health, Detox Hospitalization, IOP and Medication Assisted D&A Treatment, Outpatient D & A, Recovery Houses and Halfway Houses, etc.

- Please note this schedule is slightly different from that presented on June 4, 2009 at the Executive Directors' Meeting

- We will post to the website more formal announcements as to Provider Profile planned meetings and discussions for each level of care.

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- Thanks for your continued involvement!!