CAPITAL AREA BEHAVIORAL HEALTH COLLABORATIVE, INC.
CONTINUOUS QUALITY IMPROVEMENT PLAN
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It was the year nineteen hundred and ninety-nine, where five counties established the Capital Area Behavioral Health Collaborative (CABHC). The agency was developed to oversee the management of behavioral health services delivered under Medical Assistance funds as part of the HealthChoices Behavioral Health Program. Cumberland, Dauphin, Lancaster, Lebanon, and Perry Counties contracted with Community Behavioral HealthCare Network of Pennsylvania (CBHNP) to direct behavioral health services for their HealthChoices Members. CABHC continues to maintain a secure working relationship with CBHNP to ensure that behavioral health services are delivered in an approach that supports each County's particular needs and goals, both individually as well as collectively. CABHC also remains consistent with the objectives of the HealthChoices program, which is to improve Members' access to health care services, to improve the quality of care available to Members, and to stabilize Pennsylvania's Medical Assistance spending. In addition to these goals, the mission of CABHC is:

> *To ensure access to and delivery of a coordinated, effectively managed, comprehensive array of quality mental health and substance abuse services that reflect the holistic needs of eligible residents throughout the five county territory.*

The Continuous Quality Improvement Plan (CQIP) is a document that identifies key areas that will be monitored by CABHC. The CQIP 2010 also provides a brief summation of specific objectives that will be implemented as priorities for CY 2010.

CHILDREN'S SERVICES

Services to children and adolescents account for almost 70% of all HealthChoices expenditures in the five Counties. Often, services to these Members must be coordinated among multiple systems of care, including (but not limited to) education, early intervention, the juvenile justice and child protective service systems. These Members are often present with the most multifaceted symptoms and needs for services across numerous systems of care. CABHC continues to support a variety of initiatives to improve access and delivery of services to children.

Priorities for Children's Services for 2010

1. Summer Therapeutic Activities Program (STAP)

Summer Therapeutic Activities Program (STAP) is a service that uses group treatment as a way to deliver medically necessary mental health treatment. These services provide a range of age appropriate therapeutic activities with professional staff trained in the delivery of mental health treatment. It is designed for children and adolescents under age 21.

A Summer Therapeutic Activities Program (STAP) workgroup was developed through the Clinical Committee. This group, made up of representatives from the counties, CBHNP, CABHC, school districts, providers and families, identified a number of changes in order to more effectively meet the needs of the Member/child during the summer. The intention was to plan in a more comprehensive way that families can take advantage of the extended school year. The STAP Planning Committee evaluated the results of the 2009 STAP, and determined that STAP can enhance the needs of children/adolescents with ASD by revising the schedule so that it could contain options for children to attend both the Extended School Year (ESY) and STAP, and how that could be implemented.

It was the collaboration of this workgroup where it was decided that *STAP 2010* will run from July 19, 2010 to August 20, 2010. This will then leave three weeks for ESY at the beginning of summer and at least a week for preparation time before school starts. CBHNP will be creating a timeline for Providers to get service descriptions completed and submitted to the State for approval. The State will be partaking in county meetings to assist with the review of these descriptions.

STAP has been an important service to families, so as part of our 2010 objective, CABHC will assess how many children/adolescents participate in both ESY and STAP. Follow up meetings will be held with the same workgroup members to determine whether or not there was better coordination of treatment between the educational system and STAP. In addition to our 2010 objective, this group will take a more in depth look at the efficacy and outcomes of STAP in 2010. At the conclusion of STAP, the workgroup will reconvene and evaluate the success of the program, and learn from STAP 2010, in regards to planning STAP 2011.

2. Behavioral Health Rehabilitation Services (BHRS) Best Practice Workgroup

Behavioral Health Rehabilitation Services (BHRS) are Medicaid-funded services, based on medical necessity, provided through trained professional support for children under age 21 with a serious emotional or behavioral disorder, to reduce or replace problem behavior with positive, socially appropriate behavior. BHRS are family and child-centered, and they can take place in a variety of settings, not just one place. Services are guided by the Treatment Plan. Progress is monitored with data, updated regularly and reevaluated as necessary.

In order to address the clinical challenges faced by providers of Behavioral Health Rehabilitative Services, *The BHRS Best Practice Workgroup,* which commenced on October 16, 2009, is in process of developing the Best Practice Guidelines, or a qualitative set of standards expanding on the current regulations, and encompassing OMSHAS directives, CASSP best practice recommendations, published best practice guidelines utilized by other professional organizations, academic review of the literature, and extensive Health Choices provider input.

This workgroup has been specifically assigned to the task of gathering relevant data from these various sources; creating a new best practice document addressing a wide variety of service delivery concerns; and eventually piloting the best practice guidelines before full implementation takes place. By taking a systematic approach to developing these guidelines for clinical practice, the expectation is to attain a higher level of consistency and efficiency in service delivery across the provider network. The purpose of the Best Practice Guidelines is to create the framework of recommendations for systematic clinical decision making. The goal for completion is spring 2010.

3. The Functional Behavior Assessment (FBA) Workgroup

The Functional Behavior Assessment (FBA) workgroup commenced on November 6, 2009 and had the task to develop best practices guidelines for the FBA in response to national and statewide interest in implementing evidence based treatment in the mental health field. The workgroup is composed of CBHNP, Providers, Family Representatives, CABHC, and Counties to ensure that all parties are in agreement with the design and content of this document.

These guidelines will incorporate information gathered from the Autism Task force, OMHSAS, published guidelines from professional organizations, academic reviews of literature, and feedback from proficient clinicians in our network. This systematic approach will allow an opportunity to ensure that the highest quality of care is provided to our Members, and also to fully consider the integration of FBAs into our existing systems of care.

The FBA Workgroup will be diligently working in 2010 to continue development of a comprehensive Best Practice Document for conducting an FBA. The document will include the following components: 1.) The Purpose of conducting an FBA, 2.) The Content that should be included, and 3.) The Results of the FBA.

The overall goal of developing these guidelines is to assist in providing the child and his or her family the ideal identification of BHR Services to optimize their chance of successful completion of treatment and continued integration with the natural support system in the home community. Completion of this project in draft form is anticipated for April of 2010, and presentation to OMHSAS in May 2010.

4. The Residential Treatment Facility (RTF) Workgroup

The RTF Workgroup developed out of the Clinical Committee. They have made several notable accomplishments in 2009, including: 1.) Development of a new CRR-HH description, 2.) Requested waiver of a 30 day expiration of evaluation for RTFs. CABHC received approval to extend RTF evaluations to 60 days from admission. Appendix T requirement remains that the Member on a waiting list for an evaluation to be "current" for an additional thirty days provided the evaluation is reviewed and approved, and documented by the original qualifying diagnostician prior to admission. 3.) CBHNP RTF and CRR-HH Pre-Discharge Planning Meeting Policies and Procedures were approved by OMHSAS.

Focus areas for 2010 include evaluating the effectiveness of evaluators, in addition to the effective use of evaluators with the ISPT process in order to have a comprehensive review of

appropriate alternative community treatments to RTF placement for children. Recommendations also came from the group to change the ISPT meetings to before an evaluation is conducted for out of home placements. This way, the treatment team input and recommendations gets to the evaluator first. This work plan will be discussed and analyzed further in 2010 for a policy change.

This group is also in the development of a draft CRR-HH Therapeutic Vacation Policy. It will be shared in detail in March 2010 for additional comments, and then will be looked at for approval in mid 2010.

Trainings will also be conducted in 2010. The first will be a basic presentation for level of care and how to make assessments. It will be geared for JPO and C&Y professionals. The second will be a follow up training for supervisory staff. The tentative dates for these trainings are May and June 2010.

Lastly, a RTF and CRR-HH Utilization List will be monitored in detail by CABHC and CBHNP. This lists every Member in the five counties who are currently in an out-of-home placement. Barriers to discharge will be analyzed in detail and shared with the counties per quarter. This will be monitored and reviewed throughout 2010.

5. BHRS Continued Stay Evaluation Model Change

OMHSAS conducted a retreat in 2009 to look at the current model of BHRS Services, specifically TSS, and how it is and is not meeting the needs of our Members. CABHC had representation at the event. One of the recommendations that came out of this retreat was the elimination of the required four month evaluations as well as the authorization packet. CABHC, along with CBHNP have begun the task to develop a concept paper that would allow our program to model this concept. OMHSAS has agreed to entertain this effort and is in fact started the process to waive regulations that could prohibit such a project.

A workgroup will be formed that contains the Counties, CABHC, CBHNP, families, providers and evaluators. CABHC will be facilitating this process with the objective to have a plan approved by OMHSAS that will eliminate the need for continued stay evaluations for a designated population and to move to a more CASSP/family group decision model of service management and requests. The target date for completion of this approval would be July 2010.

6. Therapeutic Staff Support Schedule Implementation

During 2009, an initiative was implemented to rethink how TSS services are managed and services rendered. This was driven by concerns raised by various stakeholders regarding what factors are driving the management of TSS resources when compared to the prescription's recommended use of BHRS and specifically TSS services. As a result of this process, a new TSS Schedule program model was developed by a Stakeholder Workgroup and approved by OMHSAS. During 2010, it will be the objective of CABHC to work with CBHNP and the counties to implement this new program model and to monitor the efficacy of its objectives.

PEER SUPPORT SERVICES

Peer support is a system of giving and receiving assistance founded on key principles of respect, shared responsibility, and mutual agreement of what is helpful. Peer support is not based on psychiatric models and diagnostic criteria, but rather on the shared experience and belief in recovery. It is about understanding another's situation empathically through the common experience of emotional and psychological experience. As trust in the relationship builds, both people are able to respectfully challenge each other when they find themselves re-enacting old roles. This allows Members of the peer community to try out new behaviors with one another and move beyond previously held self-concepts built on disability and diagnosis.

Peer Support Services can be provided by free-standing peer support agencies or under the existing license of psychiatric outpatient clinics, partial hospitalization programs, crisis intervention, resource coordination, or intensive case management, but remains a separate service from these licensed services. Providers must be licensed, enrolled in MA, and have a letter of approval from the Department of Public Welfare to provide peer support services. HealthChoices providers must also be credentialed by the BH-MCO.

As part of the ongoing efforts to develop Peer Support in the five county area, the Peer Support Services Steering Committee supports both the Peer Specialists and their direct supervisors as Peer Support develops and changes. Therefore, CABHC initiated two separate professional development groups. One is for Peer Specialist and the other is for Direct Supervisor to allow a forum to share experiences and information as well as problem solving issues and provide mutual support to the involved parties. The Committee continues to recognize these groups as a vital piece in the long-term success of Peer Support.

Priorities for Peer Support Services 2010

1. Expansion of Billable Services

Peer Support Services were added in November 2006 as covered services for adults aged 18 or older who have a serious mental illness and for others by exception. As of January 1, 2010, Peer Support Services provided via telephone will be reimbursable in Medical Assistance (MA) Fee-for-Service and HealthChoices programs. This expansion of billable services was a result of strong advocacy by Certified Peer Specialists, providers, Pennsylvania's Community Provider Association (PCPA), and many others to include services provided by telephone as an integral part of Peer Support.

Peer Support Services may be provided by telephone for up to 25 percent of the total service time provided per individual, per calendar year. A calendar year limit of 16, 15-minute units per day or 3,600 units per year per individual is applicable. CABHC will review claims data and issue periodic monitoring reports for adherence to the 25 percent limitation. OMHSAS encourages providers to monitor telephone support usage though record review and internal

audits. CBHNP and CABHC plans to meet in February 2010 to discuss how to monitor this particular activity.

2. Steering Committee Survey

There has been a growing interest by the Peer Support Services Steering Committee in looking more closely at the topic of turnover rates. In July of 2009, a survey was conducted and sent to all Peer Support providers to gather information on their continued implementation of Peer Support Services, with a focus on the number of Certified Peer Specialists (CPS) that have been hired and retained in the program. Providers supplied information regarding when they first began offering Peer Support Services at their respective agencies. This included questions about the current number of peer specialist positions, experience with turnover in the peer specialist positions, and current hiring status.

As a result of this survey the importance of addressing retention needs further exploration and how responding to Certified Peer Specialist's immediate needs is critical in terms of making them want to stay with the agency.

Continued efforts in 2010 will include the further analysis and the development of recommendations based on the following key aspects of CPS retention:

- Whether or not there is an adequate pool of qualified Certified Peer Specialists to fill available positions.
- There is a successful outreach effort to ensure that Certified Peer Specialists apply for positions.
- Looking at PSS models that may render better retention or looking at specific providers that have better retention and why? Also, what state activities are occurring to address retention and can we participate in this?

3. Peer Support Services Website Page

The Peer Support Services page on CABHC's website is in development for 2010. The goal for early 2010 is to obtain feedback from the Steering Committee to determine what might need to be included or focused on. Areas that will be included are:

- A background of Peer Support Services
- Benefits of hiring a Certified Peer Specialist
- How to become a Certified Peer Specialist
- Training(s)

- Job Matching Opportunities (both Certified Peer Specialists looking for employment and Peer Support Providers with openings)
- Links

CABHC's focus is to have the Peer Support Services section of the website available to the public by April of 2010.

CONSUMER, FAMILY and ADVOCATE PARTICIPATION in the MONITORING and DEVELOPMENT of the PROGRAM

CABHC values the engagement of Members in the HealthChoices oversight, and encourages their participation on all CABHC Committees, Board Meetings, and Workgroups. The Consumer Family Focus Committee (CFFC) is no exception, and includes stakeholders in this process. The participants in a program are the most ideal people to identify where improvements need to be made to develop better quality of care, increase accessibility, and identify ways to reduce costs. By these committee participants being welcomed into the CABHC Committees, the HealthChoices program benefits greatly.

The CFFC plans to keep abreast of Member perceptions about all facets of the HealthChoices program. The CFFC will examine the Consumer Satisfaction Survey results as the data pertains to the interests of the CFFC. There is an ongoing need to listen to Members within the HealthChoices Program, to be aware of their perceptions of where the program may be falling short of expectations, and to consider ideas for making improvement to procedures, services and the provider network. Results from the survey should reflect that those surveyed are satisfied with the services and providers within the HealthChoices Program. To supplement and compliment the survey findings, the CFFC will utilize the complaint and grievance data gathered to obtain an expanded view of consumer satisfaction.

Priorities for Consumer Family and Advocate Participation in the Monitoring and Development of the Program 2010

1. Recruitment of Members

The focus for 2010 will be on recruitment of Members to actively serve on committees. Our goal is to have at least three consumers/family members actively participate on each Committee. The CFFC will develop a smaller group to go out to local Clubhouses, drop-in centers, psychiatric rehabilitation programs, and partial hospitalization programs to speak to Members regarding participation on CABHC's Committees.

2. Educational Presentations

Another goal for 2010 is for each county to identify a couple of areas/places to conduct educational presentations. The CFFC will develop a list of possible targeted groups and

prioritize a list of target audiences. Wellness Recovery Action Plan (WRAP) has been presented in the past and feedback was quite successful. A-one hour introduction to WRAP and Recovery training will be conducted in May of 2010. By offering a training of this nature, it will be helpful for both the Certified Peer Specialist and the increasing numbers of Members in recovery who need skills to support them in their recovery. Other topics for presentations will also be discussed and implemented for 2010.

3. Response to CSS Consumer Satisfaction Surveys

Lastly, the CFFC Workgroup will review and evaluate CBHNP's and provider responses to the CSS Consumer Satisfaction Surveys and will ensure that the surveys' recommendations are evaluated and implemented on behalf of the Members. As part of this process of review, CABHC and the CFFC will develop a procedure in 2010 as to how to validate if what the provider and CBHNP says in their responses are actually being implemented.

PROVIDER RELATIONS

Successful management of behavioral health services through the HealthChoices Program requires CBHNP to persistently encourage positive, shared relationships with providers throughout the Territory. These relationships are essential to maintain compliance with HealthChoices standards.

The *Provider Network Committee* focuses on monitoring CBHNP's Provider network to assure HealthChoices access standards are met and specialty needs are available to Members; developing and monitoring annual Provider satisfaction surveys; monitoring CBHNP Provider profiling reporting including identification of Best Practices; and monitoring CBHNP Credentialing Committee activity.

Priorities for Provider Relations for 2010

1. Service Access Standards

The Provider Network Committee facilitates collaboration with the Counties and CBHNP in the continued assessment of network capacity through outreach to potential new Providers and expansion of services with existing Providers. CABHC assures that CBHNP maintains a Provider network of in-plan services that meets or exceeds HealthChoices standards regarding timely access to behavioral health treatment. When the Provider network is unable to meet these access standards of a choice of at least two Providers within the designated distance to a particular in-plan service, CABHC requests an exception to the access standards from OMHSAS. This request must also attest to the efforts taken to rectify the specific access issue.
The analysis for the access standards is completed by CBHNP using GeoAccess® Accessibility Analysis reports. CBHNP found that, in most areas, access to behavioral health services has remained the same or improved over the last year. CABHC requested and received four in-plan service exceptions from OMHSAS for the 2009-2010 fiscal year. OMHSAS found that the proactive measures outlined in the request would enable Members timely access to the Providers

as needed. Any required access standard exception requests for fiscal year 2010-2011 will be submitted to OMHSAS by June 2010.

2. Provider Profiling

As a part of the profiling process, new tracking criteria in CBHNP's Provider performance tracking and reporting system will be evaluated by the Provider Relations Committee in conjunction with CBHNP to be implemented for 2010. Performance indicators will include assessment of co-occurring disorders, appropriate aftercare planning, coordination of care, and timeliness of submission of treatment information. Anticipated completion date is April 2010.

3. Provider Co-Occurring Disorders Competency

CBHNP developed a tool to score Providers in competency of co-occurring disorders. The tool was first scored by Providers as a self-measure, and was later to be added to the re-credentialing profiling tool. However, before this was put into place, OMHSAS and the Department of Health (DOH) temporarily halted the certification program for Providers in co-occurring disorders competency. In the event that the Commonwealth resumes this program, the Provider Network Committee will consider it a priority to monitor CBHNP's progress in increasing the number of in-network Providers who obtain the certification.

4. School Based D&A OP Services

As a result of a recently distributed OMHSAS policy clarification 07-09 issued in November 2009 that allows the delivery of D&A OP services in a school setting, a priority for the Provider Network Committee will be to assist in the development and monitoring of school-based drug and alcohol outpatient services as a HealthChoices Supplemental Service. This will include monitoring of CBHNP outreach to Providers to offer this service, and to increase community awareness in order to create referrals and effective utilization of this service. By September 2010, it is a goal that D&A outpatient for in-school services will be implemented.

MANAGEMENT INFORMATION SYSTEMS

The Management Information Systems (MIS) Committee provides technical oversight to ensure that CABHC has the necessary hardware and software to manage the complex coordination of efforts by the Managed Care Organization (CBHNP), area providers, and Members.

CABHC contracts with Alan Collautt Associates, Inc. (ACA) for its MIS system. As such ACA provides CABHC staff with immediate access to multiple varieties of established reports, and provides the capacity for CABHC staff to develop ad hoc reports to meet specific requirements as they arise. To assist in the oversight of this contract, the MIS Committee monitors the effectiveness of ACA to provide services to the CABHC staff. This is an ongoing objective and is analyzed in detail at the quarterly meetings. ACA also hosts and manages the CABHC website.

The MIS Committee develops and monitors ACA's performance standards related to their responsiveness to the help desk logs. During CY 2009, ACA fell slightly below the established performance standards. The Committee also reviews data regarding the utilization of the CABHC web-site. They have noted that utilization for 2009 declined from previous years. The Committee noted that one of the reasons for this could be that the design of the web-site has not been revised in the past 5 years. The Committee's findings were presented to the CABHC Board. Therefore, in 2010 CABHC will continue to analyze utilization, and seek suggestions from CABHC Committee members as a part of the process to upgrade the website.

MIS Priorities for 2010

1. Evaluate MIS Needs

The Committee will evaluate MIS needs to ensure that CABHC maintains adequate computer hardware and software to meet and carry out its oversight role effectively. Specifically, they will assess the need for off-site storage, researching available options and cost to benefit analysis, and will make a determination by November 2010.

2. Offsite Disaster Recovery Backup System

The Committee will consider the need to develop an offsite disaster recovery backup system for CABHC user files. This will be done by evaluating the need for such a plan, and if one is indicated, to research which options are available and the cost benefit to such a plan. Any final recommendation would be reached by June 2010 and presented to the Board.

3. Review of ACA's Performance Objectives

CABHC will quarterly review ACA's Performance Objectives noting any change or trends in the Help Desk Response rate (goal of 98%), and Help Desk Log Resolution rate (goal of 95%).

4. Redesign of Website

By receiving input from the Counties, CABHC Committee Members and CABHC Board Members, CABHC will evaluate and implement an entire redesign of the website, by July 2010.

FISCAL STABILITY

Financial oversight remains an ongoing, collaborative effort between CABHC staff and CABHC's Fiscal Committee, who reports monthly to the Board. CABHC continues to monitor the financial performance of the HealthChoices Program and CBHNP, as well as CABHC's own financial operations, to ensure the continued solvency and success of HealthChoices for the Territory.

During the year, financial solvency of HealthChoices and CBHNP is maintained through monitoring financial reports and reviewing them with the CABHC Finance Committee and CABHC Board of Directors. CABHC also reviews the Capital Region and Consolidated CBHNP Financial Statements.

CABHC also ensures the accuracy and timeliness of financial data and reporting to OMHSAS by completing the monthly OMHSAS accuracy review check list. During the past year fiscal stability and financial solvency has been maintained.

CABHC Financial Priorities for 2010

1. Financial Solvency

CABHC will monitor and report on the financial solvency of the HealthChoices Program and CBHNP. This will be accomplished by reviewing medical claims surplus/deficit and CBHNP Financial Statements through the year.

2. Financial Reporting to OMHSAS

CABHC will ensure accuracy and timeliness of financial data/reporting to OMHSAS by reviewing monthly, quarterly and yearly submissions to OMHSAS.

3. Monitoring of Reinvestment Programs

Further development of a plan to monitor Reinvestment Programs will be implemented in May 2010. This was suggested by the HealthChoices auditors. Further, the goal is to work collaboratively with other CABHC committees to develop a plan that would determine if providers are providing the contracted services and if they are achieving the stated outcomes.

4. Monitoring of Medical Healthcare Expenses

CABHC will monitor the Medical Healthcare expenses for the HealthChoices Program to determine actions that may need to be taken in a surplus or deficit situation. This will be ongoing throughout 2010. This will include the need to shift risk reserve funds to pay claims, assuring that the equity reserve meet minimum standards, that all reporting required by the bank for the Letter of Credit are maintained and designation of potential clams surplus is tracked for Board action.

5. CABHC Financial Position

Monitoring and reporting on the financial position of CABHC is key. The Fiscal Committee will review CABHC Financial Statements to determine solvency and compare administrative budget to actual expenses and revenues. This will also be constant throughout the year.

PERFORMANCE IMPROVEMENT PROJECTS (PIP)

CABHC oversees CBHNP's submission of OMHSAS required Performance Improvement Projects (PIP). CABHC ensures that the reports follow the approved OMHSAS format, the data is accurate, the analysis is consistent with the data, and that they are submitted to OMHSAS in a timely manner.

There are currently two PIP reports that are reviewed and analyzed by CABHC: Youth Receiving Substance Abuse Service and Increase the rate of Follow-Up after Hospitalization for Mental Illness. These reports are reviewed quarterly with CBHNP and then submitted to OMHSAS.

The first is **Youth Receiving Substance Abuse Service.** This is designed to improve access for youth ages 13-17 to substance abuse services throughout the Territory. CBHNP utilized data to evaluate and develop strategies for identifying youth in need of substance abuse services.

The second PIP report is to **Increase the Rate of Follow-Up after Hospitalization for Mental Illness.** Overall, the data during CY 2009 has shown improvement. CBHNP conducted a Root Cause Analysis of this PIP and has established short and long term goals for the four indicators. CABHC has analyzed and reviewed the initial preliminary drafts of the Root Cause Analysis addressing the Rate of Follow-up after Hospitalization with CBHNP and IPRO. IPRO serves as the independent external quality review agent for Pennsylvania's Department of Public Welfare. The final draft of this document was submitted for IPRO's review in December 2009, with the final version due early in 2010.

Objectives for 2010 PIP Reports:

1. Root Cause Analysis

CABHC will meet regularly with CBHNP's QI Department to review and analyze CBHNP's development of the Root Cause Analysis. Addressing the Rate of Follow-up after Hospitalization PIP is due to IPRO in January 2010.

2. Objective for Youth receiving Substance Abuse Services

CABHC will meet quarterly with CBHNP's QI Department to review the Objective for Youth Receiving Substance Abuse Services to evaluate the quarterly results and to ensure that the data, the analysis, and the interventions are based on the data results. The objective is that each county meets or exceeds the HealthChoices Average of 1.54% this year.

3. Increase Rate of Follow-up after Hospitalization

CABHC will meet quarterly with the CBHNP's QI Department to review the Increase Rate of Follow-up after Hospitalization for Mental Illness. The purpose of the meeting is to evaluate the data for accuracy, to review the analysis to ensure that it accurately reflects the data results, and that the interventions target the findings of the data analysis. The data objectives are that the

four quality indicators (QI) improve as follows: QI 1 (HEDIS) 7-day follow-up after discharge and QI B, 30 day follow-up, each improve 10% and that QI 2 (PA Specific), 7 day follow-up improves 5% this year.

REINVESTMENT PROJECTS

Reinvestment Projects utilize HealthChoices treatment funds and county discretionary funds that are not completely expended during a given fiscal year. Reinvestment funds are designated as start-up costs for In-Plan Services, development, and purchase of Supplemental Services, or non-medical services that support Members' behavioral health.

Once reinvestment projects have moved beyond the start–up phase and the designated funding period of the reinvestment plan, the counties must determine if the program is meeting the stated objectives and if they have demonstrated cost efficacy in relationship to in-plan services. If this is the case and the service can qualify as treatment, the Counties may choose to request that the service becomes a Supplemental Service and therefore eligible for Medicaid funding. During 2009, several reinvestment projects were assessed and moved over to being funded by MA as a Supplemental Service. Mobile Psychiatric Nursing became an MA Reimbursable program and was removed as a reinvestment project. The Buprenorphine Coordinator and Community Treatment Team projects also transitioned to Medical Assistance funding as Supplemental Services in 2009.

Priorities for Reinvestment Projects for 2010

1. Respite Care

The Respite Brokerage Program offers both planned and urgent short-term respite services to children, adolescents, and adults. Respite services are provided both as In-Home, where services are in the individual's own home, and in a variety of Out-of-Home settings.

The Satisfaction Surveys conducted by Pennsylvania Mentor, the contracted company administering respite, found a high degree of satisfaction by families for both the management of the respite service by Pennsylvania Mentor as well as the actual respite services they received from the providers. In 2010, CABHC will continue to work with Pennsylvania Mentor's Program to obtain feedback from families and Providers of the need for respite services for children and adults and the level of satisfaction with Pennsylvania Mentor and respite services.

Another objective for 2010 is to evaluate the use of overnight respites to determine if there is an increased risk incurred by using overnight respites. This will be evaluated through a respite workgroup to develop the methodology. In addition, recruiting efforts to obtain more providers to provide respite services is also key. Outreach efforts will be initiated, and presentations to providers by Pennsylvania Mentor will take place by mid-year.

2. Specialized Transitional Support for Adolescents

Specialized Transitional Support for Adolescents provides support to adolescents ranging from sixteen (16) to twenty-one (21) years old as they transitioned from children's services into the adult world. The program provides a variety of support focusing on four transitional domains. These domains include employment, education, living situation, and community life. The support provides the participants with skills and knowledge of community resources that will enable them to become functioning adults in their community.

Individuals who succeed in this support should be better equipped to handle their life needs, and hopefully will become productive citizens. Some of the participants are able to obtain employment or continue their education goals. It would also be anticipated that Members would not have need of as many services as they had prior to participation in this program. CABHC will ask the providers for follow-up data to measure the successful goals of the participants and also will review claims data to track former participant's utilization of services for a period of one year following their participation in the program.

3. The Recovery House Scholarship Program

Upon completion of non-hospital rehabilitation or halfway house treatment services, there are some individuals who may require transitional housing services that are specifically designed to support their recovery. This may be because someone is homeless, or because their previous living arrangement would undermine recovery to abstain from drug and alcohol use. A scholarship fund has been established to pay up to two months' rent and/or the initial security deposit for eligible Members stepping down from non-hospital rehabilitation or halfway house services who otherwise would not be able to pay to live in a Recovery House.

This program set aside monies to assist MA recipients with access to Recovery House services. Through this program, CABHC began issuing scholarships in late December 2007. By the end of June 2009, 232 scholarships were provided to MA recipients from each of our five counties. Due to the depletion of funds, the grant process was suspended in September 2009. After a thorough review of the program, the CABHC Board of Directors restored funding effective, March 2010. CABHC will implement the program and will collect and analyze the data related to grant expenditures, and present its findings quarterly to the CABHC Clinical Committee and the CABHC Board of Directors.

4. New Recovery House Start Up Project

This project will provide funding for the start-up of three new Recovery Houses to be physically located in our five county area. These funds may be used to purchase and/or renovate properties for use as Recovery Houses. The objective and contractual expectation of the three providers who were awarded the funds is that they will be fully operational by the end of 2010.

CONCLUSION

As each year brings new visions for changes and challenges ahead, CABHC will continually do its best to carefully monitor, and collaborate with various organizations, agencies and systems of care to meet the needs of its Members. Our priorities for the upcoming year accentuate advanced

innovation in service delivery based on ongoing monitoring to ascertain the continued stability of the Program. The results of these goals stated in this Annual Plan will be revisited and reported as part of the 2010 Quality Improvement Annual Report.