2010

CONTINUOUS QUALITY IMPROVEMENT ANNUAL REPORT

MISSION STATEMENT

THE CAPITAL AREA BEHAVIORAL HEALTH COLLABORATIVE WILL 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 AREA.

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EXECUTIVE SUMMARY

The **2010 Annual Report** reflects the status The Capital Area Behavioral Health Collaborative (CABHC) has shown in the Continuous Quality Improvement (CQI) Plan for Calendar Year (CY) 2010. There are two major headings in this year's report: **Clinical Management** which seeks to capture clinical services, and **Administrative Oversight** which looks at areas that are significant to the operations of and support of the Program, and have either a direct, or in-direct impact on services provided. The revisions to the format will continue to follow the design of the Annual Plan.

The 2010 Annual Report represents the fourth year of reporting on a calendar year (CY) rather than a fiscal year (FY). However, certain sections of the report cannot be adjusted from a FY to CY; therefore a few areas, such as the Financial Stability section, are reported as FY.

Highlights of the CABHC CQI Plan for CY 2010 are as follows:

CLINICAL MANAGEMENT

The **Children's Services** is committed to the services for children and adolescents throughout the Territory. Children and Adolescents Members make up over 50% of the total number of Members and accounts for 65% of all HealthChoices medical claims expenditures in the five counties. CABHC continued to review the **Summer Therapeutic Activities Program (STAP**) through the efforts of the STAP 2010 Planning Committee. The committee consisted of a broad base of participants, including parents and providers. For 2010, STAP was reduced to a five week program to allow flexibility for parents to enroll children both in STAP and the Extended School Year (ESY). Although the program was shortened, overall attendance increased 13.1%. A Best Practices Work Group reviewed the existing OMHSAS Best Practice Guidelines and found it to be somewhat vague. The end result included the recommendation for changes in the policy. The recommendations are now waiting OMHSAS approval early in 2011. The **Functional Behavior Assessment (FBA) Workgroup** developed FBA guidelines to support the child/family to identify the best Behavioral Healthcare Rehabilitation Services (BHRS) to optimize success in treatment. This document is in the process of being reviewed by OMHSAS, with approval expected in 2011. The **Residential Treatment Facility (RTF) Workgroup** developed a Community Residential Rehabilitation – Host Home (CRR-HH) Intensive program description. The workgroup secured an exception from OMHSAS to extend the evaluation period from 30 days to 60 days. Further, they secured OMHSAS approval for the RTF and CRR-HH Pre-Discharge Planning meeting Policies and Procedures which will foster more effective communication related to discharge planning. A Stakeholder Workgroup was formed to review the implementation of the Therapeutic Staff Support (TSS) Schedule to address ways to improve the delivery of TSS services. The workgroup began its work in November with the focus on improving the TSS Schedule procedures and to address provider concerns. The Children's Home of York (CHOR) is the provider of the Multidimensional Treatment Foster Care (MTFC) services. CABHC continues to monitor the startup activities for this service. In an effort to monitor the efficacy of BHRS, CABHC composed the *Do Children and Adolescents Who Had TSS Services Still Receive CBHNP Funded Services Into Adulthood.* The report examined whether children and adolescents who had TSS services in the past five years still

receive CBHNP funded service upon turning 18. The results found that individuals with an Autism Spectrum Disorder (ASD) specifically used BHRS more often than non-ASD. Further study will be conducted in the future.

Peer Support Services (PSS) saw the expansion of billable services by adding two new service providers, one of which (Recovery Insight, Inc.) is a fully peer-run program. PSS expanded through the approval Medical Assistance for funding telephone support as a reimbursable service. CABHC developed and implemented a Peer Support section to the CABHC website. This enables providers to post peer support job openings and affords Certified Peer Specialists (CPS) the opportunity to register on the site. This provides an additional resource to link CPS to job opportunities.

The Provider Network Committee continued to evaluate the CBHNP development of performance indicators in the provider profiling process. The Provider Network Committee will monitor CBHNP's implementation of School Based drug and alcohol outpatient services. This includes education of Providers and increasing Member awareness of this service. Through the committee, CABHC will assess the fidelity of Assertive Community Treatment Teams (ACT). Outcome measures were developed for the ACT, which CABHC will collect and analyze their outcomes in 2011.

In November 2010, the CABHC Board of Directors determined that the **Management Information System (MIS) Committee,** which provided technical oversight and monitoring of the contract with Alan Collautt Associates, Inc (ACA), had achieved its goal for when it was organized. It determined that CABHC staff will continue with the MIS oversight.

CABHC monitored two **Performance Improvement Projects (PIP)** during the year. Youth Receiving Substance Abuse Services rate of 2.02% exceeded the HealthChoices average of 1.35%. The second PIP, Increase rate of Follow-up after Hospitalization, scores fell below OMHSAS standards in all four quality indicators. **Program Evaluation Performance Summary (PEP)** continued in 2010. CABHC continued monitoring the corrective action plan (CAP).

Reinvestment Projects continued to have positive developments in 2010. In September, **Respite Services** restarted through the Youth Advocate Program (YAP). The percent of Members served increased 30.8% while respites delivered increased 25.3% over last year. **Specialized Transitional Support for Adolescents** served 58 Members between 16-21 years of age. The **Recovery House Scholarship Program** increased the number of sites by 50%, with 19 organizations offering 44 sites. Eighty-five percent of the recipients of the **Housing Initiative Program** in Cumberland and Perry Counties had been homeless. Dauphin County served approximately 23 individuals through two projects, while Lancaster County began operating in November. Lebanon's housing initiative partnered with the Lebanon County Action Partnership to provide housing to prevent people with mental illness from being homeless.

ADMINISTRATIVE OVERSIGHT

The results of the **CBHNP Performance Objectives** revealed that CBHNP scored 80 points for the year, to earn the right to retain 75% of the available funds. The support service contract with **Substance Abuse Services Inc./The RASE Project** led to positive results toward supporting

Members in recovery from substance abuse problems and by providing educational opportunities throughout the Territory. During the year, they presented 24 “In My Own Words” presentations to over 2,000 students in two different school districts.

The **Children’s Service Delivery System** saw the percent of school participation in Integrated Service Planning Team (ISPT) meetings decline for the fourth year. Delivery of initial BHRS was mixed with Mobile Therapy (MT) increasing and Behavioral Specialists Consultants (BSC) and TSS decreased. Readmission rates for **Adult Mental Health and Drug and Alcohol Services** declined in 2010.

Both **Enrollment and Penetration** rates increased during the year.

In the area of consumer safety, the number of **Critical Incidents** filed increased this year, after declining last year. However, the use of restraints/seclusion declined.

In the area of **Complaints and Grievances**, the data for complaints were similar to the previous year; however the grievance rates continued to decline. CABHC’s monitoring of CBHNP’s ability to conduct Level I reviews in a fair and unbiased manner was positive, allowing CABHC to discontinue monitoring Level I reviews.

In the area of **Quality Satisfaction** regular assessment of consumer and provider satisfaction is essential to ensuring that the HealthChoices Program is responsive to the needs of its Members. Thus, conducting Consumer and Provider Satisfaction surveys is extremely important. CSS conducted 1.246 surveys this year, a significant increase over last year. Members surveyed reported 86.4% overall satisfaction with services received, which is similar to last year.The CBHNP Member Satisfaction Study found an increase in the number of Members reporting that it was more problematic to get the help they needed when they called CBHNP member/customer service department. The CABHC Provider survey found that the overall satisfaction all CBHNP departments/areas experienced slight declines this year.

The **Financial Overview** of CABHC’s financial performance remained strong this year. Continued higher than anticipated enrollment was the main factor in the strong financial standing of the corporation.

The Executive Summary is only a snap shot of the entire report and aids to highlight areas of focus for the reader. Reviewing the entire report will provide the reader with a more comprehensive understanding of the activities accomplished during the 2010 CY and will allow the reader to gain a better understanding of the services and quality management that was realized.

CABHC OVERVIEW and ORGANIZATIONAL STRUCTURE

CABHC Overview

The Capital Area Behavioral Health Collaborative (CABHC) is a private, not-for-profit company established in 1999 through the collaboration of Cumberland, Dauphin, Lancaster, Lebanon, and Perry Counties' Mental Health and Substance Abuse programs in order to provide monitoring and oversight of the Office of Mental Health and Substance Abuse Services' (OMHSAS), HealthChoices managed behavioral healthcare contract with the Counties' managed care partner, Community Behavioral HealthCare Network of Pennsylvania (CBHNP). The goals of the OMHSAS HealthChoices Behavioral Health Program are to enhance Members' access to health care services, to improve the quality of care accessible to Members, and to stabilize Pennsylvania's Medical Assistance spending. In accordance with these goals, CABHC's mission 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 area.

This report is intended to summarize CABHC's efforts during the 2010 calendar year to continue execution of its mission, and the goals of the HealthChoices program.

CABHC Organizational Structure

CABHC has continually emphasized cooperation and unity between individuals, organizations, and systems for ongoing improvement in the quality and effectiveness of behavioral health services throughout the Territory. This philosophy of partnerships continues to be mirrored in the supportive efforts of CABHC's professional staff, the integration of consumers, county staff, and family members within each of CABHC's committees and workgroups. It also stems through CABHC's contracts and cooperation with other organizations in the community, including CBHNP, to promote quality and effective service delivery.

The county commissioners of each of CABHC's member Counties appoint two representatives to the Board of Directors, one representing Mental Health and one representing Substance Abuse. In addition, two non-voting representatives from the Consumer and Family Focus Committee serve as liaisons to the Board. In their role, they keep the Board updated regarding information and concerns expressed by the Consumer Family Focus Committee (CFFC) concerning MH and D&A matters, and keep the CFFC briefed regarding the Board's actions related to the Program.

CABHC staff is structured into three specific areas which are Administrative, Financial, and Clinical. They are each supervised by a member of the Management Team. The Management team is supervised by the Chief Executive Officer (CEO).

The Administrative area is comprised of our Receptionist/Administrative Assistant, who is supervised by the Executive Assistant to the CEO. The Financial area includes our staff Accountant, supervised by the Chief Financial Officer (CFO). Lastly, the Clinical area includes professional specialist positions in Children's Services, Drug and Alcohol Services, Member

Relations, Provider Network, and Quality Assurance. These five positions are supervised by the Clinical Director.

A sizable element of the efforts of CABHC is accomplished through our committee structure, with the support of the CABHC staff positions outlined above. By design, each of the committees are chaired by a Board member and includes representation from each of the Counties, from individuals receiving behavioral health services through HealthChoices, families of these individuals, or individuals recovering from substance abuse conditions. As needed, staff members from CBHNP are invited to attend the committee meetings. Our committees include:

The Clinical Committee is responsible for providing clinical analysis and to review continuity of care issues across all levels of care and oversight of treatment related activities of the HealthChoices program. This committee also reviews continuity of care issues across all levels of care, analyzes best practice guidelines and developments, and monitors activity of Reinvestment Services.

The Consumer and Family Focus Committee responsibilities include recruitment and training of Consumers' participation in the CABHC committee structure, providing feedback and recommendations to how the Program is managed, and education and outreach efforts to consumers and Members in the community regarding HealthChoices and recovery.

The Fiscal Committee is responsible for providing oversight regarding the financial matters associated with our HealthChoices program and the Corporation. .

The Provider Network Committee is responsible for the oversight of the provider network developed by Community Behavioral HealthCare Network of Pennsylvania, Capital Area (CBHNP), who is the contracted Behavioral Health Managed Care Organization (BH-MCO). Areas of focus include, monitor the BH-MCO's provider network to assure access standards are met, choice is provided, and specialty needs are available to Members, develop and monitor, need for additional existing service locations and for new services, develop and monitor provider satisfaction surveys, monitor provider profiling reports, monitor CBHNP credentialing committee activity

In addition to these standing committees, CABHC also develops workgroups and other committees as needed to address a number of issues (e.g. the STAP Workgroup, the Peer Support Services Steering Committee (PSSSC), the Drug & Alcohol Reinvestment Steering Committee, and the Residential Treatment Facility (RTF) Workgroup). These workgroups also include consumers and representatives from each of the Counties.

CLINICAL MANAGEMENT

CHILDREN'S SERVICES

CABHC is committed to the services for children and adolescents throughout the Territory. The Collaboration strives to form new, integrated partnerships across children's services in order to reduce duplication and increase responsiveness of services to families and their children. This includes coordination with early intervention, early childhood care and education programs. Of the 172,960 total Members, 91,317 Members fell into the 0-17 year old category. It is noted that 0-17 year olds utilizing services during the year account for 65% of all HealthChoices medical claims expenditures in the five counties. CABHC continues to support a variety of initiatives to enhance access and delivery of services to children. What follows is a review of the Children's quality activities related to services identified in the Annual Plan.

Summer Therapeutic Activities Program (STAP)

Summer Therapeutic Activities Program (STAP) is a service that uses group treatment as a way to 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.

Extended School Year (ESY) and STAP

This objective explored the impact of these two programs on children during the summer. Information was gathered from parents and providers.

CABHC and CBHNP established a STAP 2010 Planning Workgroup in order to evaluate utilization of children's services throughout the summertime. The objective was to plan in a more comprehensive way where families could benefit from the Extended School Year (ESY) and STAP.

Information from providers/family members showed that the majority of Members who attended STAP did not attend both ESY and STAP. Members that did attend both ESY and STAP were found more in the ASD population. One reason for that is there is not a consistent schedule that is used for ESY among all school districts and the Intermediate Units (IU's.) This makes it difficult to schedule STAP around ESY. It was determined that in order to meet children's needs better, STAP would be held later in the summer of 2010 making it easier for children to have the option of attending both STAP and ESY.

The data in Table 1 below shows the service and capacity of the providers. There were three Mental Health (MH) Providers with seven sites, Community Integration STAP (CI) had one provider and 1 site, and ASD STAP had 2 providers with four sites. Since this is the first year for tracking this data, these figures will serve as a baseline for future analysis.

Table 1: STAP/ESY Attendance CY 2010

Service	Capacity	# of Members utilizing STAP	# of Members- utilizing ESY
Mental Health	180	150	5
CI STAP	25	23	4
ASD-STAP	126	122	7

Improve coordination between education system and STAP

The STAP 2010 Workgroup also explored ways to improve the coordination between the education system and STAP. Therefore, the Workgroup brought together a wide-range of individuals needing to enhance communication of this program. The Committee consisted of 35 individuals representing a variety of interests. The Committee included parents (6 or 17.1%), School Districts & Intermediate Units (4 or 11.4%), Providers (10 or 28.6%), Counties (3 or 8.6%), OMHSAS (1 or 2.9%), and CABHC/CBHNP (11 or 31.4%). The results of the workgroup were positive.

Evaluate efficacy of STAP

The STAP Workgroup also reviewed the changes, implementation, schedule, extended school year coordination, as well as recommendations for STAP. The 2010 data shown in Table 2, confirmed that the changes had a positive impact on attendance, as there was an overall increase of 13.1% in total number of Members receiving STAP. Participants with ASD showed the greatest increase, 16.4%.

Table 2: STAP Attendance

STAP ATTENDANCE	2007	2008	2009	2010	Increase from 2009
Non-ASD	454	479	336	376	10.6%
ASD	225	302	235	281	16.4%
Total Participants	679	781	571	657	13.1%

Providers reported that having a later start date was effective when planning for STAP. Also, having a later start date allowed children to transition back to school easily. However, due to the late start date, it was also noted that it was somewhat difficult to staff STAP this summer as many of the staff returned to school or other employment at the end of August. Providers also reported that the later start time for STAP made it more difficult to keep full attendance because many children started school and parents would discontinue attendance so that their children could have a short break prior to returning to school.

It was recommended by the STAP Workgroup that eight weeks was too lengthy for STAP, yet five weeks was too short. Providers and parents also expressed the desire for STAP to begin at a consistent time each year either the last week of June or first week in July. After considerable discussion of the pros and cons for a lengthier STAP, it will remain a five week program.

Behavioral Health Rehabilitation Services (BHRS) Best Practice

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 is child-centered, and it can take place in a variety of settings, not just one place. Services are guided by the treatment plan. Progress is monitored with data that is updated regularly and reevaluated as necessary.

Best Practice Guidelines

CABHC established a Best Practices Workgroup to review the OMHSAS Best Practices Guidelines. The Department of Public Welfare (DPW) OMHSAS Best Practice Guidelines are intended to be used as recommendations for quality clinical practice, the workgroup addressed issues which they identified as vague or unclear in the existing policy. They also discovered that after direction and clarifications from OMHSAS, some of the existing information regarding BHRS role clarifications conflicted with CBHNP's current billable activities. Discussion between CBHNP and OMHSAS led to OMHSAS revising the guidelines.

The revised document will be qualitative set of standards expanding on the existing regulations, and encompassing OMSHAS directives, Child and Adolescent Service System Program (CASSP) best practice recommendations, published best practice guidelines utilized by other professional organizations, academic review of the literature, and extensive Health Choices provider input.

The Best Practices Workgroup for BHRS completed gathering of information and data from OMHSAS/CASSP/HealthChoices (HC) Providers in August 2010. The information was processed by the workgroup and sent to CBHNP to prepare the BHRS Best Practice Guidelines. It is anticipated that the guidelines will be available early in CY 2011.

Functional Behavior Assessment (FBA) Workgroup

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

The overall goal of developing such guidelines was to support the child/family to identify the best BHRS in order to optimize their chance of successful completion of treatment and continued integration with the natural support system in the home community. The guidelines incorporated information collected from the Autism Task Force, OMHSAS, published guidelines from professional organizations, academic reviews of literature, and feedback from proficient clinicians in the network. The development of FBA best practice guidelines provides the structure to ensure that the utmost quality of care is provided to Members, and to fully take into account the integration of FBA's into our existing systems of care.

The document was completed and submitted for review to CBHNP management and CABHC for review. The approved document will be submitted to OMHSAS for final approval. It is anticipated that the guidelines will be approved in 2011. Once approved, CABHC will monitor their implementation.

Residential Treatment Facility (RTF) Workgroup

The CABHC Clinical Committee created the RTF Workgroup in order to address concerns related to the evaluation of the Interagency Service Planning Team (ISPT) process, and effective communication and coordination of services between providers, specifically Juvenile Probation Office (JPO) and Children & Youth (C&Y). By addressing these concerns, services for Members utilizing RTF for treatment will improve.

The workgroup had several notable accomplishments: 1.) Development of a new CRR-Host Home service description, and 2.) Requested waiver of a 30 day expiration of evaluation for RTFs. The waiver requested that the 30 day expiration be extended to 60 days. CABHC received approval to extend RTF evaluations to 60 days from admission. Appendix T's requirement now states that the Member on a provider's pending list for an evaluation to be "current" for an additional thirty days (a total of 60 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.

Evaluate effectiveness of Clinical Evaluators

CBHNP Psychologist Advisor Dr. Jerri Maroney and the CBHNP Quality Improvement (QI) department initiated a series of educational emails for all network evaluators to provide the evaluators with an educational "toolkit" to be used with all evaluations. The educational emails provided links and resources for low cost or free objective measures for conducting psychological evaluations. CBHNP Quality Improvement (QI) staff also provided feedback to low scoring evaluators. Low scoring evaluators are those who fell below standards (80%), had high grievance rates, and /or an inability to fully utilize CASSP principles in recommendations. Feedback was provided via peer to peer reviews, as well as ongoing assistance, education, and guidance.

In addition to the education emails and feedback, TSS Scheduling was implemented effective May 1, 2010. The purpose of TSS Scheduling is to assist evaluators in providing accurate and targeted prescriptions that best match the individual Member with needs while being consistent with CASSP principles.

Interagency Service Planning Team (ISPT) Meetings

A focus area for 2010 included changing the ISPT meeting to be held prior to an evaluation for out of home placements. This way, the treatment team input and recommendations are sent to the evaluator prior to the evaluation. Several workflow drafts were completed in 2010. The major concern raised is whether CBHNP will have enough Clinical staff to attend all of the

ISPT meetings. Without adequate Clinical staff, it would be difficult to focus on all out of home placements. The goal is for CBHNP to attend each ISPT meeting. In order to fully analyze this concern, CBHNP conducted a root cause analysis leading them to reconfigure workload and job responsibilities of the Clinical Care Managers (CCM). The goal for completion of the reconfiguration of BHRS is March 2011. The BHRS Best Practice Workgroup will monitor the BHRS redesign.

CRR-HH Therapeutic Vacation Policy

During the year, CRR-Host Home (CRR-HH) providers raised the question if they were allowed to take their HH child with them on their vacation. In response to the providers, the workgroup addressed this inquiry and drafted a Community Residential Rehabilitation-Host Home (CRR-HH) Therapeutic Vacation Policy. The policy was approved by OMHSAS in September 2010.

Training for Juvenile Probation Office and Children & Youth (JPO & CYS)

Communication and coordination of services is critical to effective treatment. Therefore, the RTF Workgroup designed a number of trainings that would improve understanding and foster cooperation between the Juvenile Probation Office (JPO) and Children & Youth services (CYS).

CBHNP presented a series of informational training sessions that were held between JPO & CYS. The presentations included an overview of CBHNP, roles of CBHNP staff and departments, what staff CYS or JPO would interact with, the complaint process, the grievance process, different levels of care that CBHNP funds, Medical Necessity Criteria (MNC), and opportunities for future CYS/JPO and CBHNP collaboration.

The first session occurred in Cumberland/Perry Counties on June 2, 2010. The Dauphin County presentation was on November 17, 2010. Additional trainings will continue in 2011.

Barriers to Discharge from RTF/CRR- HH

The RTF Workgroup has also been composing methods to overcome barriers to discharge from both CRR-HH and RTF levels of care. Overcoming barriers to discharge will ensure that positive communication has taken place between providers so that families and children who are discharged will be provided adequate support and continuity of service. In order to facilitate the process, Counties are sent lists from CBHNP via CABHC of Members who are either in a CRR-HH or RTF. Originally, the list was created to monitor RTF admissions and barriers to discharge from RTFs. Overtime, it was expanded to include CRR-HH. The lists will encourage communication between providers and other services to identify and address barriers to services needed following discharge.

As this process continues, the RTF Workgroup will continue to evaluate the collaboration between Counties and CBHNP. Barriers to discharge will be analyzed in detail and shared with the Counties quarterly. This will be monitored and reviewed throughout 2011.

Therapeutic Staff Support Schedule Implementation

The initiative to rethink how TSS services are managed and services rendered began in 2009 and carried through 2010. This initiative 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. The objective for 2010 was for CABHC to work with CBHNP and the Counties to implement this new program model and to monitor the efficacy of its objectives.

TSS Schedule

CABHC and CBHNP have received numerous comments and feedback on the TSS schedule at various provider meetings. This led CBHNP to send clarification regarding the scheduling process to providers. Unfortunately, due to continued confusion and concern, it was decided to form a workgroup comprised of CBHNP, CABHC, Counties, and providers to fully analyze the TSS Schedule program and to make recommendations to improve its effectiveness. The workgroup was formed in November 2010.

The workgroup focused on two major concerns: the procedural aspects of using the TSS Schedule and to address the variety of concerns posed by providers. The end result of their efforts should be that the TSS Schedule provides a smooth process between the evaluators and team members that will ensure Members will receive needed services. Additionally, to enhance the process between the evaluators and the team, CBHNP will provide TSS Schedule training to direct line staff. The TSS Schedule will continue to be reviewed in the coming year.

Multidimensional Treatment Foster Care (MTFC) Implementation Team

MTFC is an alternative to regular foster care, group or residential treatment, and incarceration for youth who have difficulty with chronic disruptive behavior. The evidence of positive outcomes from this unique multi-modal treatment approach is compelling.

During the year, a team comprised of CBHNP, CABHC, Children's Home of York (CHOR), Dauphin County Mental Health Staff, Dauphin County CYS and JPO, as well as Cumberland County Mental Health, JPO, and CYS began meeting in April 2010. The team developed a program description, obtained letters of support from the Counties, and developed a timeline for program implementation.

CHOR is the provider of this service. CHOR developed advertising, designed training for JPO and CYS staff regarding MTFC. CHOR began marketing in June 2010 with the goal of implementing services in Cumberland and Dauphin counties during CY 2011. CABHC will continue to monitor the start up of these services.

Efficacy of Children and Adolescent Services

In an ongoing attempt to monitor the efficacy of children and adolescent services, CABHC's report *Do Children and Adolescents Who Had TSS Services Still Receive CBHNP Funded Services Into Adulthood* examined whether children and adolescents who had TSS services in the past 5 years still receive a CBHNP funded service upon turning 18. The assumption was that most Members would age out of traditional BHRS. The data which was based on claims did not support this assumption. In fact, the report found that among 301 Members who received TSS services in the past 5 years and since turned 18, 201 Members still received some type of CBHNP funded service. Among that group, 108 Members received a traditional BHRS. The report also compared services received among Members with an ASD diagnosis and Members who do not have an ASD diagnosis. The data showed that while Members without an ASD diagnosis utilize some type of CBHNP funded services more frequently after turning 18, Members with an ASD diagnosis specifically used BHRS most often.

As a result of this study, CABHC will review and evaluate two areas in the year ahead: the impact of services on transitional aged youth and utilization of other services by 18-21 year olds.

PEER SUPPORT SERVICES

Peer support for individuals with similar life experiences has proven to be tremendously important towards assisting many Members as they move through difficult situations. Certified Peer Specialists (CPS) are uniquely qualified to assist peers in making personal transformations. Their lived experiences provide a unique outlook, and enforces that recovery is possible and provides a very strong message of hope for the peer, family, and other providers on the team. Maintaining its vantage point is crucial in assisting individuals rebuild their sense of community when they had a disconnecting experience.

CPS's are individuals who have been able to "live recovery and resiliency" and have the ability to assist others develop the skills and attitudes they require to enhance their own resiliency and recovery. CPS allows qualified providers the capability of adding peer support services to their array of services. The addition of Peer Support Specialist to the public behavioral health systems is a powerful tool that includes the peer experience.

Peer Support Services can be under the existing license of psychiatric outpatient clinics, partial hospitalization programs, crisis intervention, targeted case management, or provided by free-standing peer support agencies. However, it remains a separate service from the noted licensed services. Providers must be enrolled in Medical Assistance (MA), licensed as required by OMHSAS, 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 (PSSSC) supports both the Peer Specialists and their direct supervisors as peer support develops and changes. CABHC continues to support two separate professional development groups. One is for CPS and the other is for Direct Supervisors which

allows a forum to share experiences and information as well as work on problem solving and providing 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.

Expand Billable Services

One way to expand billable services is to add new providers to the provider network. During the year, two providers were added: NHS, Helen Steven Center in Carlisle and NHS Capital Region, in Harrisburg was awarded the opportunity to operate a pilot program for Telepsychiatry and Recovery InSight. Inc., Lancaster County, was approved in November 2010 as the only free standing consumer run agency.

Recovery Insight, Inc. is the only fully peer-run and operated CPS program in the Capital area. Recovery Insight's mission: "Is to be involved in the process of making positive changes in people's lives by providing support with the highest integrity and compassion to individuals working towards recovery, by individuals in recovery, with similar experiences." Their vision: "to focus on the person and not the illness" and their desire is to develop a one-to-one, supportive relationship with the person we are mentoring in recovery. At the close of the year, Recovery InSight, Inc. reported that they had served 60.

Another resource for expanding billable PSS services was provided when MA added telephone support as a reimbursable service. This expansion of billable services was a result of strong advocacy by CPS, providers, Pennsylvania Community Providers Association (PCPA), the counties. It should be noted that PSS must still be primarily conducted face-to-face with a cap of no more than 25% of billable services in a year being telephonic. Telephonic support services became an effective service on January 1, 2010.

Table 3 shows that the amount of units of service delivered increased 5.4% during CY 2010, with 617 units of telephonic support. The addition of telephonic support appears to be a feasible service. CABHC will continue to monitor this service in for its effectiveness in providing support to our Members.

Table 3: Utilization of PSS Telephone Supportive Services 2009 to 2010

	CY 2009			CY 2010		
	Consumers	**Units**	**Dollars**	**Consumers**	**Units**	**Dollars**
Peer Support Services	189	24,023	$ 399,267	225	24,796	$ 416,482
PSS Telephonic Support				79	617	$ 10,267
Totals	189	24,023	$ 399,267	304	25,413	$ 426,749

Analyze Peer Support Services Retention Rates

There has been an ongoing interest by the Peer Support Services Steering Committee (PSSSC) in reviewing retention rates. In May 2010, the results of the Peer Support Services Staff Retention Report Summary was reviewed by the PSSSC and sent to all Peer Support providers to request additional information on their continued implementation of PSS. The focus of the survey was to identify the number of Peer Support Specialists hired and what their experience with turnovers in

the Certified Peer Support Specialist positions. Data was reviewed since the December 2006 inception of PSS,

The survey found that there were a total of 17 PSS positions, with 50 CPS hired and that 34 (68%) had left the position for a retention rate of 32% since December 2006. The five reasons cited by providers for turnover were: job stress, 22.2%, career advancement 13.8%, personal issues, physical health issues, and affect on own recovery/own mental health each with 11.1%.

The results, of the survey, appear to underscore the need to for CABHC to proactively address CPS job retention in the future.

Develop Peer Support Webpage on CABHC Website

The Peer Support Services page on CABHC's website was completed in June 2010. The intent of adding the Peer Support Webpage is to provide an opportunity for providers and CPS to connect related to open employment positions. Operationally, the website offers the provider the opportunity to list job openings; they also have the ability to view registered CPS's to fill the openings. The CPS, in addition to registering on-line, they are able to view the job listing posted by the providers. The CABHC Member Specialist monitors this process to ensure that it is functioning and that providers and CPS have a clear understanding of how to use the website.

Since July, seven providers have listed seven different positions and three CPS registered to receive job notifications. Although the initial data could be somewhat disappointing, the activity to date is encouraging.

IMPORTANCE of CONSUMER, FAMILY and ADVOCATE INVOLVEMENT

CABHC values the engagement of Members in the HealthChoices oversight, and encourages their participation on all CABHC Committees, Board Meetings, and workgroups. The Consumer and Family Focus Committee (CFFC) provides CABHC valuable input from Members and families. The participants in a program are the most ideal people to identify where improvements need to be made to improve the quality and responsiveness of services so that they support recovery and resiliency. The HealthChoices program benefits greatly as those who use services can truly participate on the CABHC Committees.

Recruitment of Members

In 2010, the CFFC developed a smaller workgroup 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. This CFFC Workgroup presented eight outreach presentations. Two occurred in Cumberland County, two in Lebanon County, two in Dauphin County, one at CABHC, and one at CBHNP. In 2010, five individuals were recruited for CABHC Committees/Workgroups.

Educational Presentations: To offer a Wellness Recovery Action Plan (WRAP) Training

This goal was achieved by offering a 2.5 day Introduction to Wellness Recovery Action Plan (WRAP) on May 10-12 of 2010. CABHC sponsored a second 2.5 day training December 6-8, 2010. Ms. Gina K. Calhoun, OMHSAS Educator/Certified Peer Specialist, presented both trainings.

In addition to the WRAP training the CFFC identified topics for educational presentations. The following educational presentations have occurred at CFFC meetings:

February 22, 2010 -I'm the Evidence Campaign
April 26, 2010 -Understanding Autism, CBHNP
June, 28, 2010 -Addiction/Recovery, The RASE Project
August 23, 2010 -Lancaster County Mental Health Court
October 25, 2010 -Dauphin County Mental Health Disposition Programs
December 7, 2010 -Respite-Youth Advocate Programs (YAP)

Looking ahead, it is CABHC's goal to sponsor WRAP trainings on a quarterly basis in 2011. Additionally, training topics scheduled for 2011 include: peer support, and supported employment. Additional topics will be determined throughout the year and will be presented at future CFFC meetings.

Develop validation procedure to monitor implementation of survey recommendations

In October 2010, an internal policy for monitoring Consumer Family Satisfaction Team (C/FST) was revised and implemented. The policy allowed the CABHC Member Relations Specialist to develop a tracking chart in order to track Member issues.

In an effort to effectively utilize the CSS Member surveys to enhance services in the Territory, the Systems Improvement Committee (SIC) began to meet again. The objective of the SIC is to be an action oriented group of committed individuals who share the concerns not only raised in the reporting but also from comments made directly by consumers whom are encountered by County MH/MR, SCA Administrators, CSS staff, CABHC, and CBHNP.

Membership of SIC includes representatives from Consumer Satisfaction Services (CSS), CABHC, CBHNP as well as Member stakeholders, joined together again for the first meeting of the resurrected SIC. The SIC provides a forum to review the findings of CSS's Provider Specific and Quarterly Reports. The forum enables stakeholders the opportunity to respond to concerns that have been raised by persons interviewed during the consumer satisfaction survey process.

Since the committee has just begun its work, CABHC will monitor the activities of this committee and include the results in the 2011 Annual Report.

PROVIDER NETWORK

Successful management of behavioral health services through the HealthChoices Program requires CBHNP to develop positive relationships with Providers throughout the network. These relationships allow CBHNP to support Providers while maintaining 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 offered to Members.

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 choice and timely access to behavioral health treatment. When the Provider network is unable to meet the 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 attest to the efforts taken to rectify the specific access issue and is granted for one year.

The analysis for the access standards is completed by CBHNP using GeoAccess® Accessibility Analysis reports. CBHNP found that access to behavioral health services has remained the same over the last year. CABHC requested and received four in-plan service access exceptions from OMHSAS for the 2010-2011 fiscal year. OMHSAS found that the proactive measures outlined by CABHC in the request would still enable Members timely access to a choice of Providers as needed. Listed below are the four exceptions approved by OMHSAS.

Methadone Maintenance (Adult): Access standard of distance for Southwest (SW) quadrant of Lancaster County; Northwest (NW) and Northeast (NE) quadrants of Dauphin County; and NW quadrant of Perry County.

Hospital Drug and Alcohol Rehabilitation (Adult and Child/Adolescent): Access standard of distance for all five Counties.

Hospital Drug and Alcohol Detoxification (Adult and Child/Adolescent): Access standard of distance for all five Counties.

Inpatient Psychiatric Hospitalization (Children): Access standard of distance for NE, SW, and SE quadrants of Lancaster County.

Provider Profiling and Performance

CABHC continues to monitor CBHNP's Provider profiling processes, which results in identifying capacity and network needs and identifying areas where Provider communication and education is needed. As a part of the profiling process, amended tracking criteria in CBHNP's Provider performance tracking and reporting system is being evaluated by the Provider Network Committee in conjunction with CBHNP for implementation in 2011. Performance indicators will include assessment of co-occurring disorder competency, appropriate discharge planning, coordination of care, readmission rates, and claims denied for non-administrative reasons, complaints, and timeliness of submission of treatment information.

Provider Co-Occurring Disorders Competency

CBHNP uses a Co-Occurring disorder competency tool annually to evaluate provider agencies according to level of care in their ability to serve Members with co-occurring disorders Mental Illness and Substance Abuser (MISA). During 2010 CBHNP obtained baseline scores for all providers across all levels of care. CBHHP found that there was a discrepancy in the performance of various levels of care. Through a variety of interventions, such as outreach and education, CBHNP encouraged providers to develop procedures for screening co-occurring disorders upon Member intake, and to make appropriate referrals if the provider is unable to address Member treatment needs. CABHC will continue to monitor CBHNP's progress in assisting providers in increasing their competency ratings.

School Based D&A Outpatient Services

As a result of an 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 is to assist in the development and monitoring of school-based drug and alcohol outpatient services. 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. The service began in the fall of 2010 with two Providers (Diakon Family Life Services and Gaudenzia West Shore).

In April 2010, a workgroup was formed to research the policy clarification as it pertained to licensing and to explore which school districts within the five counties may benefit from access to this service. Representation from each of the five counties was present on the workgroup committee, as well as representation from CBHNP and CABHC. Additionally, a representative from Cumberland County's Student Assistance Program offered ongoing support and information, as this service has been implemented in coordination with two providers through county funding for some time. Through the establishment of this workgroup, several objectives were met:

- Successful application of the Policy Clarification (OMHSAS #07-09) issued in November 2009.

- Verification of licensing requirements through the Division of Drug & Alcohol Program Licensure.
- CBHNP implemented a billing site code for Providers of D&A school-based outpatient that will indicate therapy was conducted at a school. This will be used on claims for future outcomes measurement.
- Identified a course of action for a provider intending to provide D&A OP services in the school setting that will mirror the process established for enrollment as a supplemental service.

Increase Community Awareness of School-Based D&A Services

Throughout the year, applications from existing providers to offer school-based outpatient services were reviewed by CABHC and OMHSAS. At the close of 2010, one provider had been approved by OMHSAS with additional approvals due early in the 2011. New providers are required to complete supplemental service applications. It is hoped that with the approval of new providers that referrals and utilization will increase for this service.

The workgroup discontinued official meetings in October 2010, after the designated goals were accomplished and the Supplemental Provider Enrollment Applications were submitted to OMHSAS on behalf of the existing school based D&A outpatient providers in the Capital Area. In addition, CABHC and CBHNP have presented information at county provider meetings to ensure that providers are aware this service is an option should they have an interest in participating. Utilization will be monitored by the committee in report form for 2011.

Monitor and Evaluate the Development of Network Services

When the Counties or CBHNP determine a need for additional services, identify a gap in network composition and services, or know of another service that would be beneficial, current services may be expanded or new services may be brought into the network.

During the year, telepsychiatry services were evaluated and found to be a valued service that should be made available to Members. Telepsychiatry is a service delivery option offering individuals the opportunity to communicate with a psychiatrist from various outpatient clinic locations via secure video conferencing. The service includes both psychiatric evaluation and medication management. This service is targeted to begin in Dauphin and Cumberland/Perry Counties early in 2011. The benefits to this service will allow both County sites to increase psychiatric time, and improve access to psychiatric services; however it does not replace existing access to site based services.

Another new service initiated this year was the utilization of telephonic support services to Members through Peer Support Services. Please refer to page 16 for more information related to the service.

Provider Satisfaction Survey

CABHC conducts a survey annually to ascertain the satisfaction of Providers with CBHNP and HealthChoices. In 2010, the Provider Network Committee formed a Provider Satisfaction Survey Workgroup. The workgroup was tasked with revising and restructuring the survey so

that it is more efficient and user-friendly. This is expected to be completed for distribution of the survey in June 2011. The results of the 2009 Provider Satisfaction Survey will be found in the Quality Satisfaction section of this report.

Assertive Community Treatment (ACT)

In 2010, CABHC began the process of bringing Community Treatment Team (CTT) services into compliance with the Assertive Community Treatment (ACT) fidelity model as outlined in OMHSAS Bulletin 08-03. This was initiated by an OMHSAS presentation and training using the Tool for Measurement of ACT (TMACT) in May 2010. The TMACT is the tool that will be used by CABHC to assess the fidelity of ACT Providers. In addition, an ACT Workgroup convened in June 2010, consisting of CABHC, Counties, and Providers, developing five outcomes measurements that will be used for these programs. CABHC will begin collecting outcomes data, and measuring program fidelity in early 2011. This information will be evaluated and reported on in the next Annual Report.

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. In turn, ACA provides CABHC staff with immediate access to multiple arrays of established reports, and offers the capacity for CABHC staff to develop ad hoc reports to meet detailed requirements as they occur. To assist in the oversight of this contract, the MIS Committee monitors the effectiveness of ACA to provide services to the CABHC staff.

In November 2010, the longstanding chair of the MIS Committee retired. Since much of the committee's work was accomplished during the initial phases of starting up the HealthChoices Program and that the current need was more of a monitoring role, the CABHC Board evaluated the need for a standing MIS Committee. As a result, the Board decided the MIS Committee was not needed as a standing committee, therefore it should disband. The board determined that CABHC will serve as the oversight to monitor ACA's Performance Objectives, offsite disaster recovery backup system, redesign of the website, offsite storage and evaluate any future MIS needs. The CABHC Board will request the committee to reconvene if any pertinent matters arise that would warrant the regrouping of the committee.

Ensure CABHC Computer Hardware & Software Needs Are Met

CABHC utilizes ACA to evaluate its computer hardware and software needs. Although ACA continually reviews hardware and software needs, a complete review is conducted on a tri-annual basis. The last review and upgrades were completed in 2008. The next review is due in 2011.

Offsite Disaster Recovery Backup System

The committee determined that CABHC did not have a disaster plan for storing files they generated and were not backed up by ACA. After a review of the situation, ACA proposed that CABHC contract with Iron Mountain as the offsite backup facility. The CABHC board approved the plan and a contract was executed prior to the close of the year.

Develop Off-site Disaster Plan

While reviewing the need for off-site storage for its files, CABHC determined that there was not a plan in place that would keep its day to day operations working in the event that the physical site would not be accessible. An offsite disaster plan is the process of being developed and will be completed in 2011.

Review ACA Performance Objectives

During FY 2009-2010, ACA Response rate to CABHC helpdesk requests was 98.21% with only July 2009 below 100%. The Resolution rate to helpdesk requests was 100% for the year.

Redesign of CABHC Website

The committee evaluated the website and noted that the website had not been updated since its inception. Therefore, in order to maintain pace with current trends/technology, the website should be updated.

CABHC sought to involve all stakeholders in the process. The first step was to request feedback regarding the current website from all stakeholders, Board members, all standing committees and their members, and other selected bodies. The feedback was reviewed, compiled and submitted to ACA. During the course of the year, the Clinical Director worked with ACA to ensure that the redesign moved forward. At the close of the year, a prototype was almost completed. Once completed, the redesign will be beta tested with stakeholders. The target for this project to be competed is in the early spring of 2011.

PERFORMANCE IMPROVEMENT PROJECTS (PIP)

CBHNP Review Root Cause Analysis

During CY 2010 the rates for the three of the indicators for the Increase rate of Follow-up after Hospitalization PIP continued to fall below the CY 2009 HealthChoices goals. Due to a lack of positive progress CBHNP was required by OMHSAS to develop a Root Cause Analysis for the three of the Quality Indicators. Root cause analysis (RCA) is a problem solving method aimed at identifying the root causes of problems or events. RCA is typically used as a reactive method of identifying event(s) causes, revealing problems and solving them.

CBHNP identified short term goals for the identified quality indicators: QI 1 (HEDIS) 7-day follow-up after discharge and QI B 30-(PA Specific) day follow-up each improve 10% and QI 2 (HEDIS), 30 day follow–up improves 5%. The long-term goal for each of these is that by the end of 2013 each indicator will equal or exceed the interim goal established by NCQA and adopted by OMHSAS. The goals are: QI 1-57.4%, QI-B 75%, and QI-2 75%.

The RCA addressed the question: "What factors contributed to the need for improved performance?" which applied to four different areas: Policies, Procedures, People, and Provisions. CBHNP conducted an analysis of each area, identified any root cause(s), and then developed an action plan to address the identified issues. Based on the analysis, CBHNP implemented a number of actions designed to improve the follow-up rates. Some of the interventions were:

- Revised information technology reports to more effectively monitor Provider rates and trends.
- Developed methodologies to be more pro-active with Member reminders, such as:
    - CBHNP Follow-up Specialists would place reminder calls to Members within a few days of their discharge.
    - "Fax Blast" inpatient units (IP) the list of CBHNP Members in IP to remind them to begin discharge planning with the Member.
    - Survey Members for effectiveness of discharge planning that encourages follow-up after discharge.
- Assist Providers to identify barriers to successful follow-up and to work with the Member and CBHNP to eliminate barriers to follow-up.
- Encourage utilization of Peer Support Services as a follow-up service.

Prior to its submission to IPRO, CABHC analyzed and reviewed the final Root Cause Analysis (RCA) addressing the Rate of Follow-up after Hospitalization. IPRO serves as the independent external quality review agent for Pennsylvania's Department of Public Welfare. The Root Cause Analysis was approved by IPRO, and the impact of the interventions is followed by CABHC during the year. Below is a review for CY 2010 of the Increase Rate of Follow-Up after Hospitalization and the second PIP that is monitored by CABHC, Youth receiving Substance Abuse Services.

Review of PIPS for CY 2010

CABHC establishes the specific PIP and then oversees CBHNP's submission to OMHSAS. 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.

CABHC meets quarterly with CBHNP's QI Department to review both PIPS prior to submission to OMHSAS. 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.

Increase the Rate of Follow-Up after Hospitalization for Mental Illness. The Quality Indicators measured by CBHNP for this PIP are consistent with the national standard for follow-

up measures available from the National Committee for Quality Assurance (NCQA) as part of the Health Plan Employer Data and Information Set (HEDIS®). This permits comparison of CBHNP's data with both national Medicaid data from HEDIS® and state HealthChoices data from OMHSAS.

The second PIP report is **Youth Receiving Substance Abuse Service** is designed to improve access to substance abuse services for youth ages 13-17 throughout the Territory. CBHNP utilized data to evaluate and develop strategies for identifying ways for youth to improve access to substance abuse services.

Increase Rate of Follow -up after Hospitalization

Throughout the year, this PIP was submitted by CBHNP, reviewed by CABHC, and then submitted to OMHSAS each quarter. At the close of CY 2010, the Territory rates for all four indicators are below the rates at the close of CY 2009. All four indicators continue to fall well below the OMHSAS goal. Table 4 provides a summary of the scores over the past two years.

Table 4: PIP-Increase Rate of Follow-up after Hospitalization

Increase Rate of Follow-up after Hospitalization for Mental Illness				
	HEDIS-Within 7 or 30 days after discharge. (Calculation based on Industry Standard Codes.)		*Pa Specific-Within 7 or 30 days after discharge. (Calculation based on Industry Standard Codes +PA local codes)*	
	Numerator 1-7 day	*Numerator 2-30 day*	*Numerator A.7 day*	*Numerator B- 30 day*
CY 2009	*42.9%*	*63.4%*	*56.5%*	*73.4%*
CY 2010	*40.2%*	*62.1%*	*53.6%*	*70.6%*
OMHSAS Goal	*56.6%*	*75.7%*	*64.2%*	*81.2%*

Due to the low scoring for this PIP, and in an effort to monitor the interventions and actions CBHNP identified in the Root Cause Analysis that is effective July 1, 2011, CABHC will add this PIP to the CBHNP Incentive Performance Objectives. This will be reviewed quarterly by the CABHC Clinical Committee and the CABHC Board of Directors.

Youth Receiving Substance Abuse Services

At the close of CY 2010, the data shows improvement from 2.11% during CY 2009 to 2.44% in CY 2010. The Territory rate at the close of CY 2010 exceeded the HealthChoices average of 1.35%. For the first time, all five counties also exceeded the 2010 HealthChoices average. This is the first year that CBHNP has been able to present a demographic review of the data for this PIP. A demographic breakdown of the data shows that the largest groups receiving treatment are 16 and 17 year olds, males (72.6%), and Caucasian (61.3%).

PROGRAM EVALUATION PERFORMANCE SUMMARY (PEPS)

As part of the Office of Mental Health and Substance Abuse Services' (OMHSAS) monitoring of the HealthChoices Behavioral Health Program, OMHSAS conducts PEPS reviews on an annual basis, rotating key areas of the Program Standards and Requirement document on a three year cycle. During the review, OMHSAS obtains information about the specific requirement by reviewing documentation and conducts interviews with CBHNP and CABHC staff. The findings determine if the requirements are met, part met, or not met. Recommendations were then made for each requirement. A corrective action plan (CAP) is required for those items that do not fulfill all of the requirements. The CAP for this review would be from the Triennial PEPS 2009 review. CABHC monitored all activity of the CBHNP 2010 Action Plan. The CBHNP Highlights for 2010 are listed below. Each area has the OMHSAS recommendation followed by the action taken by CBHNP.

Care Management Section-Required Corrective Action

- Recommendation: Change practice so that all clinical information received from providers requesting authorization for inpatient and partial hospitalization services are consistent with CBHNP's initial proposal.

CBHNP addressed this issue in various ways: revision of Member Services job descriptions, revision of the eCura Initial Assessment Event and/or Documentation Template addressed staffing schedules, monitored utilization review caseloads and reports in order to analyze the impact on caseloads. These were accomplished during the first quarter of 2010. The end result of these actions resulted in assuring that the Clinical Care Managers are gathering all clinical information for inpatient and partial hospitalization rather than Member Services Representatives.

- Recommendation: Evaluate care management staffing in relation to CBHNP established BHRS caseload standards and utilization metrics.

CBHNP addressed this issue by reviewing caseload reports and compared them to caseload standards; evaluated FTE's and, as needed, hired additional Utilization Review & Children's Care Managers. CBHNP conducted a Caseload analysis which revealed a downward trend in caseloads for the year. It is anticipated that CBHNP will meet the target range for caseloads between 200-250.

- Recommendation: Expand training and increase monitoring of CCM documentation to ensure quality of care concerns are identified, documented, referred for Physician Consultation, and that the provider is engaged to resolve the concern.

CBHNP addressed this concern by revising the Staff to Physician Consultation event in eCura, using existing Physician Advisors Management Reports as basis for a Quality Improvement Department audit of identification of quality of care concerns, and conduct a root cause analysis with a plan to decrease levels of denial/grievances. Changes to the Staff to Physician Consultation event were completed early in 2010.

- Recommendation: Develop a plan for a renewed focus and comprehensive understanding of the effective use of recovery/resiliency and CASSP principles.

These were addressed through mandatory Clinical Department Training which included pre and post tests. CBHNP reviewed and revised the Quality Treatment Record Review Process in order to reinforce provider network awareness of effective use of Recovery/Resiliency and CASSP principles.

- Recommendation: For children's services, train and supervise CCM to increase more active care management. The focus is to encourage care managers to follow-up with providers regarding clinical information and/or more detailed reviews of treatment plans and progress.

This area was addressed by developing a review process for initial BHRS Treatment plans with provider feedback in quarterly BHRS meetings. CBHNP also addressed children's services through provider training to address treatment planning. CBHNP also adjusted provider performance monitoring to include targeted Treatment Plan areas with the results reported out at the BHRS provider meetings. Develop and explore feasibility with county oversight entity to provide a Treatment Plan Template for use by BHRS providers. Lastly, CBHNP revised the CCM documentation audit tool to mirror Mercer/OMHSAS and incorporate the focus areas of treatment planning. These items have been accomplished.

The adult area will also revise the CCM documentation audit tool, as they did for the children's area. Additionally, MH Inpatient provider training will incorporate treatment planning objectives with mandatory training for high-volume facilities. The MH Inpatient and partial hospitalization Quarterly Treatment Record Review process was also redesigned to focus on treatment planning.

- Recommendation: Provide on-going training and supervision about community resources and ambulatory care options that might prevent hospitalization. Expand provider network to fill any gaps in community care so that care managers have an array of treatment options available for Members.

This was addressed through quarterly meetings between Utilization Review Care Management and Clinical and Provider Relations.

- Recommendation: Support care managers in addressing the lack of specific youth/family-focused rationale for TSS authorizations for individuals with Autism Spectrum Disorder.

CBHNP developed a specific CCM documentation audit tool with the QI department for ASD case reviews including specific rational for TSS services. Further, they added rationale for TSS to the Quality Treatment Record Review for BHRS providers, developed a QI Quick Tip Provider mailing, adjusted the Initial Evaluation review to be in compliance with CASSP principles, and coordinated with CABHC to assess the effectiveness and any planned implementation of TSS schedule for TSS services.

- Recommendation: Encourage increase of school involvement with delivery of ASD services and address discharge planning early in treatment.

Through utilization of quality reviews to ensure that discharge planning and the transfer of skills from school staff to the primary caregivers included in the process. CBHNP will also continue to monitor school participation at ISPT meetings.

- Develop a process to address the lack of specificity in assessments for individuals with ASD.

This area was addressed through the development of a process for the Functional Behavioral Assessment audit tool to be consistent with the OMHSAS bulletin, and the implementation of the audit tool.

- Recommended Corrective Action: Care Management Section

There were four areas recommended for Corrective Action which CBHNP chose to develop plans to address.

- Recommendation: Develop training and documentation standards to improve care managers' active involvement in gathering comprehensive assessment and treatment-planning information more readily for PC consultation in order to facilitate treatment process. This is addressed by revising the CCM documentation audit tool to mirror Mercer/OMHSAS items regarding treatment planning.

CBHNP addressed this by revising the CCM documentation audit tool to mirror Mercer/OMHSAS items.

- Recommendation: Enhance the clinical management system to identify candidates for high-risk care management to increase efficiency of handling Enhanced Care Manager (ECM) cases.

CBHNP reviewed this recommendation by having their Medical Management group pilot predictive modeling and risk scoring through AmeriHealth Mercy.

- Recommendation: Require in-service training and evaluation with CBHNP staff regarding trauma-informed assessments and diagnostic formulations.

CBHNP addressed this by conducting mandatory CCM and Physician Advisor training on trauma-informed assessment and care. Temple University conducted the training in April 2010.

- Recommendation: Delink the authorization for ASD services from the review of treatment plans. Review treatment plans quarterly to ensure that any changes in treatment plan specifics are included in the authorization.

CBHNP address this by moving the monitoring process to Clinical Associate staff to more closely monitor submission and do follow-up with provider performance.

REINVESTMENT PROJECTS

Reinvestment Projects utilize HealthChoices County discretionary and treatment 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.

Reinvestment programs were identified through a collaborative process in which Members and their families, individuals in recovery, representatives from each of the Counties, CABHC, and CBHNP discussed services that would benefit Members served under the HealthChoices program in the Territory using reinvestment funds (surplus medical claims and administrative dollars that are designated for reinvestment by the Counties). Once the projects become operational, the CABHC Board of Directors actively reviews all reinvestment projects throughout the year.

Respite Care

Respite services uses reinvestment funds to offer planned and short-term respite services to children, adolescents, and adults. This service provides support for proper administration of medication, assures that Members receiving this service retain access to treatment services already in place while receiving respite, and provides emotional support for Members receiving this service during the period they are separated from their caregiver/family member.

Respite offers two types of respite: In-Home where services are in the individual's own home, and Out-of-Home services which take place outside of the individual's home. Out-of-Home settings can occur in two types of settings: Family Placement, where the individual resides in a family setting, and Residential/Facility Placement which can be a group home, residential, or community living setting.

During CY 2010, CABHC issued a Request for Proposals for the Respite Brokerage Program, which was re-titled the Respite Management Agency (RMA). Following the review process, the CABHC Board of Directors chose Youth Advocate Programs, Inc. (YAP) to be the provider of respite services. YAP began management of the Respite Program on September 1, 2010.

From September to December 2010, with CABHC overseeing and assisting with their goals, YAP accomplished several goals which included:

- Four new providers – Community Services Group, Med Staffers (who can accommodate children and adults), Jewish Family Services, and a chapter of Visiting Angels that caters to Cumberland County and can accommodate adults only.

- YAP has developed a fact sheet for parents and providers that has been distributed at various CBHNP and county meetings as well as mailing this to providers for distribution. The fact sheet responds to many basic questions families may have regarding respite.

- YAP has given several presentations in an effort to discuss the respite process and ideas and concerns regarding the agency in general. YAP has also met individually with all providers to discuss the referral process and training manual.

- YAP has made contact with the president of the Pennsylvania Respite Coalition, MaryJo Alimena-Caruso, and the local organization, Cumberland-Perry Respite Group, with which they will further their relationship.

- YAP has applied to be part of the Lifespan Respite Advisory Council, which will foster continued support, contacts, and relationships in the respite community.

Table 5 provides a summary of respite services provided throughout the Territory and shows increases in both Members Served and Respites delivered. The percent of Members served increased 30.8% while Respites delivered increased 25.3%. These are positive results for CY 2010.

Table 5: Respite Services: Utilization Summary

County	CY 2009[1]		CY 2010[1]	
	# Members Served	# Respites Delivered	# Members Served	# Respites Delivered
Cumberland	10	41	22	81
Dauphin	36	128	40	122
Lancaster	30	139	57	215
Lebanon	12	63	11	84
Perry	2	4	0	0
Totals	90	375	130	502

[1]Ten months of CY 2009 and 12 months of CY 2010

CABHC will continue to provide support to this program as needed, and will continue ongoing monitoring of this project.

Specialized Transitional Supports for Adolescents

This project is targeted to support adolescent Members 16-21 years of age who are active with CBHNP. These Members are characterized by their need to begin planning their transition from children services to adult supports.

This program began providing services late in CY 2007 and now provides services in three counties: Cumberland, Dauphin, and Perry. The data for CY 2010 shows that both new referrals (54) and Members served decreased during the year. The number of Members served declined from 67 to 58. There are two providers for transitional services, The Jeremy Project in Dauphin County and NHS, Inc., The Stevens Center in Cumberland and Perry Counties

In Dauphin County, the Case Management Unit's Jeremy (Joint Efforts Reach & Energize More Youth) Project assisted over 50 adolescents and their families. The Jeremy Project consists of a set of specialized services designed for adolescents in the form of Independent Living Resources to maximize their transition to independence through person-centered planning. On average, 12 unique groups are held each month to assist the participants to be successful in their transition.

Highlights for 2010 included two participants graduating high school, one individual was accepted and enrolled into Franklin and Marshall College for veterinary science. Another individual enrolled in Harrisburg Area Community College (HACC) and is working towards becoming a social worker. Another is a participant at Hiram G. Andrews Center, which offers quality individualized post-secondary education, and provides career opportunities and independent life skills. In August, The Jeremy Project also created a partnership with AHEDD to provide an additional resource for employment opportunities for those with a disability. October saw a partnership develop with the Magnificent Minds Project. Magnificent Minds is a non-profit organization created to celebrate creativity, ingenuity and artistic brilliance that exist within individuals who have mental illness. Magnificent Minds assists program participants with artistic talent to find community resources to display and sell their works. Another partnership was forged with Sylvan Learning Center that will enable participants to prepare for taking their Scholastic Aptitude Test (SAT).

Cumberland and Perry Counties are served by NHS, Inc (The Stevens Center). In addition to directly working with adolescents, it offers monthly parent support groups. The support group affords parents and caregivers an opportunity to openly discuss concerns with one another. The results of the support groups have been positive as there has been an average of ten parents/caregivers in attendance monthly. Table 6 provides aggregate data for the Specialized Transitional Support for Adolescents projects.

Overall, both of these projects provide needed services to individuals transitioning from adolescence to adulthood. CABHC will continue to support these projects in 2011.

Table 6: Utilization for Specialized Transitional Support for Adolescents

Comparison CY 2008-2010						
County	**# Members Served**			**# New Referrals**		
	2008	2009	2010	2008	2009	2010
Cumberland	11	11	9	10	14	10
Dauphin	36	54	49	52	49	43
Perry	1	2	0	4	3	1
Total	48	67	58	66	66	54

Recovery House Scholarship Program

There are a number of individuals who, upon completing non-hospital rehabilitation or halfway house services, require some form of transitional housing to support their recovery. This group may include individuals who are homeless, or whose previous living arrangements would undermine their efforts to abstain from substance use. A local network of Recovery Houses has been developed to provide living environments that reinforce recovery for these individuals. However, individuals stepping down from rehabilitation cannot always afford initial costs to reside in these homes.

In order to assist individuals who quality for this project, CABHC can provide scholarships to fund up to two (2) months' rent (not to exceed $300/month) for persons to move into a Recovery House that participates with this program. Referrals for this program come from each County's Single County Authority (SCA) or inpatient substance abuse providers.

At the end of CY 2009, due to a depletion of funds, the Recovery House Scholarship Program was suspended. Early in 2010, the CABHC Board reviewed the program and restored funding. In May, scholarships were again being offered to eligible individuals. At the close of 2010, the number of organizations nearly doubled, from 10 to 19, while the number of sites increased nearly 50% (21 to 44).

Through the close of CY 2010, 68 Members received Recovery House scholarships which were paid to 19 organizations, with a total of 44 sites. There was a total of $34,428 in scholarships paid out during the year.

Table 7: Recovery House Members and Scholarships CY 2010

County	Members Served		Scholarships Paid	
	CY 2009	CY 2010[1]	CY 2009	CY 2010[1]
Cumberland	1	5	$496	$2,600
Dauphin	32	16	$13,716	$7,800
Lancaster	78	39	$41,700	$20,128
Lebanon	9	7	$4,200	$3,300
Perry	2	1	$1,096	$600
Total	122	68	$61,208	$34,428

[1]CY 2010 is for the period of May-December 2010.

The overall results for the Recovery House Scholarship Program this year is very positive. As a result, CABHC is allocating approximately $200,000 for 2011**.**

Recovery House Project

This project provided funding for the start-up of three new Recovery Houses to be located in our five county area. These funds were to be used to purchase and/or renovate properties for use as Recovery Houses. After the completion of a request for proposal process, start up money was provided to Daystar in Harrisburg, Just for Today, Inc. in Mechanicsburg and Spanish American Civic Association (SACA) in Lancaster. The objective and contractual expectation of the three providers who were awarded the funds was that they would be fully operational by the end of 2010. Daystar was the first to open a Recovery House, with eight beds, and began accepting residents in June 2010. Just for Today, Inc. opened its Mechanicsburg House in July 2010 with a capacity of four males and SACA opened its Recovery House in October 2010, which can accommodate seven individuals and specifically caters to the unique needs of the Latino population. By the end of October 2010, all three Recovery Houses met their contractual obligation and are now serving the needs of males in recovery. Through this initiative, 19 new beds have been made available to assist males in need of support as they transition into their new life of sobriety. These new Recovery Houses will be subject to annual site visits by CABHC per the terms of their contract, unless warranted otherwise.

Housing Initiative Program

Reinvestment funds designated for this project will assist each of the five Counties in the development and implementation of a Housing Initiative Plan to assess and address local

housing needs, particularly of those individuals diagnosed with serious mental illness, substance abuse, or co-occurring disorders. This service is targeted to serve Medicaid eligible Members.

Cumberland and Perry Counties (CU/PE) two programs, Enola Chapel and Supportive Living New Bloomfield, continue to provide services with HealthChoices reinvestment funding. At the close of the CY, 32 persons were provided services, with a priority given to individuals who are actively enrolled in treatment. The two counties have identified several factors in their success: their relationship between the Housing and Redevelopment Authority and the County MH office, the commitment of both the County and the Perry Housing Authority/Redevelopment Authority to community based provider agencies, and the active pursuit of available funding sources for priority populations. CU/PE reported that 85% of those served are Homeless and 5% each from the following three populations; Transition Age, Forensic, and CRR/State Hospital.

Dauphin County serves approximately 23 individuals through its two programs, Capital 811 and Fairweather Lodge. At the close of the year, they reported that all 14 units at the 811 (Creekside Village) project were occupied. Dauphin County reported that the most significant factors to their success were the knowledge of the 811 provider to serve this population, the cooperation of the mental health network, and their relationship with the Housing Authority of Dauphin County.

Lancaster County's project, Park Avenue Apartment, became operational in November 2010 with six units becoming fully occupied by persons receiving mental health services. The occupation of the six units allowed four people who were in CRR's to move into their own homes. The project is a partnership with Lancaster Coalition to End Homelessness and Lancaster County MH/MR/EI. The target population is those who are at risk of losing their housing or are in unsafe or inadequate housing options to find better places to live.

Lebanon County has partnered with the Lebanon Community Action Partnership in diverting people from becoming homeless by providing temporary funding. The Housing Authority has partnered with Philhaven to provide housing for homeless individuals with serious mental illness in a program called Partners for Progress.

ADMINISTRATIVE OVERSIGHT

CBHNP INCENTIVE PERFORMANCE OBJECTIVES[1]

The Counties are committed to ongoing innovation and quality enhancement in the delivery of HealthChoices behavioral health care services. As the Managed Care Organization (MCO) for the Territory, CBHNP plays a significant role in the management and delivery of services. The

[1] The information and data related to the CBHNP Incentive Performance Objectives will be reported using FY -2009-2010 data. Utilizing FY data rather than CY will provide a more accurate report of CBHNP performance.

Counties established incentives for CBHNP to continually improve their efficacy in identified objectives to impact both quality and ease of access to services for HealthChoices Members.

The terms of the *County CBHNP 2009-2010 Agreement, Section 8.1.D Performance Based on Incentives and Penalties; Subcontractor Earnings Formula,* provide CBHNP the opportunity to earn available incentive funds above and beyond their administrative fee if they meet stated objectives. CABHC monitors data regarding CBHNP's performance relative to these objectives. Ratings of performance for each objective are compiled into a single composite rating, which is then used to determine a final performance score for CBHNP. The composite score is used to determine the percent of available incentive funds that may be retained by CBHNP.

The Incentive Performance Objectives Scoring for FY 2009-2010 is presented in table 7 below.

Drug and Alcohol (D&A) Readmission Rate

The **D&A Readmission** rate for the fiscal year is 10.14%. During the analysis at the close of the fiscal year, CBHNP raised concern regarding the use of the claims logic to determine readmission rates for persons who were discharged from D&A non-hospital Detox, Residential Rehabilitation and Halfway Houses. The concern was that if an individual was active in treatment for one of these services, most notably Residential Rehabilitation and Halfway Houses, and during the course of the treatment they required hospital based medical or psychiatric care, and were therefore transferred to another facility, and then later returned back to the D&A program to complete treatment, this was being counted as a readmission. The Clinical Committee agreed that this should not be counted as a readmission and tasked CABHC to work with CBHNP to determine how many of these situations occurred and to make any required adjustments to the final scoring of this performance objective.

During a review of a secondary concern, CBHNP questioned how step downs to lower levels were being viewed and if this might be counted as a readmission. CABHC, in discussion with ACA, determined that the step down scenario did not count as readmissions. However, during review of this matter, CABHC and ACA discovered an error in the logic being used to calculate the readmission rates in cases where the individual stepped down from multiple levels of treatment, and then was readmitted to one of the levels of care. The error consisted of counting a readmission for each level of care the person had stepped down, all occurring within the 60 day measure:

Admission to D&A no-Hospital Detox on 011/01/10
Discharged from Detox and admitted to Residential Rehab (RR) on 01/05/10
Discharged from RR and admitted to Halfway House (HH) on 02/06/10
Left HH AMA on 2/10/10 and readmitted to Detox on 2/28/10

The intent of the readmission scoring would view the above as one readmission occurrence for this individual. The logic problem discovered is that it counted this as 3 readmissions since they went back into an equal or higher level of treatment within 60 days of each service. So the faulty logic said the individual went to Detox within 60 days of discharge from Detox, (1 readmission), went into Detox within 60 days discharge from RR (1 readmission), and went into Detox within 60 days of discharge from HH (1 readmission), thus resulting in 3 readmissions when in fact there was only one. Upon discovery of this logic error, ACA corrected the logic and has

updated the MastrrMonitor report so that it now is correct in only county such situations as one readmission.

The data presented in the report included all adjustments due to the revisions in the data logic. CABHC was able to compare the adjusted scores for 2009-2010 to 2008-2009 and found that the current score of 10.14% is slightly lower than the score that would have been achieved last year (10.71%).

Seriously Mentally Ill Mental Health Inpatient (SMI MH IP) Readmission Rate

The performance standard measures establishes a goal of 21% or less of Members, who meet the SMI definition who are served by CBHNP, will be re-admitted to an Inpatient Mental Health Treatment facility within 30 days of discharge from this same level of care commonly referred to as Recidivism.

The data for **SMI MH Inpatient Readmission** during the FY year found the year-end score of 18.54%, which is slightly lower than the 19.21% recorded for FY 2008-2009. CBHNP continues to meet the standard of being below 21.0%, thus earning the maximum of 33.3 points.

Access to Behavioral Health Rehabilitative Services (BHRS)

As part of the ongoing monitoring of the BHRS access standard for children and adolescents who need BHRS services (MT, BSC, and TSS) OMHSAS has established an expectation that Members are to begin receiving approved BHRS within 50 days of the initial evaluation for BHR services. The does not measure if the total frequency of the service is prescribed is being rendered, but when the actual service begins. Each service prescribed will be scored as part of the overall score for each of the three measured services. Thus the goal for this objective is that 50% of Members who are prescribed and authorized for BHRS will begin treatment within 50 days of the service request.

The data from CBHNP **Behavior Health Rehabilitation Services (BHRS) Access** for FY 2009-2010 shows improvement from last year in two of the three areas. Therapeutic Staff Support (TSS) and Mobile Therapy (MT) both improved. TSS improved from 31.10% to 32.51%, and MT improved considerably from 25.64% to 34.40%. The improvement in MT brought it into scoring range for the first time. BSC declined from 34.43% to 32.66%. All BHRS Access areas scored 6.7 points each for an aggregate total of 20.1 points earned.

Overall Scoring for Performance Objectives FY 2009-2010

Table 8 provides a look at the CBHNP Performance Incentives for FY 2009-2010.

The total points earned for this report period is 80.0. This is an increase from the 46.7 points at the close of last year. The current score would result in CBHNP earning the right to retain 75% of the available funds.

Table 8: CBHNP Incentive Performance Objectives 2009-2010

Performance	Standard	Score[1]	Points Earned
D&A Readmission Rate	9.4% or less	10.14%	26.6
SMI MH IP Readmission Rates	21.0% or less	18.54%	33.3
BHRS Access			
TSS	50.0% or greater	32.51%	6.7
MT	50.0% or greater	34.40%	6.7
BSC	50.0% or greater	32.66%	6.7
COMBINED BHRS			20.1
Total			80.0

[1]Scoring is based on a tiered scoring system with minimum and maximum points awarded based on the score achieved. The points earned for all three areas are totaled for the final score. The D&A range are 9.4% or less (33.3 points) to 11.2% (0 points). The range for SMI MH Inpatient Readmission is 21.0% or higher (33.3 points) to 25.3% (0 points). The range for BHRS is 50.0% or greater (11.1 points) to 30.0% (0 points). Note, access to BHRS score is a total of all three areas added for a single aggregate score.

SERVICE SUPPORT CONTRACTS

CABHC contracts with two companies for services related to areas of need within the Territory. The contract with **Community Satisfaction Services Inc. (CSS)** fulfills the HealthChoices requirement for having Consumer/Family Satisfaction Teams, to conduct consumer satisfaction surveys throughout the Territory. Their work is summarized in the Consumer Satisfaction section of this report. CABHC also contracts with the **Substance Abuse Services, Inc. (SASI),** which maintains the Recovery, Advocacy, Service, and Empowerment Project (RASE)**,** to provide education and outreach in order to aid Members in recovering from substance abuse. CABHC's partnership with SASI/RASE is described in the following section.

Consumer Satisfaction Services (CSS)

Consumer Satisfaction Services, Inc. (CSS) is a non-profit organization whose mission is to gauge and report on the satisfaction of consumers receiving behavioral health services through HealthChoices who reside in Cumberland, Dauphin, Lancaster, Lebanon, and Perry Counties. CSS's goals include surveying consumers/families to reveal whether they are being provided behavioral health services that are high quality, culturally sensitive and effective. Additionally, CSS seeks to ensure consumers/families of these services have a strong voice in evaluating the services that are being provided.

During CY 2010, CSS underwent internal reorganization that resulted in a more efficient operation. This, in turn, has enabled CSS to be more effectve in fullfilling its agreement with CABHC. More surveys have been completed during 2010, with more survyes completed face-to-face suveys than in previous years.

In order to ensure contniued performance, CABHC developed a Corrective Action Plan (CAP) to monitor CSS continued performance. OMHSAS suggested that the CAP address three areas: 1. CABHC monitoring activities from annual to quarterly or biannually, 2. Incorporate onsite activies to ensure the survey process is effectively carried out, and 3. The Purchase of Serivce agareement include such things as scheduling of quarterly meetings with surveyors, timely distribution of the minutes at meetings, and staff training documentation. The CAP was addressed by CSS and has been completed and submitted to OMHSAS. CABHC will continue to moniotor CSS activies throughout 2011.

During the year, CABHC continued to conduct more on-site reviews that included observing calls made by sureyors, interviews with CSS staff, and conducting quality assuance calls with Members surveyed. CSS developed procedures for their meetings, which included complete and timely distribution of minutes. They also, provided CABHC with all policy and procedures related to the survey process. Additionally, CABHC surveyed other CSFT's to explore alternative methods to develop valid satisfaction samples. The results of those surveys will be processed and incorporated by CSS, as they are appropriate to their operations. Discussion between CABHC and CSS led to the implemention of procedures outlining frequent monitoring of Request for Assistance. The procedures will ensure that CABHC and CBHNP will receive a copy of a Consumer Request for Assistance on a more timely basis. Lastly, CABHC assisted CSS to reconvene the SIC. The SIC was reconvened early in 2010.

Substance Abuse Services, Inc. (SASI)-Recovery, Advocacy, Service, and Empowerment Project (RASE)

The RASE Program Mission is: To assist all those individuals affected by substance abuse issues, problems, and concerns by fostering progress, enriching lives, and ultimately enhancing the recovery process.

The RASE Project provides ongoing advocacy services via the dissemination of all relevant information from the HealthChoices Initiative to the recovery community. The RASE Project provides advocacy services for individuals in, or seeking recovery from the disease of addiction, safe and secure therapeutic recovery housing for women in early recovery, peer to peer recovery services, positive social events, and conscience raising activities.

RASE accomplishes this by providing representatives at various CABHC Committees (i.e., Clinical and CFFC), who then disseminate relevant information throughout the Territory. RASE also provides Trainings and the *In My Own Words* speakers bureau, a trained group of speakers, to share their personal stories of triumph over addiction.

Trainings provided are: *Life Skills, Recovery Planning & Vocational Assistance, Addiction and Recovery 101, Addiction, and Recovery & the Family*. The target population for trainings and speaking engagements are professional, civic, or stakeholder groups, schools, and churches. The

target audience also includes persons in recovery, family members, and those without addiction concerns.

RASE presented the following activities during the year:

From January 1, 2010 – June 30, 2010 - RASE facilitated 16 "In My Own Words" Speaking Engagements at two different school districts, with a total of 1,212 in attendance, and 10 Trainings with a total of 172 in attendance.

From July 1, 2010 – December 31, 2010 - RASE facilitated 8 "In My Own Words" Speaking Engagements, at two different school districts, with a total of 885 present and 2 Trainings with a total of 60 in attendance.

RASE continues to provide representation on local, private, county, state and federal levels attending various Boards, stakeholders groups, committees, and public policy forums. As such, RASE acts as a conduit for information exchange and dissemination. RASE continues to represent the recovery community on issues relating to the anonymous recovering populations in the five county region by taking part in meetings and rallies on Capitol Hill in Harrisburg, PA and Washington DC.

COOORDINATION BETWEEN SYSTEMS OF CARE: DPW PHYSICAL HEALTH AND BEHAVIORAL HEALTH (PH-BH) INITIATIVES

In October 2010, a PH-BH Workgroup was established by the CABHC Clinical Committee. The purpose of the PH-BH Workgroup is to review available national, state, and local data and recommend integration project(s) focused on specific interventions, services, and/or care coordination processes that will improve the mental and physical well being and overall recovery of Members. This is a group of nine individuals representing CABHC, CBHNP, Counties, and individuals in recovery.

By the end of CY 2010, the PH-BH Work Group developed a list of existing PH-BH integration programs, activities, and processes currently available in the Capital Area region. The PH-BH Work Group will identify new possibilities for enhanced collaboration in the year ahead.

CBHNP fully participates assigned in work group tasks and implements actions to address DPW physical-behavior health joint QI initiatives: Domestic Violence awareness and reduction, Smoking Cessation in Pregnant Women, and Reduction of Childhood Obesity. CBHNP provides education for providers and Members through articles in their newsletters.

The CBHNP Perinatal Depression Project initiative began in November 2008, and continued through this year. This project is a joint project between AmeriHealth Mercy Health Plan (AMHP) and CBHNP and is designed to enhance the detection of women with untreated perinatal depression and improve the coordination of care between PH/BH healthcare providers.

In July, the program was expanded to identify additional pregnant women and to follow up with the Members that were already outreached and engaged in the WeeCare Program. The women identified by the WeeCare nurses are high risk pregnancies. During the year, a total of 71 members were referred by AMHP with an 82% success rate for treatment.

CHILDREN'S SERVICE DELIVERY SYSTEM

School Participation in Interagency Service Planning Teams (ISPT)

CABHC and CBHNP, operating with each of the Counties, remain committed to the Children and Adolescent Service System Program (CASSP) principles. The Interagency Service Planning Team (ISPT) is a natural outgrowth of this model, fostering coordination and accountability between the various adults and agencies involved in the care of each child or adolescent. As part of the efforts to ensure effective, efficient coordination of services, CABHC monitors documentation of attendance at the initial ISPT meetings on an ongoing basis.

One significant aspect of ISPT meetings is the participation and involvement of school personnel in contributing to the identification of the needs of child and adolescent Members, and planning appropriate interventions to meet these needs. School participation at the initial ISPT meeting play an important role in assisting to identify the needs of the child and in recommending interventions that target the child's needs. This information is important as the evaluator and team identify services to meet the child's treatment needs.

One of the objectives this year was to increase school participation at the ISPT meetings. Although the number of initial meetings was similar to last year, the percent of schools participating in the initial ISPT continued to decline in CY 2010.

Table 9: School Participation in Initial ISPT Meetings

	Number of Initial Meetings				Percent of Schools Participating in the Initial ISPT			
	2007	2008	2009	2010	2007	2008	2009	2010
Participation in Initial ISPT Meetings	1268	2064	2477	2461	43.62%	24.5%	17.7%	15.7%

Delivery of Authorized Children's Services

Services authorized as medically necessary by CBHNP are not always delivered to Members. In some cases, this may be due to a Member's choice not to participate in services. CABHC needs to monitor when services are not delivered due to the lack of appropriate coordination with or among providers, or because of a lack of available staff or other resources required to provide the authorized services.

BHRS Service Delivery

Concerns regarding reduced delivery of authorized BHR services have led CABHC and CBHNP to closely monitor the delivery of these services when authorized.

The focus of this area is the delivery of BHRS units billed for Behavioral Specialist Consultant (BSC), Mobile Therapy (MT), and Therapeutic Staff Support (TSS) compared to the total units authorized. Throughout the year, this is monitored by the CBHNP Quality Improvement Utilization Management Committee. In 2010, the average number of children served monthly increased, although the average number of authorized units declined from 167,342 to 151,487. The average monthly percentage of services delivered compared to the average monthly authorized increased to 51% from 49% last year. Table 10 shows the average monthly data for CY 2010.

Table 10: 2010 Average Monthly Data for BHR Services Delivered Compared to Authorized

Monthly average number of Members with open BHRS authorizations	Monthly average number of authorized BHRS hours	Monthly average number of BHRS hours claimed	Monthly average percent of BHR services delivered
2,848	151,487	77,199	51%

[1]Due to claims lag, the data from the fourth quarter is incomplete; calculations were made from available data.

CABHC and CBHNP addressed the gap between authorized BHRS hours and provider capacity in a number of ways:

- CBNNP conducted peer reviews with quarterly report card feedback, and an expectation for corrective action plans for low scoring evaluators.
- CBHNP conducted individual meetings with BHRS providers addressing all aspects of operation in comparison to other providers. Will continue evaluate audit results, with a focus on the educational "toolkit" for evaluators.
- CBHNP reviewed TSS delivery concerns regarding the TSS Scheduling initiative. The TSS Schedule will aid in ensuring Members and their families recognized the commitment necessary for successful BHRS treatment.

Delivery of Initial BHR Services

Analysis of the referral process indicates two critical periods of time between a child or adolescent receiving an evaluation that recommends BHRS and the first date of delivery of those services. The first period ranges from the date of evaluation to the date CBHNP approves the recommended services as meeting medical necessity criteria. The second period ranges from the date the services are approved by CBHNP to the date the service begins.

The performance objective states that 50% of Members receive the first date of service within 50 days of the evaluation. This is measured for three services: BSC, MT, and TSS. Rating for the services during CY 2010 showed minimal change from last year, as revealed in the table below.

Table 11: Percentage of Initial BHRS Delivered within 50 Days

Calendar Year	BSC	MT	TSS

2008	34.88%	29.24%	20.39%
2009	34.46%	29.02%	34.46%
2010	32.66%	32.40%	32.51%

During the year, CBHNP continued to address the need for initial services through quarterly meetings with high volume providers and a review of the quality of the evaluations for possible gaps in the evaluation that could delay service delivery. CBHNP also revised the ISPT process to include the TSS schedule policy to allow the evaluators to become a more integral member of the treatment team.

Although there have been multiple interventions addressing both BHRS service delivery and initial BHRS access, the data has shown that over time there improvement has not met expectations. Therefore, late in the year CABHC initiated a BHRS Access Workgroup to evaluate this area and return its findings to the CABHC Clinical Committee.

Critical Incidents for Children/Adolescents

The Critical Incident Reporting section of this report summarizes CABHC and CBHNP's efforts to ensure the health, safety, and rights of Children and Adolescents. Our goal is to reduce all critical incidents for children. CABHC works closely with CBHNP to identify and analyze trends in practices used by providers which might compromise the safety and/or well-being of our Members. During CY 2010, critical incidents for the 0-17 year-olds increased 34.6% this year, an increase from last year.

CBHNP reports that there were 826 restraint episodes for 878 unique members, with services provided in 17 RTF facilities serving a minimum of five members. They report that three providers with the highest percentage of restraint episodes in relationship to total members served is significant because of what seems to be a culture that exists within the facilities where physical restraints seem to be an acceptable form of intervention. CBHNP is developing a Restraint Reduction Proposal to include strategies and initiatives to support provider's efforts to utilize safer alternatives of intervention. CABHC will continue to strongly support efforts to reduce the use of restraint practices throughout our Territory, and will continue to monitor and report trending regarding these practices.

SUBSTANCE ABUSE SERVICES UTILIZATION

Although utilization of substance abuse penetration rates is significantly less, when compared to mental health service, they are an important part of the services provided through HealthChoices. In addition to the utilization rates reviewed in this section, CABHC engages in a review and monitoring of several areas directly related to substance abuse services that are discussed in other sections of the Annual Report. Readmission rates are reviewed in the next section. D&A Readmission Rates is an important component of the CBHNP Incentive Performance Objectives discussed on page 34. Youth Receiving Substance Abuse Treatment is examined in the Performance Improvement Project (PIP) on page 25. CABHC also contracts with SASI/RASE to provide Members with ongoing advocacy services via presentations and the

dissemination of D&A information throughout the Territory. Additionally, RASE provides a variety of training opportunities to the Members. These are discussed in the Contracts section, beginning on page 36.

During CY 2010, three services experienced increased penetration rates and one declined from the previous year: Hospital based D&A Rehabilitation (.02%), Outpatient D&A Clinic (1.90%). and Outpatient D&A – Targeted Case Management (.04 %) increased, while Non-Hospital D&A Detox/Rehabilitation decreased from .37% last year to .34%. Utilization of Outpatient D&A Clinic has increased each year for the past five years, a positive trend for utilization of outpatient services. The other three categories are showing mixed utilization over time.

Table 12: Penetration Rates: Substance Abuse Services

Category	CY 2005	CY 2006	CY 2007	CY 2008	CY 2009	CY 2010
Hospital-based D&A Rehab	.03%	.02%	.02%	.02%	.01%	.02%
Non-Hosp D&A Detox/Rehabilitation	.28%	.28%	.02%	.28%	.37%	.34%
Outpatient D&A Clinic	1.20%	1.22%	1.23%	1.46%	1.75%	1.90%
Outpatient D&A - Targeted CM	.07%	.06%	.05%	.04%	.03%	.04%

ADULT MENTAL HEALTH and DRUG and ALCOHOL SERVICES

Readmission

Readmission rates within 30 days are a measure of a Member's return during a given period to the same or higher level of service after discharge. Because high readmission rates can indicate serious quality of care issues in service delivery, CABHC monitors the readmission rates of CBHNP Members in seven different Levels of Care:

Inpatient (IP) Psychiatric
IP Psychiatric – Extended Acute Care
Hospital-based D&A Detoxification
Hospital-based D&A Rehabilitation
Non-Hospital D&A Detox
Non-Hospital D&A Rehabilitation
Non-Hospital D&A Halfway House

The goal for the MH readmission rate is to be below 10%; however the overall readmission rate for MH Inpatient services was 12.90%. This was a decline from last year and is the third consecutive decline. This shows progress towards the goal of meeting the OMHSAS standard of 10.0%. Although this demonstrated progress, in the latter part of the year, OMHSAS directed the BH-MCO's with readmission rates higher than 10% to develop root cause analysis and an action plan to address reducing the readmission rates. In December, CBHNP submitted the initial draft to OMHSAS/IPRO for review. The action plan will be implemented early in the new

calendar year and will be closely monitored by CABHC during the year with a full report in the next Annual Report.

Table 13 shows the readmission rates over the past three years. The overall D&A readmissions rate decreased slightly from 8.44% last year to 7.48% in 2010. Total MH rates declined from 13.31% last year to 12.90% this year. All services, except one, showed a decline in readmission rates. The only service with an increase is Non-Hospital Residential Halfway House.

Table 13: Readmission Comparison by Year

Service Category	CY 2007	CY 2008	CY 2009	CY 2010
IP Psych	14.72%	14.68%	13.28%	12.96%
IP Psych- EAC[1]	6.90%	3.77%	15.31%	8.70%
Total MH	14.57%	14.49%	13.31%	12.90%
IP D&A Detox	2.70%	8.00%	4.17%	0.00%
IP D&A Rehab	10.71%	7.69%	27.78%	0.00%
Non-Hosp D&A Detox	7.66%	6.63%	6.58%	5.86%
Non-Hosp D&A Rehab	9.99%	6.28%	13.00%	7.91%
Non-Hosp Res Halfway	8.96%	9.05%	8.50%	10.84%
Total D&A	9.17%	8.14%	8.44%	7.48%

[1]Tracking of IP Psych-EAC began in FY 2005-2006.

Utilization of Services: Child/Adolescent and Adults

As part of our oversight, CABHC monitors the service utilization submitted by Providers for both adults and children/adolescents. The data is analyzed by level of care, services paid, and Members served with the current data compared to the previous year. Tables 14 and 15 show the Territory results for these areas.

Data related to children/adolescent services paid for 2010 shows that four different levels of care with the highest percent of services paid are: BHRS (MT, TSS, BSC), 34.0%, Residential Treatment Facilities (RTF) and CRR-HH, 20.4%, Family Based Mental Health (FBMH), 14.3%, BHRS (Other/Exception Services), 10.6%. When comparing these services to last year, the data shows minimal change for the two BHRS areas and FBMH, while RTF and CRR-HH experienced a 19.3% decline. The areas that showed the most significant increases from last year are: D&A Residential (33.1%), MH Inpatient (25.8%), and MH Outpatient (23.5%). During the year, the total amount paid for services declined 0.5%. Although there were other areas that experienced greater changes, the volume of those services was smaller; therefore, the variation in the data was larger than the higher volume services.

In terms of the actual number of children/adolescents served in 2010 compared to 2009, the data shows that the number served increased in 11 areas and declined in two. The services with the most significant increases in utilization were D&A Outpatient (19.4%) and MH Outpatient (11.6%). The two showing the greatest decline were RTF and CRR-HH (14.5%) and FBMH (1.1%). Overall, the number of C/A Members served for all services increased 9.5%.

During 2010, data related to adult services showed that four areas with the highest percent of services paid were: MH Inpatient (31.3%), D&A Residential (14.1%), MH Outpatient (31.2%), and Targeted Case Management (11.3%). Overall, services paid for adults increased 11.4% during 2010.

Examining the data in changes in adults served from 2009 to 2010, the data shows the three areas with the highest percent of increases in Members served were: D&A Outpatient (16.1%), MH Outpatient (13.0%), and MH In-Patient (7.7%). MH Partial decreased by 10.7%. Overall, there was a 10.7% increase in the number of adults served this year. Although there were other areas that experienced greater changes, the volume of those services was smaller; therefore, the variation in the data was larger than the higher volume services.

Table 14: Utilization Data for Child/Adolescent Services

Services[1]		Child/ Adolescent Services Amount Paid	Percent of All Child/ Adolescent Services Paid	Change in Child/ Adolescent Services Paid 2009 to 2010	Children/ Adolescents Served	Percent of All Children/ Adolescents Served	Change in # Children/ Adolescents 2009 to 2010
BHRS (MT, TSS, BSC)	2009	$36,301,264	33.6%		3,848	30.2%	
	2010	$36,901,739	34.0%	1.7%	4,207	30.2%	9.3%
RTF and CRR-HH	2009	$27,376,780	25.4%		586	4.6%	
	2010	$22,091,832	20.4%	-19.3%	501	3.6%	-14.5%
FBMH	2009	$15,214,358	14.1%		1,283	10.1%	
	2010	$15,454,731	14.3%	1.6%	1,269	9.1%	-1.1%
BHRS *Other/ Exception Services*	2009	$10,382,749	9.6%		5,244	41.2%	
	2010	$11,542,181	10.6%	11.2%	5,572	39.9%	6.3%
MH Outpatient	2009	$6,821,963	6.3%		9,468	74.3%	
	2010	$8,422,776	7.8%	23.5%	10,562	75.7%	11.6%
MH Inpatient	2009	$5,228,857	4.9%		554	4.4%	
	2010	$6,578,299	6.1%	25.8%	597	4.3%	7.8%
Targeted Case Mgmt	2009	$2,983,800	2.8%		1,494	11.7%	
	2010	$3,077,711	2.8%	3.2%	1,504	10.8%	0.67%
D&A Residential	2009	$1,569,781	1.5%		131	1.03%	
	2010	$2,089,940	1.9%	33.2%	143	1.02%	9.2%
MH Partial	2009	$1,793,924	1.7%		669	5.3%	
	2010	$2,004,027	1.9%	11.7%	700	5.0%	4.7%
D&A Outpatient	2009	$89,835	0.08%		289	2.3%	
	2010	$139,835	0.13%	55.7%	345	2.5%	19.4%
Crisis	2009	$107,803	0.10%		804	6.3%	
	2010	$126,206	0.12%	17.1%	875	6.3%	8.9%
Other D&A Services	2009	$21,171	0.02%		27	0.21%	
	2010	$43,843	0.04%	107.1%	65	0.47%	140.7%
Other MH Services	2009	$12,448	0.01%		110	0.86%	
	2010	$10,356	0.01%	-16.8%	117	0.84%	6.4%
TOTALS	**2009**	**$107.904,732**		**0.5%**	**12,742**		**9.5%**
	2010	**$108,483,475**			**12,742**[2]		

[1]Services within categories:

- D&A Residential: Hospital-based and Non-hospital based detox and rehabilitation, and halfway house.
- D&A Other: Methadone Maintenance, D&A LOC Assessment, D&A Targeted Case Management Services, Partial Hospitalization, D&A Intensive Outpatient Services, Buprenorphine Support Services.
- MH Other – Adults: Clozapine, ACT/CTT, Mobile Psychiatric Nursing, Peer Support Services, and Laboratory services.
- MH Other – Child/Adolescents: Only laboratory services.

- BHRS Other: Evaluations, EIBS, Summer Therapeutic Activities Program, After School Program, and Multi-Systemic Therapy.

[2]Duplicated total, Members could receive more than one service during the year.

Table 15: Utilization Data for Adult Services

Services[1]		Adult Services Amount Paid	Percent of All Adult Services Paid	Change in Adult Services Paid 2009 to 2010	Adults Served	Percent of All Adults Served	Change in # Adults Served 2009 to 2010
	2009	$14,701,028	31.7%		1,787	10.9%	
MH Inpatient	2010	$16,167,749	31.3%	10.0%	1,924	10.6%	7.7%
	2009	$8,412,648	18.1%		1,376	8.4%	
D&A Residential	2010	$9,596,089	18.6%	14.1%	1,495	8.3%	8.7%
	2009	$7,083,353	15.3%		12,203	74.6%	
MH Outpatient	2010	$9,296,299	18.0%	31.2%	13,787	76.2%	13.0%
Targeted Case	2009	$5,439,344	11.7%		2,971	18.2%	
Mgmt	2010	$5,833,107	11.3%	7.2%	3,056	16.9%	2.9%
	2009	$4,648,342	10.0%		636	3.9%	
Other MH Services	2010	$3,893,359	7.5%	-16.2%	630	3.5%	-0.94%
Other D&A	2009	$2,684,919	5.8%		1,386	8.5%	
Services	2010	$3,268,376	6.3%	21.7%	1,661	9.2%	19.8%
	2009	$1,893,066	4.1%		561	3.4%	
MH Partial	2010	$1,817,180	3.5%	-4.0%	501	2.8%	-10.7%
	2009	$1,227,081	2.6%		2,603	15.9%	
D&A Outpatient	2010	$1,390,696	2.7%	13.3%	3,023	16.7%	16.1%
	2009	$323,299	0.70%		2,181	13.3%	
Crisis	2010	$380,546	0.7%	17.7%	2,288	12.6%	4.9%
TOTALS	**2009**	**$46,403,485**		**11.4%**	**16,362**		**10.7%**
	2010	**$51,709,485**			**18,105**[2]		

[1]Services within categories:

- D&A Residential: Hospital-based and Non-hospital based detox and rehabilitation, and halfway house.
- D&A Other: Methadone Maintenance, D&A LOC Assessment, D&A Targeted Case Management Services, Partial Hospitalization, D&A Intensive Outpatient Services, Buprenorphine Support Services.
- MH Other – Adults: Clozapine, ACT/CTT, Mobile Psychiatric Nursing, Peer Support Services, and Laboratory services.
- MH Other – Child/Adolescents: Only laboratory services.
- BHRS Other: Evaluations, EIBS, Summer Therapeutic Activities Program, After School Program, and Multi-Systemic Therapy.

[2]Total is unduplicated number.

ENROLLMENT – PENETRATION – DEMOGRAPHICS

Enrollment

Enrollment refers to the number of eligible Members enrolled in the HealthChoices Program. At the end of Calendar Year (CY) 2010, enrollment for the Counties totaled 172,960 eligible Members, an increase of 6.95% from CY 2009.

Table 16: Eligible Members and Change from Previous CY[1]

Year	CY2007		CY 2008		CY 2009		CY 2010	
Members	146,704	.70%	150,171	2.31%	160,941	6.69%	172,960	6.95%

[1]Unduplicaated Members eligible at any point during the report period

Table 17 provides the eligible Member population by county. The data shows that all counties experienced increases over last year, as they have each year since CY 2007.

Table 17: Number of Members by County

County	CY 2007	CY 2008	CY 2009	CY 2010
Cumberland	18,159	18,967	20,806	23,111
Dauphin	44,041	44,787	47,390	50,230
Lancaster	62,659	63,588	68,762	74,382
Lebanon	17,901	18,667	19,874	21,151
Perry	5,681	5,830	6, 019	6,258
	148,441[1]	151,839[1]	162,581[1]	175,132[1]

[1]County totals are duplicated numbers

The age breakdown, as shown in Table 18, shows that all of the age groups experienced increases in the total number of Members. Although each age group experienced an increase in the number of Members, the percent of members served remained almost the same as last year for each age group. Although the number of Members has increased in almost all age categories over the past four years, the percent of Members has been fairly consistent during the same time period.

Please that the data in the year columns in this table will not add up to the grand total shown above. The reason is that these figures are duplicated and count Members who change age categories and/or counties during the year. Any Member who changes age categories or counties during the year would be counted once within each applicable county and age category but only once in the Grand Total shown above.

Table 18: Number and Percent of Eligible Members by Age

Age Category	CY 2007		CY 2008		CY 2009		CY 2010	
	Num	Pct	Num	Pct	Num	Pct	Num	Pct
Ages 0 - 5	35,590	23%	36,623	23%	39,046	23%.	46,620	22 %
Ages 6 - 12	29,220	19%	29,769	18%	32,025	18%	34,652	19%
Ages 13 - 17	19,667	12%	19,588	12%	20,622	12%	22,143	12%
Ages 18 - 20	11,046	7%	11,500	7%	13,338	8%	14,894	8%
Ages 21 - 44	38,820	25%	39,535	25%	42,408	24%	45,486	24%
Ages 45 - 64	16,771	11%	17,538	11%	18,944	11%	20.743	11%
Age 65+	6,575	4%	6,716	4%	6,734	4%	6,970	4%

Members by Category of Aid

The HealthChoices program classifies Member Medical Assistance eligibility into nine different categories of aid. Capitation, the allocation of Medical Assistance funds is based on the distribution of each County's eligible Members across these categories.

Table 19 breaks down enrollment by category of aid. All of the categories increased in enrollment during CY 2010. The data in the table below reflects a duplicated count as Members can change categories during the year. The two with the highest enrollment are TANF (age groups combined) and Healthy Beginnings.

Table 19: Enrollment Changes by Category of Aid

Category	CY 2007	CY 2008	CY 2009	CY 2010
Temporary Assistance to Needy Families (TANF) (0-21)[1]	75,429	76,738	56,825	59,073
Temporary Assistance to Needy Families (TANF (22+)[1]	n/a	n/a	23,655	24,651
Healthy Beginnings	40,059	41,509	46,378	51,848
Supplemental Security Income and Healthy Horizons with Medicare	15,804	16,437	17,199	18,143

Category	CY 2007	CY 2008	CY 2009	CY 2010
Supplemental Security and Healthy Horizons without Medicare 0-21	26,354	28,234	15,025	16,276
Supplemental Security and Healthy Horizons without Medicare (22+)[1]	n/a	n/a	15,698	17,146
Categorically Needy, State Only General Assistance	4,858	5,312	6,060	6,782
Medically Needy, State Only General Assistance	2,300	2,335	2,557	2,842
Federal General Assistance	2,365	2,406	2,733	3,219

[1] Beginning with CY 2009, two categories were divided into two age groups, 0-21 and 22+, Temporary Assistance to Needy Families (TANF) and SSI without Medicare.

Penetration

Penetration signifies the percentage of Members who accessed a behavioral health service during the period under review. A Member is considered to have accessed a given service if a claim has been paid for that service on the Member's behalf for a service date that falls within the review period.

Table 20 documents penetration rates for each County and the Territory. The results for the year show that all Counties and the Territory experienced increased penetration. Cumberland County experienced a slight decline (.03%) for the first time since CY 2007, all of the other counties increased for the fourth year. Over-all the trend for the Territory shows penetrates rates increasing.

Table 20: CY 2009 Penetration Rates

Fiscal Year	CY 2007	CY 2008	CY 2009	CY 2010
Territory	15.96%	16.94%	17.70%	18.16%
Cumberland	15.76%	16.49%	17.11%	17.08%
Dauphin	15.78%	16.42%	16.92%	17.26%
Lancaster	15.60%	16.85%	17.66%	18.28%
Lebanon	17.93%	18.99%	20.41%	21.01%
Perry	13.94%	14.94%	15.38%	16.46%

Table 21 shows that penetration rates within specific age groups increased in five age groups, declined in the 18-20 year olds, and remained unchanged in the 0-5 year old age group.

Table 21: Penetration by Age

Age Category	CY 2007	CY 2008	CY 2009	CY 2010
Ages 0 - 5	3.72%	4.13%	4.32%	4.32%
Ages 6 - 12	18.12%	19.72%	20.38%	20.85%
Ages 13 - 17	22.36%	24.36%	24.99%	25.68%
Ages 18 - 20	13.01 %	13.72%	15.23%	14.89%
Ages 21 - 44	20.30%	21.26%	22.53%	23.16%
Ages 45 - 64	24.75%	25.50%	25.97%	26.67%
Ages 65+	4.76%	5.18%	5.02%	5.77%

Table 22 highlights the penetration rates for Members by category of aid over the past four years. The penetration rate for six of the categories increased, while three declined. The two categories experiencing the highest increase from last year were Supplemental Security and Healthy Horizon with Medicare (1.85 %%) and Supplemental Security and Healthy Horizon without Medicare 0-21 (.45%). The categories experiencing the greatest decline from a year ago is Supplemental Security and Healthy Horizons without Medicare 21^{+} (3.94%) and Federal General Assistance (2.19%)

Table 22: Penetration by Category of Aid

Category	CY 2007	CY 2008	CY 2009	CY 2010
Temporary Assistance to Needy Families 0-21 (TANF)	10.53%	11.38%	10.93%	11.12%
Temporary Assistance to Needy Families 22+	11.99%	12.89%	14.42%	14.72%
Healthy Beginnings	6.04%	6.69%	7.19%	7.50%
Supplemental Security Income and Healthy Horizon with Medicare	20.78%	21.10%	21.41%	23.26%
Supplemental Security Income and Healthy Horizon without Medicare 0-21	40.17%	41.63%	43.76%	44.21%
Supplemental Security Income and Healthy Horizon without Medicare 21+	38.90%	33.61%	35.53%	31.58%
Categorically Needy, State Only General Assistance	35.45%	38.42%	38.38%	38.47%
Medically Needy, State Only General Assistance	8.22%	7.79%	9.62%	9.15%

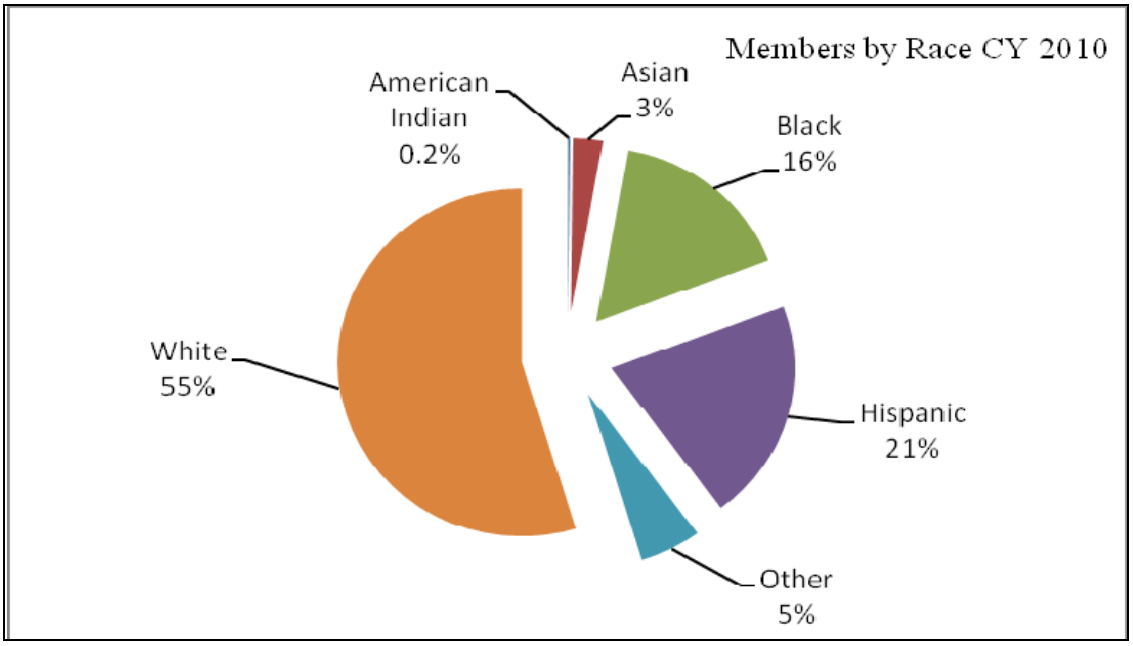
Category	CY 2007	CY 2008	CY 2009	CY 2010
Federal General Assistance	39.79%	42.44%	43.32%	41.13%

Note: Both TANF and SSI without Medicaid were split into two age groups, starting in CY 2009.

Membership by Race & Gender

CABHC strives to ensure quality of care and timely access to services for all Members, regardless of gender. Figure 1, below, illustrates the percentage of Members for the six categories of race. Three groups make 92.0% of all Members served: White (55%), Hispanic (21%), and Black (16%). When comparing the 2009 data to 2010 the findings show that the numbmer of members increased for all categories.

Figure 1: CY 2010 Members by Race



Tables 23 through 28 document enrollment and penetration by race for each County. Beginning with this report, we have added penetration rates for the past three years allowing for an easier comparison of the data.

As summarized in Table 23 data for Cumberland County reflects increases in eligible Members and Members served in four of the six categories.

Table 23: Cumberland County Members by Race

Cumberland County	CY 2008			CY 2009			CY 2010		
	Eligible	Served	Penetration	Eligible	Served	Penetration	Eligible	Served	Penetration
American Indian	55	9	16.4%	50	13	26.0%	63	9	14.3%
Asian	464	19	4.1%	540	28	5.2%	301	32	5.3%
Black	1,764	184	10.4%	1,829	190	10.4%	2,052	229	11.2%
Hispanic	927	109	11.8%	1,019	149	14.6%	1,214	176	14.5%
Other	1,599	199	12.4%	1,713	226	13.2%	1,836	249,	13.5%
White	14,155	2,543	17.9%	15,656	2,938	18.8%	17,346	3,217	18.5%

Table 24 indicates that Dauphin County experienced increases for all categories in eligible Members, while there were increases in three categories for Members served.

Table 24: Dauphin County Members by Race

Dauphin County	CY 2008			CY 2009			CY 2010		
	Eligible	Served	Penetration	Eligible	Served	Penetration	Eligible	Served	Penetration
American Indian	87	16	18.4%	104	30	28.8%	119	25	21.0%
Asian	1,104	40	36.2%	1,316	42	3.2%	1,561	42	2.7%
Black	17,456	2,671	15.3%	18,200	3,000	16.5%	18,981	3,262	17.2%
Hispanic	6,692	991	14.8%	7,156	1,056	14.8%	7,573	1,110	14.7%
Other	2,942	309	10.5%	3,032	371	12.2%	3,186	399	12.5%
White	16,505	3,144	19.0%	17,586	3,460	19.7%	18,812	3,770	20.0%

Table 25 for Lancaster shows increases in eligible Members in all six categories, as did Members served.

Table 25: Lancaster County Members by Race

Lancaster County	CY 2008			CY 2009			CY 2010		
	Eligible	Served	Penetration	Eligible	Served	Penetration	Eligible	Served	Penetration
American Indian	112	19	17.0%	132	20	15.2%	115	19	16.5%
Asian	1,400	62	4.4%	1,757,	70	4.0%	2,121	78	3.7%
Black	6,295	1,015	16.1%	6,531	1,131	17.3%	6,853	1,231	18.0%
Hispanic	19,073	2,574	13.5%	19,781	2,941	14.9%	20,353	3,263	16.0%
Other	3,044	370	12.2%	3,440	513	14.9%	3,919	584	14.9%
White	33,665	6,445	19.1%	37,121	7,400	19.9	40,721	8,322	20.4%

Table 26 documents that Lebanon County's experience is mixed with three categories increasing while three decreased. Eligible Members increased in five categories, while experiencing increases in three of the categories of Members served.

Table 26: Lebanon County Members by Race

Lebanon County	CY 2008			CY 2009			CY 2010		
	Eligible	Served	Penetration	Eligible	Served	Penetration	Eligible	Served	Penetration
American Indian	26	9	34.6%	25	8	32.0%	23	6	26.1%
Asian	169	18	10.7%	196	18	9.2%	208	15	7.2%
Black	741	119	16.1%	750	135	18.0%	805	148	18.4%
Hispanic	5,631	804	14.3%	5,945	932	15.7%	6,350	1,053	16.6%
Other	416	55	12.2%	407	66	16.2%	421	66	15.98%
White	11,683	2,472	21.2%	12,551	2,879	22.9%	13,344	3,141	23.5%

Table 27 documents that Perry County experienced increases in penetration rates in four of the six categories.

Table 27: Perry County Members by Race

Perry County	CY 2008			CY 2009			CY 2010		
	Eligible	Served	Penetration	Eligible	Served	Penetration	Eligible	Served	Penetration
American Indian	8	2	25.0%	9	2	22.2%	6	2	33.3%
Asian	18	2	11.1%	19	2	10.5%	24	1	4.2%
Black	55	10	18.2%	56	9	16.1%	65	9	13.9%
Hispanic	70	12	17.4%	81	15	18.5%	104	14	13.5%
Other	83	12	14.5%	86	16	18.6%	98	22	22.5%
White	5,598	813	14.5%	5,769	879	15.2%	5,961	974	16.3%

Table 28 provides an analysis of Members Served by Gender showing that the average number and percentage of males to females for the past three years is relatively unchanged.

Table 28: Percent of Members Served by Gender

Gender	CY 2007		CY 2008		CY 2009		CY 2010	
	Consumers	Percent	Consumers	Percent	Consumers	Percent	Consumers	Percent
Female	11,700	50.0%	12,485	49.1%	13,933	48.9%	15.473	49.2%
Male	11,707	50.0%	12956	50.9%	14,575	51.1%	15,984	50.8%

CRITICAL INCIDENT REPORTING

CABHC's oversight responsibilities include ongoing monitoring of CBHNP's incident management system, which has been designed to ensure the health, safety, and rights of every individual who receives services through the Territory's HealthChoices Program. It is CBHNP and CABHC's goal to reduce critical incidents, yet the total number of all critical incidents in CY 2010 increased 9.6% after a slight decline from 2008 to 2009.

The Clinical Committee reviews critical incidents semi-annually in January and June. As a result of the review, the committee requested CBHNP to review several areas: use of restraints with Members, use of the category of "Other" in the CI Report, and Quality of Care Counsel Review of Critical Incidents.

In terms of Member safety, it is noted that for the report year the use of restraints increased by 4.6% during the year. The increase could be attributed to providers being more compliant with reporting incidents and CCM more effectively reviewing reports submitted by providers. It was noted by CBHNP that the increases were from 24/7 type providers, such as RTF's, and that several high volume providers consider restraint as an acceptable form of intervention.

CBHNP will address these providers utilizing a Restraint Reduction Proposal to include additional staff education and training and the development of interventions and strategies and initiatives to introduce alternative, safer, forms of interventions. CBHNP will meet with RTF providers to discuss their plans for restraint reduction, develop tools to track and trend restraints, and target high volume providers for restraint reduction.

In an effort to enhance communication this information to each County, CABHC continues to distribute, via secured electronic mail, the CBHNP Quality of Care Council, Critical Incident Report logs to designated County representatives.

CBHNP reviewed the use of the category of "Other" and will separate this from the list in the next CY. Incidents falling into this category are not required to be reported by OMHSAS; however CHBHNP will continue to track them in the future. Table 29 summarizes critical incident data from CY 2007 through CY 2009.

Table 29: Critical Incidents by Category

Category	CY 2007	CY 2008	CY 2009	CY 2010	CY 2010 % less Seclusion Restraint
Death of a Member while in Treatment	21	30	35	18	0.73%
Attempted Suicide	25	19	20	27	1.09%
Medication Error	51	47	62	64	2.59%
Any event requiring the services of the fire department, or law enforcement activity	331	310	310	360	14.58%
Abuse or Alleged Abuse of a Member	146	175	179	258	10.45%
Any injury or illness (non-psychiatric) of a Member requiring medical treatment more than first aid	200	232	249	233	9.44%

Category	CY 2007	CY 2008	CY 2009	CY 2010	CY 2010 % less Seclusion Restraint
Unexplained Absence of a Member (AWOL)	72	137	189	270	10.94%
Any fire, disaster, flood, earthquake, tornado, explosion, or unusual occurrence that necessitates the temporary shelter or relocation of residents.	3	17	2	27	1.09%
Other incident identified by providers as Critical, Adverse, or Unusual	363	978	1,040	1,191	48.24%
Blank/Not Provided	N/A	6	3	21	0.85%
Subtotal	1,212	1,951	2,089	2,469	63.85%
Seclusion	194	130	154	94	6.72%
Restraint	1,121	1,559	1,251	1,304	93.28%
Total of Seclusion/Restraint	1,315	1,686	1,405	1,398	36.15%
Total of All Incidents	2,527	3,637	3,494	3,867	

The data in Table 30 shows that the total number of critical incidents for all age groups increased 10.7% in 2010. The data shows that 85.2% of all critical incidents fall into the children/adolescent age range (0-17), which is only a slightly higher percent than last year's 84%. Critical Incidents declined by 48 for the 18-64 age groups, and two in the 65+ age group.

Table 30: Critical Incidents by Age

Age Category	CY 2007	CY 2008	CY 2009	CY 2010	% of CY 2010
Children (0-12)	1,038	1,284	1,050	1,281	33.13%
Adolescents (13-17)	1,226	1,852	1,883	2,014	52.08%
Adults (18-64)	346	496	553	505	13.06%
Adults (65+)	5	5	8	6	0.16%
Totals	2,615	3,637	3,494	3,867[1]	100%

[1]Total includes 61(1.57%) that were submitted with no age identified.

If there are irregularities in reporting practices or an increase in the number of any specific reporting category occurs, the Clinical Committee discusses the findings with CBHNP. CBHNP then identifies possible interventions and strategies to address the findings. CABHC will continue to monitor critical incidents, and the classification process. CABHC will also identify and analyze trends in order to determine if corrective action plans will be needed.

TREATMENT DENIALS

Denials to pay for a requested service can result in appropriate, efficient care or create a barrier to necessary treatment. CABHC seeks to ensure that Members have access to medically necessary services by monitoring trends for denials to pay for requested services.

CABHC monitors all treatment denials issued by CBHNP in order to ensure that the process is fair and equitable, follows required standards, and that Members receive treatment necessary to improve their quality of life.

A review of treatment denials without putting in perspective of the number denials to requests for service authorizations would be short sided. This data is provided to offer a better perspective of the volume of requests handled each year.

During the year, there were 36,062 requests for services; 15,067 for children and 20,995 for adults. The total requests are only 25 more than in CY 2009. Data from CBHNP shows that the percentage of denials to requests for children was 6% while the percentage of denials to requests for adults was 1%, with a combined percentage of 3%. While some of the data in the tables below show some high percentages, in perspective to the total number of services requested, they represent a rather small number compared to the aggregate totals.

On a positive note the number of denials significantly fell this year, from 2,179 last year to 1,023 this year. The decline is a result of a concerted effort by CBHNP to enhance the authorization process in order to ensure that evaluations requests for service effectively focus on the needs of the Members. Improvement has been seen in the evaluation process and in the level of collaboration between CBHNP, the Member, and Providers.

Table 31 summarizes the reasons for treatment denials for the past four years. The main reason for denials continues to be Service Not Medically Necessary at 99.2% in 2010.

Table 31: Reasons for Denials

Denial Reason	CY 2007			CY 2008		
	Denials	% of Total Denials	Unduplicated Members	Denials	% of Total Denials	Unduplicated Members
Service not medically necessary	2254	94.75%	1790	2025	96.2%	1367
Service not covered under the plan	1	0.04%	1	0	0.00%	0
Facility failed to provide sufficient information	120	5.04%	116	74	3.5%	59
Recipient not covered for the service	4	0.17%	4	2	0.10%	2
Total	2379	100.00%	1911	2106	100.00%	1,428
Denial Reason	**CY 2009**			**CY 2010**		
	Denials	**% of Total Denials**	**Unduplicated Members**	**Denials**	**% of Total Denials**	**Unduplicated Members**
Service not medically necessary	2778	97.2%	2,109	1313	99.2%	1,013
Service not covered under the plan	2	0.1%	2	0	0.0%	0
Facility failed to provide sufficient information	76	2.7%	68	11	0.8%	10
Recipient not covered for the service	0	0.0%	0	0	0.0%	0
Total	2856	100%	2,179	1324	100%	1,023

A denial does not necessarily indicate that a Member is not authorized to receive treatment. During the year, 63.3% of service requests that were denied were approved for some level of treatment. This is slightly lower than the 67.1% last year. The percent of Totally Denied

increased for the fourth year. During the coming year, CABHC will explore reasons for this increase with CBHNP. Table 32 summarizes the number of treatment denials across various dispositions with respect to alternative services.

Table 32: Disposition of Requested Service

Denial Reason	CY 2007			CY 2008		
	Denials	**% of Total Denials**	**Unduplicated Members**	**Denials**	**% of Total Denials**	**Unduplicated Members**
Totally denied	703	23.56%	624	655	31.10%	539
Service approved at different amount	731	24.50%	630	575	27.30%	501
Service approved at different duration	476	15.95%	435	72	3.42%	65
Service approved at different amount and duration	307	10.29%	278	321	15.24%	217
Different service approved	767	25.70%	708	483	22.94%	460
Grand Total	2984	100.00%	2675	2106	100.00%	1420
Denial Reason	**CY 2009**			**CY 2010**		
	Denials	**% of Total Denials**	**Unduplicated Members**	**Denials**	**% of Total Denials**	Unduplicated Members
Totally denied	941	32.9%	839	486	36.71%	448
Service approved at different amount	710	24.8%	647	343	25.91%	313
Service approved at different duration	139	4.9%	136	46	3.47%	45
Service approved at different amount and duration	395	13.8%	374	95	7.18%	91
Different service approved	676	23.6%	656	354	26.74%	343
Grand Total	2,861	100.00%	2,163	1324	100.0%	1240

Table 33 summarizes the breakdown of treatment denials by age group. Over the past four years, the majority of treatment denials have been issued for children's services. The table shows that ages 0-17 accounted for 90.6% of all denials. Treatment denials for the 0-17 age group are the lowest percent in four years.

Table 33: Denials by Age

Denial Reason	CY 2007			CY 2008		
	Denials	% of Total Denials	Unduplicated Members	Denials	% of Total Denials	Unduplicated Members
Ages 0 - 5	314	13.41%	264	318	15.28%	182
Ages 06 - 12	1279	54.61%	974	1,182	56.82%	650
Ages 13 - 17	600	25.62%	481	474	22.77%	327
Ages 18 - 20	46	1.96%	42	31	1.49%	26
Ages 21 - 44	68	2.90%	66	55	2.64%	19
Ages 45 - 64	35	1.49%	30	20	1.00%	19
Ages 65+	0	0.00%	0	0	0.00%	0
Denial Reason	**CY 2009[1]**			**CY 2010**		
	Denials	**% of Total Denials**	**Unduplicated Members**	**Denials**	**% of Total Denials**	**Unduplicated Members**
Ages 0 - 12	2,041	71.3%	1,464	910	67.86%	658
Ages 13 - 17	615	21.5%	505	305	22.74%	258
Ages 18 -64	204	7.1%	193	122	9.10%	114
Ages 65+	1	0.0%	1	4	0.30%	3

[1]Age categories were revised in CY 2009

COMPLAINTS AND GRIEVANCES

Complaints

In the HealthChoices Program, a *Complaint* is an objection filed by or on behalf of a Member with a BH-MCO (e.g., CBHNP) regarding a participating health care provider or the coverage, operations, or management policies of a BH-MCO. The complaint process typically follows a sequential protocol: first, a Level I Complaint is filed; then, if necessary, a Level II Complaint may be filed. Thereafter, a Member or a Member's representative may request an External Review. A Fair Hearing may be requested at any time.

CABHC monitors CBHNP's complaint process to ensure that all complaints are resolved thoroughly and in a timely manner. CBHNP is required to resolve both Level I and Level II complaints within thirty (30) calendar days of receipt. During CY 2010, CBHNP resolved 100% of the Level I complaints within the required timeframe. Data analysis showed there were 0.47

Level I complaints per 1000 Members for the year. For the first time, were no Level II Complaints filed during the fiscal year.

CABHC monitors the type of complaints that are filed with CBHNP. During CY 2010, of the 64 Level I complaints filed, 63 were filed against providers and 1 against CBHNP. Three of the nine complaint categories made up 80% of all complaints: *Dissatisfied with Treatment* 53% (34), *Treatment Inappropriate,* 19% (12), and *Provider Staff Rude* 8% (5).

Members were satisfied with the complaint resolution 95% of the time, up from the 79.2% last year. CABHC reviews complaints through its Clinical Committee, the Consumer Family Focus Committee, and through participation on the CBHNP Quality Improvement/Utilization Management Committee.

Grievances

A *Grievance* is a request by or on behalf of a Member to have a BH-MCO or other utilization review entity reconsider a decision solely concerning the medical necessity and appropriateness of a health care service. A grievance may be filed regarding a BH-MCO decision to:

- Deny, in whole or in part, authorization for a requested service.
- Deny the requested service but approve an alternative service.
- Totally deny the requested service.

A Member may file a grievance either orally or in writing with CBHNP. All BH-MCOs under the HealthChoices Program, including CBHNP, are required to resolve any grievance within 30 days from the date the grievance was filed.

As with complaints, the grievance process usually follows a sequential protocol: first, a Level I Grievance is filed; then, if necessary, a Level II Grievance may be filed. Thereafter, a Member or a Member's representative may request an External Review. A Fair Hearing may be requested at any time.

In addition to these options, a Member or Member's representative may request an expedited review. A Member who files a request for expedited review of a grievance to dispute a decision to discontinue, reduce or change a service that the Member has been receiving will continue to receive the disputed service at the previously authorized level pending resolution of the grievance. For continuation rights to occur, the request for expedited review must be hand delivered, done by phone, or post-marked within ten days from the date of the written notice of decision.

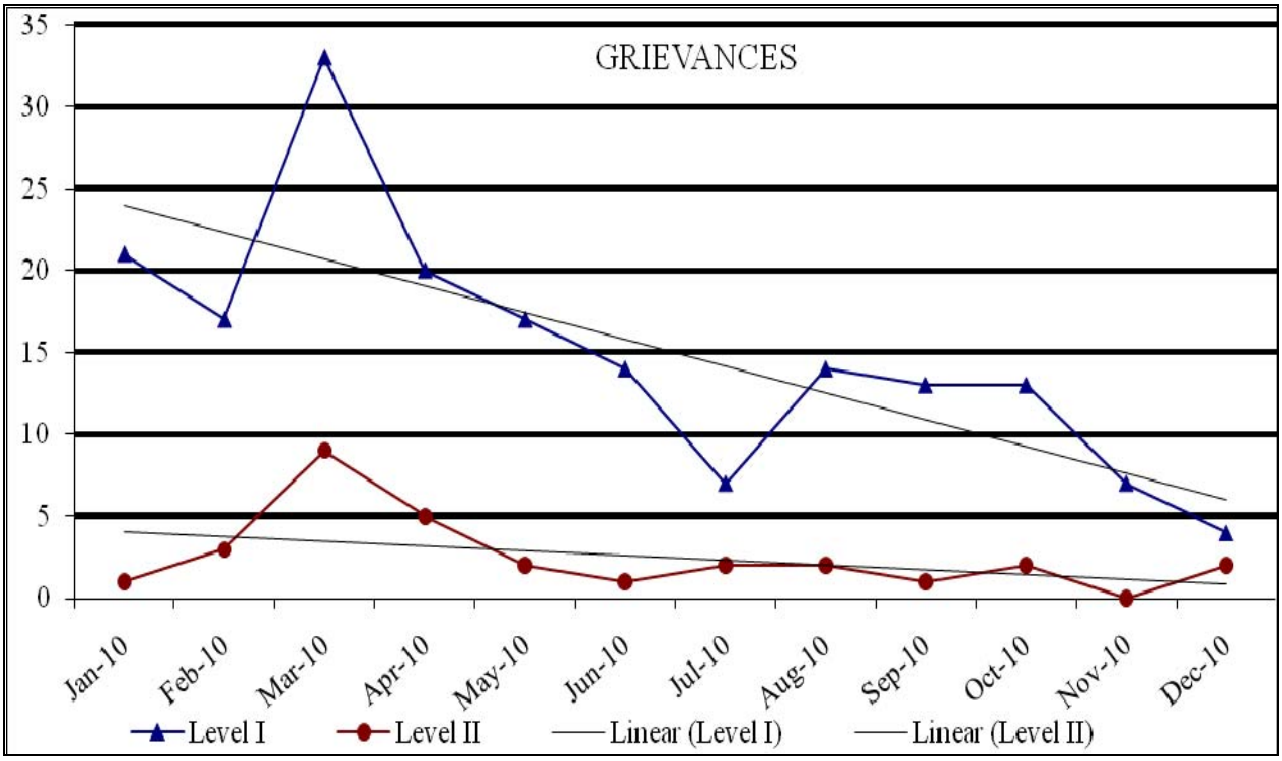
Since 2008, CABHC effectively monitored 25% of all Level I grievances to ensure that a fair process was taking place, and to evaluate if the Level I process was being handled in such a way as to reduce the need for Members to file a Level II grievance. The evidence that the process improved was evident as CABHC evaluated the monitoring data.

In October 2010, CABHC completed an analysis of the 31 Level I grievances that had been filed from January-October and found that CBHNP had conducted the Level I grievance reviews fairly. As stated in the report: "The data supports that the reviews are being conducted fairly,

that procedures are being followed, and that the presentations made by CBHNP were completed in a respectful and understandable manner." As a result of the study CABHC discontinued monitoring the Level I grievance process. CABHC continues to facilitate Level II grievance reviews.

Figure 2 shows the decline in Level I and Level II reviews that took place during CY 2010.

Figure 2: Level I and Level II Grievances



Tables 34-37 summarize the outcomes for grievances filed during CY 2010. The data illustrates that compared to last year, there were considerable decreases seen in all areas: Level I, Level II, External Reviews, and Fair Hearings. The data clearly shows that the changes CBHNP made to this process during CY 2009 continued to be effective this year. The percent reduction of grievances for the year was Level I declined by 54.1% (392 to 180), Level II 70.9% (103 to 30), External Reviews 83.3% (30 to 5) and Fair Hearings 50.0% (2 to 1).

Another goal for the year was to reduce the number of Level I grievances that moved to Level II. Members who believe that their Level I Grievance was not satisfactorily resolved may appeal and file a Level II Grievance. CBHNP's efforts in this area also continue to be positive. The data shows a decline of 9.6%, from 26.3% to 16.7%. This marks the fourth year that this area has shown a decline.

County data shown in the tables below reflect declines in both Level I and Level II grievances in every County. Level I grievances for Cumberland and Lebanon both declined by 57.6% and Level II grievances declined in Cumberland by 94.0%. The declines for Level I grievances in the other counties are: Dauphin 54.5%, Lancaster 52.2%, and Perry 43.7%.

CBHNP continues to show improvement in reducing the number of Level I grievances moving to Level II, again indicative that Members are satisfied with the results of their Level I review. The percent of Level I to Level II grievance reviews declined for the fourth year. The analysis looked only at grievances that were either upheld or overturned; those which were withdrawn were not considered in the analysis as there was no action taken on them. During CY 2010, 16.7% (30 of 180) moved to a Level II review. This is a positive as it is lower than in the previous two years.

Outcomes for Level I grievance reviews this year experienced a considerable increase in the number overturned in favor of the Member. This year 53 (47.3%) were overturned, compared to 32 (10.2%) last year. In contrast, the percent of those upheld for the MCO/Provider fell to 57.7% this year compared to 89.8% last year.

Table 37 provides data related to External Reviews and Fair Hearings. An External Review is filed when a Member is not satisfied with the outcome of a Level II grievance decision. A Fair Hearing can be requested when a Member is unhappy or disagrees with something that CBHNP did or did not do. Some circumstances for requesting a Fair Hearing are: a Member was denied a service because it was not covered, that CBHNP did not decide the complaint or grievance within 30 days when it was filed, CBHNP's provider did not provide service by the time the Member should have received it.

During CY 2010 there were only five External Reviews, compared to 30 in CY 2009. The decline could be attributed to CBHNP's efforts to ensure a more effective process for evaluating and identifying appropriate services needed by the Member. Of the five External Reviews, three were upheld for the MCO, one overturned for the Member, and one was withdrawn. Of the two Fair Hearings filed last year, one was withdrawn and one was overturned for the Member.

Table 34: Level I & Level II Grievances by County

County	Level I Grievances				Level II Grievances			
	CY 2007	CY 2008	CY 2009	CY 2010	CY 2007	CY 2008	CY 2009	CY 2010
Cumberland	61	38	52	22	20	7	17	1
Dauphin	121	70	134	61	38	15	27	11
Lancaster	155	101	138	66	55	35	36	10
Lebanon	73	41	52	22	28	5	19	6
Perry	13	8	16	9	3	2	4	2
Territory	423	258	392	180	144	64	103	30

Table 35: Grievance Escalation: Level I to Level II

County	CY 2008			CY 2009			CY 2010		
	Level I	# to Level II	% to Level II	Level I	# to Level II	% to Level II	Level I	# to Level II	% to Level II
Cumberland	38	8	21.1%	52	17	32.7%	22	1	4.5%
Dauphin	70	18	25.7%	134	27	18.7%	61	11	18.03
Lancaster	101	40	39.6%	138	36	22.5%	66	11	16.7%
Lebanon	41	7	17.1%	52	19	36.5%	22	5	22.7%
Perry	8	2	25.0%	16	4	25.0%	9	2	22.2%
Territory	258	75	29.1%	392	103	26.3%	180	30	16.7%

Table 36: Grievance Outcomes: Level I/Level II

Outcome	Level I						Level II					
	CY 2008		CY 2009		CY 2010		CY 2008		CY 2009		CY 2010	
Denial Upheld	166	77.6%	283	89.8%	59	52.7%	39	70.9%	72	84.7%	24	85.7%
Overturned	48	22.4%	32	10.2%	53	47.3%	16	29.1%	13	15.3%	4	14.3%
Withdrawn	44	n/a	77	n/a	68	n/a	9	n/a	18	n/a%	2	n/a
Total (less Withdrawn)	214		315		112		55		85		28	

Note: Format concerns did not allow for the inclusion of data prior to CY 2008.

Table 37: Grievance: External Reviews/Fair Hearings

Outcome	External Review						Fair Hearings					
	CY 2008		CY 2009		CY 2010		CY 2008		CY 2009		CY 2010	
Denial Upheld	4	100%	19	70.4%	3	75.0%	1	100%	1	50.0%	0	0.0%
Overturned	0	0	8	29.6%	1	25.0%	0	0%	1	50.0%	1	100%
Withdrawn	0	n/a	3	10.0%	1	n/a	1	n/a	7	n/a	1	n/a
Total (less Withdrawn)	4		30		5		1		2		1	

Note: Format concerns did not allow for the inclusion of data prior to CY 2008.

The data shows that the adjustments made by CBHNP in regard to their management of the grievance process have been effective. CBHNP and CABHC will continue to look at ways to further improve both treatment denials and ultimately grievances. CABHC continues to evaluate the efficacy of CBHNP's denial process through constant monitoring of the volume and timely resolution of grievances.

QUALITY SATISFACTION

CONSUMER SATISFACTION

Regular assessment of consumer satisfaction is essential to ensuring that the HealthChoices program is responsive to the needs of its Members. CABHC contracts with Consumer Satisfaction Services (CSS) to conduct consumer satisfaction surveys within the Territory. This organization is staffed entirely by consumers and family members, to regularly survey/assess Member satisfaction with their behavioral health services and their inaction with CBHNP. CABHC also reviews Member satisfaction surveys conducted by CBHNP. CSS reports are based on the Fiscal Year; therefore, in order to maintain data integrity the FY data from the CSS Annual Reports for the past three years will be used in this report.

CSS Consumer/Family Satisfaction Survey

Every other month, CABHC provides CSS, the Consumer/Family Satisfaction Team (C/FST), with a confidential list of Members who received the designated HealthChoices mental health service from selected providers in the CBHNP network. CSS then randomly selects Members from this list to be surveyed. Surveys take place either face-to-face or by telephone. However, due to confidentiality regulations, surveys with Members receiving drug and/or alcohol services are only conducted face-to-face at drug and alcohol service providers. All surveys are voluntary and remain confidential to the Member's identity.

During the 2009-2010 CSS made a number of significant changes to their approach to the implementation of the survey and their responsibilities. CSS initiated training in the "Introduction to Recovery in Mental Health" and their staff attended number of HealthChoices Advisory Committee meetings, the Survey Methodologies Workgroup, Drug and Alcohol Commission provider meetings and the Central Region Consumer/Family Satisfaction team (C/FST) meetings. Additionally, in an attempt to make the surveys more meaningful to both the consumers and survey specialists the majority of surveys are completed in person. CSS also added a bi-lingual survey specialist who is fluent in the Spanish language. These efforts resulted in a significant increase in interviews this year (1,246) compared to last year (451).

Data was collected by 13 interviewers from 42 treatment facilities. The 570 adult consumers received services from 25 treatment facilities. The 676 child consumers received services from 26 treatment facilities. Of the 42 treatment facilities, 16 provided services only to adult consumers, 17 provided services only to child consumers, and the remaining 9 treatment facilities provided services to both adult and child consumers.

The data from the survey is shown in tables 38 through 42. During FY 2009-2010 the percent of face-to-face interviews increased from 35% to 37%. The gender break down revealed slightly

more males (53.7%) than females (46.3%) were interviewed. A review of the number of surveys by County reveals the largest number of respondents report residence in Lancaster County (38.3%).

Table 38: CSS Survey: Adult and Child/Adolescent

ADULT/CHILD/ADOLESCENT SURVEYS					
	Number Surveyed	Adults	% of Adults	Child/Adolescent	% of Children
2007-2008	1,223	398	32.5%	825	67.5%
2008-2009[1]	451	264	58.5%	187	41.5%
2009-2010	1,246	570	45.7%	676	54.3%

[1]During FY 2008-2009 CSS experienced a leadership change, which reduced the total number of surveys conducted.

Table 39: CSS Interviews by County

	FY 2007-2008		FY 2008-2009		FY 2009-2010	
	Number Interviewed	% of Total	Number Interviewed	% of Total	Number Interviewed	% of Total
Cumberland	210	17.28%	84	18.6%	134	10.8%
Dauphin	341	27.9%	128	28.4%	348	27.9%
Lancaster	410	33.5%	164	36.4%	477	38.3%
Lebanon	117	9.6%	46	10.2%	236	18.9%
Perry	76	6.2%	20	4.45%	36	2.9%
Other	63	5.2%	7	1.6%	15	1.2%
Missing	6	0.5%	2	0.4%	0	0.0%
Total	1,223		451		1,246	

CSS follows a set rotation schedule for the inclusion of different types of services during the FY. During the current FY, a total of 10 different level of care reported in the survey data. Table 40 summarizes the breakdown of surveys by the different levels of care. The selection and rotation schedule of the different levels of care surveyed is a result of a collaborative discussion between CABHC and CSS. It should be noted that the rotation of services is scheduled over a two year period. It is anticipated that those not included on this list will be incorporated in future annual reports. During this cycle the majority of surveys for Child/Adolescents who received BHRS-Wraparound services, while Mental Health Outpatient (Psychiatric) services accounted for over half of all adult services.

Table 40: FY 2009-2010 CSS Survey - Level of Service

Level of Care	Adults		Child/Adolescents		All Interviews	
MH Outpatient -Psychiatric	320	56.1%	119	17.6%	439	35.2%
MH Inpatient -Psychiatric	109	19.1%	70	10.4%	179	14.4%
D&A Treatment	108	18.9%	4	0.6%	112	9.0%
MH General-Community Treatment Team/Assertive Treatment team	21	3.7%			21	1.7%
MH IP- Extended Acute Care	12	2.1%			12	1.0%
BHRS- Wrap Around Services			276	40.8%	276	22.2%
Family Based Mental Health Services			176	26.0%	176	14.1%
BHRS-MH-EIBS			18	2.7%	18	1.4%
Residential Treatment Facilities- JCAHO (RTF)			9	1.3%	9	0.7%
Residential Treatment Facilities-Non-JCAHO (RTF)			4	0.6%	4	0.3%
Total	570		676		1246	

The CSS consumer satisfaction survey includes several sets of questions related to satisfaction with Providers and the mental health and drug and alcohol services the Member is receiving. The Implementation section focuses on consumer satisfaction with the services received, and their relationships with their providers, while the Outcomes section focuses on consumer perceptions of the impact services have had on their daily lives. Another set of questions explores Members impressions of their treatment environment, including the facility and the staff where they receive services. Lastly, CSS provides a series of questions for Members to give their perception of their interactions regarding CBHNP.

Although survey is categorized by providers and by level of care, CSS continues to provide the aggregate scores for the Implementation and Outcome questions. The aggregate scores provide a glimpse of Member satisfaction throughout the Territory.

The respondents had the following choices to answer the *Implementation and Outcome* questions: “Strongly Agree,” “Agree,” “Neither Agree or Disagree,” “Disagree,” “Strongly Agree,” or “Not Applicable”. The survey analysis for this report combines the two positive scores as well as the two negative scores, “Strongly Agree” and “Agree”, and “Disagree” and “Strongly Disagree”.

Survey Results: Implementation

Overall, the majority of consumers are satisfied with their services. The mean satisfaction for both Adult and Children/Adolescent consumers during FY 2009-2010 was 80.6%, (Mean Satisfaction Level/Highest Possible Score) slightly lower than last year. When looking the overall satisfaction ratings between Adults and Child/Adolescent the scores are similar with adult respondents indicating they “Agree” or “Strongly Agree” 89.5% and those who received Child/Adolescent services reporting 83.9%.

Table 41 shows consumer responses reflecting higher levels of satisfaction for the past three FYs. The data shows improvement over the three years for all respondents that they were informed about their rights, having choice in selecting or changing their service provider, for program staff respecting the role of their ethnic, cultural and religious background in their treatment and recovery, and believing they are an equal partner in the treatment process. Although the area regarding confidentiality, that providers did not sharing their information without their permission is also rated consistently high.

Table 41: CSS Comparison Implementation Data

IMPLEMENTATION		2007-2008[1]	2008-2009	2009-2010
Mean satisfaction		76.8%	82.6%	80.6%
Overall I am satisfied with the services I am receiving.	All	77.6%	86.7%	86.4%
	Child		85.6%	83.9%
	Adult		87.5%	89.5%
I had a choice in selecting my service provider.	All	72.8%	72.9%	79.0%
	Child		77.0%	83.0%
	Adult		70.1%	74.2%
I have the option to change my service provider should I choose to.	All	74.8%	76.1%	86.1%
	Child		84.5%	89.5%
	Adult		70.1%	82.1%
My Provider does not share my personal mental health and/or substance abuse information with others without my permission.	All	88.7%	88.5%	92.3%
	Child		91.4%	92.6%
	Adult		86.4%	91.9%
I was informed about my rights and responsibilities regarding the treatment I have received.	All	86.2%	88.9%	93.2%
	Child		92.0%	93.9%
	Adult		86.7%	92.3%
Program staff respects the role of my ethnic, cultural and religious background in my recovery/treatment.	All	90.0%	90.5%	92.0%
	Child		91.4%	91.0%
	Adult		89.8%	93.2%
I am an equal partner in the treatment process.	All	83.5%	86.9%	89.9%
	Child		89.8%	90.1%
	Adult		84.8%	89.6%

[1]The FY 2007-2008 report did not provide data related to the breakdown for Child and Adult services.

Survey Results: Outcomes

As noted above, outcomes-oriented questions relate to consumer perceptions regarding the impact services have had in their lives. Respondents rated their perception of treatment impact to the areas identified in each question as "Much Better," "A Little Better," "About the Same," "A Little Worse," or "Much Worse".

Overall, the majority of all respondents perceive that services they received helped make their lives better. Table 42 provides a comparison of data for the past three years. Reviewing the rating for all respondents, three areas that improved over last year's rating ("Much Better/Better") were: enjoying my free time, dealing with problems or issue that led to seek services, and dealing with people in social situations. Four areas reflect slight declines from last year, managing daily problems, strengthen social support network, feeling good (hopefully) about the future, and feeling in control of their life.

Table 42: CSS Comparison Outcome Data

OUTCOME		2007-2008[1]	2008-2009	2009-2010
		Better/Much Better		
Enjoying my free time.	All	60.0%	72.5%	73.0%
	Child		75.4%	72.5%
	Adult		70.5%	73.7%
Managing daily problems.	All	65.7%	73.6%	72.9%
	Child		67.4%	68.5%
	Adult		78.0%	78.1%
Dealing with problems or issue that led to seek services.	All	62.7%	70.5%	72.2%
	Child		60.4%	68.3%
	Adult		77.7%	76.8%
Strengthen my social support network.	All	55.8%	69.8%	69.1%
	Child		65.8%	66.9%
	Adult		72.7%	71.8%
Feeling in Control of my life.	All	57.1%	67.8%	66.9%
	Child		56.7%	60.9%
	Adult		75.8%	73.9%
Feeling good (hopeful) about the future.	All	57.4%	71.4%	66.9%
	Child		64.2%	61.5%
	Adult		76.5%	73.3%

OUTCOME		2007-2008[1]	2008-2009	2009-2010
		Better/Much Better		
Dealing with people in social situations	All	55.3%	65.9%	68.0%
	Child		56.1%	65.7%
	Adult		72.7%	70.7%

[1]The FY 2007-2008 report did not provide data related to the breakdown of Child and Adult services.

The data reflected in the above tables demonstrates that consumers have a positive perception of the services they have received and that their lives have improved in most of the areas.

Questions Regarding CBHNP

The survey also included several questions exploring consumer's perception of their quality of life and satisfaction with their Behavioral Health –Managed Care Organization (CBHNP) related to the services they receive through HealthChoices. The response to the questions allows Members to answer with a "Yes" or "No" or "Does Not Apply" to the questions. In order to present a more accurate picture of the results the data reflects only those who responded "Yes" while excluding those who responded "Does Not Apply".

The survey found that for CY 2009-2010 91.4% of all respondents responded "yes" that overall, they were satisfied with the interactions they had with CBHNP. Although the overall rating is slightly lower than last year, the adult respondents rated it slightly higher than last year. During this year 93.1% indicated that they knew they had a right to file a grievance or complaint compared 89.0% last year. Both child and adult respondents rated this higher than last year. Regarding being given the choice of at least two providers, 80.3% responded that they knew they had a choice of providers. Child respondents were more positive this year (85.4%) than last (68.2%), while adults rated it slightly lower than last year (73.3% to 80.0%).

When compared to last year the data in table 43 reflects over-all improvement for CBHNP in three of the four areas. The data for both child and adult also shows improvement in three of the four areas, although not in the same areas. The results, of the survey, are considered to be positive.

Table 43: Questions Related to CBHNP

QUESTIONS RELATED TO CBHNP		2007-2008	2008-2009	2009-2010
Overall, I am satisfied with the interactions I have had with CBHNP.*	All	89.5%	93.5%	91.4%
	Child		96.4%	90.6%
	Adult		90.0%	91.9%
I was able to obtain information on treatment and/or services from BHP without unnecessary delays.*	All	74.4%	78.3%	86.3%
	Child		71.4%	85.3%
	Adult		81.8%	87.4%
I am aware of my right to file a complaint or grievance.*	All	85.4%	89.0%	93.1%
	Child		88.3%	95.0%
	Adult		89.5%	96.7%
I was given a choice of at least (2) Providers from CBHNP regarding the type of service I am seeking. *	All	76.5%	76.2%	80.3%
	Child		68.2%	85.4%
	Adult		80.0%	73.3%

The FY 2007-2008 report did not provide data related to the breakdown of Child and Adult services.
* Percent is calculated without those responding that the question "did not apply", providing a more accurate response to this area.

Treatment Environment: Facility/Staff

Members responding to this section had the opportunity to rate their provider's facility for comfort and cleanliness and to rate the staff by friendliness and attentiveness. The rating ranged from Excellent, Good, Fair, Poor or NA. CSS analysis combined the ratings of Excellent and Good as well as Fair and Poor. Of those responding to this section of the survey, consumers rated the comfort of their treatment environment as Excellent/Good 79.4% of the time, with only 10.0% rating it Fair/Poor. Cleanliness was rated slightly higher with 81.2% with an Excellent/Good rating, while 7.9% rated it Fair/Poor. The treatment facilities staff received an 87.8% rating of Excellent/Good for Friendliness, while Attentiveness was rated slightly lower at 86.7%.

CBHNP Member Satisfaction Study

Since 2005, CBHNP has contracted with the Polk-Lepson Research Group, Inc. to conduct and analyze data obtained from Member surveys using the *Experience of Care and Health Outcomes Survey (ECHO™), Managed Care Organization, Version 3.0H* instrument. Both English and Spanish language versions of this instrument are made available to Members, with separate forms used for adult and child/adolescent Members.

CBHNP provided Polk-Lepson Research Group the names and addresses of 19,561 adult and child/adolescent Members who received services during 2009. Polk-Lepson conducted a random

sampling to conduct the survey. The response rate for adults was 24% compared to 17% last year. The children/adolescent survey response rate of 13.8% was slightly higher than the previous year. The survey was also available on line.

This year CBHNP introduced regression analysis of the survey. Regression analysis allows for positive or negative results to be shown through ratings identified as slopes. While regression analysis identified true trends, and is viewed as a primary tool, longitudinal analysis was also incorporated in the analysis of the results.

Regression analysis for the adult area found three areas of negative regression. Were you *Seen within 15 minutes of appointment* (Q12) was rated below 80%, with a 74.3% rating. Although this was an increase over last year, the responses to this question have not been over 80% in the past three years. Two other questions showed negative declines: *Got an appointment as soon as wanted* (Q5) was rated 75.3% marking its third consecutive decline, and *Saw someone as soon as wanted when counseling needed right away* (Q8) had its lowest rating since 2005, 61.3%.

There were several questions that showed positive regression analysis. The scores for these questions were rated the highest since 2005. *Showed respect for what member said* (Q15) achieved a score of 91.2% and *Rights as a patient* (Q23) rated 90.4%. Although questions 21 and 20 achieved their highest rating since 2005, the scores remain quite low, *Different kinds of counseling available* (Q21) was rated 64.5% and *Self-help or support groups* (Q20) achieved a 58.7% rating.

There was a noticeable decline to the number responding "Yes" to the question *In the last 12 months, not counting times you needed counseling right away, did you make an appointment for counseling or treatment?* This question was rated 75.3%, the lowest rating since 2005. In the area of being given information regarding self-help groups, Members responded "yes" only 58.7% of the time. Although this is a slight increase from 55.0% in 2009, the low rating still commands attention and is identified as a CBHNP initiative for future action. Individuals responding "Yes" to the question *Were you told about the side effects of those medicines to watch for?* improved to its highest rating since 2005, 80.4% and *Did you feel you could refuse a specific type of medicine or treatment?* also reached its highest rating of 80.5%.

Child/Adolescent Survey

The Child/Adolescent survey found two minor regressions. The ratings for both of the questions were the lowest recorded since 2005. *Seen within 15 minutes of appointment* (Q12) was rated 75.5% and *Got appointment as soon as wanted* (Q5) achieved a 75.7% rating.

The Child/Adolescent group had four positive regression findings; three minor and one moderate. One area achieved its highest rating since 2005, *Discussed goals of treatment, 95.2%*. The other three areas have demonstrated improvement overtime: *Rights as a patient* (Q23) 89.3%, *Managing one's condition* (Q22) rated 76.0%, and *Saw someone as soon as wanted when counseling needed right away* (Q8) improved to 66.0%.

When asked, *When your child needed counseling or treatment right away, how long was the wait between trying to get care and actually seeing someone?*, the percentage for same day treatment fell to 13.1%, from 24.4% a year ago. Two days increased (12.8% to 23.1%) while three days fell (10.3& to 6.8%), four and five days were close to the previous rating.

Adolescent responses to the question of getting enough information about self-help or support groups, 66.8% responded "Yes", down from 73.9% last year.

When asked if they were given information about different kinds of treatment or counseling available, the current rating fell from 73.9% in 2009 to 66.8%, the lowest rating since 2006.

Longitudinal increases/positive changes were seen in a couple of areas. To the question, *Were the goals of your child's counseling and treatment discussed completely with you?* This received a rating of over 90%. When using a scale of 1-10 (1 being the worst and 10 the best) to evaluate their treatment experience, the respondents mean score was seven, which was a strong rating (7-10). The mean score of seven accounted for over 65% of the responses.

In 2010, CBHNP did a cross walk analysis between the C/FST questions and the ECHO survey questions. While the content of the questions does vary, areas of satisfaction reviewed are similar and provide valuable comparisons. CBHNP found that the results for both surveys were similar.

During 2010, CBHNP addressed the Membership Satisfaction Survey through several initiatives. The initiatives were approved by the CBHNP Quality Improvement/Utilization Management Committee and focused on four areas: Information Received, Delays in Treatment, Customer Service. These areas were addressed by a variety of interventions.

CBHNP found that there was a lack of in-person and/or clear written materials available for Members outside the basic Member Handbook. This need was addressed by the development of an ISPT approved handout or Parent Handbook that includes description of levels of care in the HealthChoices delivery system. Development of a brochure outlining information and services for autism services, and the development of an insert used in conjunction with CBHNP's Values brochures to inform Members of county specific resources.

PROVIDER SATISFACTION

CABHC Provider Satisfaction Survey

The CABHC Provider Satisfaction Survey for 2009 is completed during 2010; therefore the data for this report represents findings from 2009. CABHC mailed 479 surveys to Providers and emailed 386 surveys for a combined total of 865 surveys distributed. The surveys went to Providers and to practitioners contracted by CBHNP to perform services in a variety of settings. Upon receipt, of the surveys, the CABHC Provider Network Specialist reviewed them to ensure that there was no duplication of surveys included in the results.

Of the 865 surveys that were distributed, 161 responses were returned, for a response rate of 19.5%. This was a slight increase over the 18.7% response rate last year.

Where possible, the survey was sent electronically using the QuestionPro online survey program. Where provider email addresses were unavailable, paper copies of the survey were mailed. Notably, 55% of the surveys were mailed, yet 74% of the responses were received electronically via QuestionPro. In 2008, 45% of the surveys were emailed, and 78% of the

responses were received electronically. CABHC will continue to expand electronic distribution of future surveys.

Eighty-nine percent of all responses came from three provider types: MH Outpatient 51%, D&A Outpatient, IOP or Partial, 21%, and MH BHRS, 17%. The age breakdown was equally split between providers serving children/adolescents and adult. .

Providers responded to the survey by using a Likert Scale to rate their experiences with CBHNP in the last year. The Likert scale provides the following responses: 5 = Very Satisfied, 4 = Satisfied, 3 = Neutral, 2 = Dissatisfied, 1 = Very Dissatisfied. Questions marked "Not Applicable" were not calculated into the scores.

Survey Results

The survey consisted of rating the departments or areas of CBHNP. The results for 2009 revealed that three areas improved from the previous year. Grievances, Administrative Appeals, and Written and Electronic Communication each increased over last year. The improvement in Grievances could be attributed to CBHNP's emphasis on improving the overall process this year, which resulted in a significant decline in grievances being filed.

Although the overall mean score was lower this year, when looking at the individual survey questions, 46% increased in satisfaction rating from last year and 44% decreased. The remaining 10% were either new questions or the score did not change.

The survey also provided a free form comments section with each category and also at the end of the survey. Most positive comments were related to the availability of electronic claims processing, the Provider Portal, and ProviderConnect®, as well as positive relationships with the Claims and Provider Relations departments. Most of the negative comments were related to difficulties obtaining clear information, as well as being dissatisfied with responses to questions.

The CABHC Provider Network Committee reviewed the results of the survey in order to make recommendations to CBHNP in any areas where improvement is needed. The table below shows the average rating for each area for the past three years:

Table 44: CABHC Provider Satisfaction Survey

Department/Area	*CY 2007*	*CY 2008*	*CY 2009*
Provider Relations	*4.03*	*4.14*	*4.11*
Clinical Department & Care Management	*3.63*	*3.76*	*3.78*
Provider Meetings and Training	*3.85*	*3.92*	*3.90*
Member Services Staff	*3.95*	*4.10*	*4.02*
Complaints	*3.86*	*4.01*	*3.73*
Grievances	*3.82*	*3.65*	*3.88*
Written/Electronic Communication	*3.58*	*3.85*	*3.94*
Provider Newsletters	*3.88*	*3.94*	*3.10*
Claims Processing	*4.00*	*4.01*	*3.89*
Administrative Appeals	*3.71*	*3.62*	*3.72*

Department/Area	*CY 2007*	*CY 2008*	*CY 2009*
Communication	*N/A*	*N/A*	*3.91*
Provider Orientation	*N/A*	*N/A`*	*3.94*
Overall Average	*3.83*	*3.90*	*3.83*

Summary of CABHC Provider Survey

Continued interaction with and feedback from Providers will be monitored and encouraged, with the objective to continue to see improved satisfaction in future surveys, specifically in the areas that decreased in satisfaction from 2008 to 2009.

CBHNP reviewed the CABHC survey results by area and by individual survey question. CBHNP targeted for improvement all individual questions that fell below the mean score of 3.75. CBHNP identified six areas that had means falling below 3.75.

Communication: Providers identified that they are usually able to reach someone at CBHNP via the Provider line to answer their question; they might not be able to reach the specific person they want to talk to. CBHNP will determine a way to better assist providers in reaching the person they called for.

Provider Newsletters: CBHNP acknowledges that although the format was recently made more reader-friendly, the content of the newsletter needs to change to provide information in a more interesting way.

Administrative Appeals: The focus will be on timeliness of response. To address this CBHNP is developing a system that will enable them to identify/trend and establish a quarterly notification process to the Administrative Appeals Committee. Additionally, the Administrative Appeals Committee is engaging the Provider Relations Representatives to offer providers technical assistance to assist them in circumventing the need for future appeals.

Claims Processing: The introduction of ProviderConnect® in 2008-2009 greatly improved provider satisfaction with the ease of submitting claims. There is room for improvement in consistency in responses to Provider inquiries, as well as the work involved in correcting claims.

Clinical Department and Care Management:
The area with the lowest score in this section was Participation in ISPT meetings with a 3.41 mean score. CBHNP responded that although this was a low score, there had been slight improvement over the past year. The improvement could be attributed to the fact that the CCMs attend all ISPT meeting for Members at risk of out of home placement and others, as schedules permitted.

Complaints: There was only one area in the Complaints section that fell below 3.75, which related to timeliness of resolution, which scored 3.72. CBHNP will review this area during the coming year.

CBHNP Provider Satisfaction Study

As in years past, CBHNP contracted with the Polk-Lepson Research Group in York, Pennsylvania to conduct the *2010 CBHNP Network Provider Satisfaction Study*. The table below provides a comparison of the survey demographics between 2009 and 2010. The response rate is slightly lower than last year. It is interesting to note that, although utilization of electronic documents and practices are becoming more prevalent, the number of online surveys had a large decline from last year.

Table 45: CBHNP 2010 Provider Survey Distribution/Response Rate

	2009	2010	Variance
Surveys distributed	1,352	1,401	+49
Surveys completed	197	160	-30
Surveys returned undeliverable	83	167	+84
Response Rate	15.5%	13.0%	-2.5%
Surveys completed online	91	20	-71

The CBHNP Survey tool is the CHCS (Center for Health Care Strategies) Clinical and Administrative Provider Satisfaction Survey, consisting of 38 items for clinical staff, and 15 items for administrative staff.

The overall clinical satisfaction with CBHNP for this survey was 94.8%, an increase from 2009 (92.0%). Other previous studies showed fluctuations in satisfaction levels: 2008, 97.2% and 2007, 88.2%. The report developers (Polk-Lepson) utilized a regression analysis this year and applied it across the survey years and trends were identified for positive and negative slopes.

The analysis found improvement with the availability of physician review for authorization, to 96.9%, an increase from last year's 89.3%. Provider relations showed overall improvement, with the exception of the credentialing process (-1.8%). Although the credentialing process did not fall below 90.0% since 2007, the regression analysis does show that it trended downward each year since 2007.

The overall administrative staff satisfaction with CBHNP rated high in 2010 showing only a minor reduction to 91.07% vs. 92.7% in 2009. Although overall satisfaction continually rates high, the regression analysis noted that it has showed a moderate downward trend since 2007. One area, Complaint and Grievances, showed an increase regarding grievance resolution.

Based on the survey results, CBHNP's Quality Improvement – Utilization Management Committee identified priority interventions and monitoring needs that were initially addressed last year and will continue to be a focus in the coming year.

Availability of Children's Services

This area showed a 17.1% decline in overall satisfaction from last year (2009-100% to 82.9% in 2010). CBHNP implemented the following interventions:

- The overall update for 2010 involved addressing the submission of authorizations to make sure that all requested information is necessary for consideration.
- Clinical supervisors will review all of the requests for additional information for ASD Members.
- Initial treatment plan review process for BHRS offers technical assistance through direct contact with providers. Additionally data collection & analysis will provide for identification of trends by provider over time/. CBHNP also conducted trainings to all providers in conjunction with the next round of level of care meetings
- Treatment plan training was developed and offered to providers.

Consistency of Staff Responses

Regarding consistency of staff responses, the results indicate that a majority of providers (88.8%) are satisfied with staff responses, this is the lowest rated attribute under Member Services/Care Management. The Capital responses for 2010 was 83.0%, 4.5% lower than last year. In an effort to address ease of authorization, CBHNP focused on several areas:

- TCM Policies and Procedures for Authorization and Re-Authorization will be reviewed and updated accordingly.
- Monitoring the Request Form helps ensure it includes only criteria based on medical necessity issues for TCM reviews.
- Unmatched treatments were implemented for TCM effective 1/1/09, eliminating the need for authorization and re-authorization of TCM services.

Ease of Authorization

The score for the Capital area fell from 100% in 2009 to 89.1% in 2010. This will be addressed along with Consistency of Staff Responses, see above.

New Initiatives

Based on the findings of the regression analysis, longitudinal studies CBHNP identified several new initiatives to address. CABHC will monitor the development and results of these initiatives in the coming year.

- Capital data shows that timeliness of response to inquiries related to service authorizations and claims decreased by 10.9% (100% to 89.1%).
- Clarity of CBHNP QM/QA goals (Data shows improvement of 2.1% from 83.3 to 85.4%).
- Credentialing process (Decreased 7.9% from 95.7% to 87.5%).
- Availability of Clinical Care Manager declined 15.7%, from 95.7% to 80.0%).

- Helpfulness of Member services staff, declined 5.1% from 95.7% to 90.6%.

A summary of the *2010 CBHNP Network Provider Satisfaction Study* is available at CBHNP's Website: http://www.cbhnp.org/qisurveyprov.aspx

FINANCIAL OVERVIEW

Financial oversight of the Corporation (CABHC), the HealthChoices Program and CBHNP remains an ongoing, shared endeavor between CABHC staff, CABHC's Fiscal Committee and the Counties. Areas of focus for 2010 were the corporate finances of CABHC and CBHNP, HealthChoices Program solvency, and state reporting requirements. Constant diligence and strong fiscal oversight are priorities for all parties involved.

CABHC Financial Performance[2]

CABHC's financial performance remained strong during FY 2009-2010. Continued higher than anticipated enrollment and an increase in OMHSAS approved administrative portion of the capitation rates from FY 2008 - 2009 were the main factors in the strong financial standing of the corporation.

During FY 2009 - 2010, CABHC did not see any significant increases in administrative expenses over FY 2008-2009. CABHC has continued in a positive cash flow. CABHC used their excess management fees received from the Counties in excess of related expenses to further fund the risk and contingency account. This account ensures that medical expenses that exceed capitation revenue received from the Commonwealth will be paid to providers.

CABHC's Fiscal Committee is responsible for monitoring and reporting on the financial position of CABHC. The CABHC's Financial Statements are reviewed monthly by the Fiscal Committee and reviewed at the monthly board meeting with the Board of Directors**.** CABHC's contracted auditors, The Binkley-Kanavy Group, also conducted a corporate audit at the close of the FY 2009- 2010. The Binkley-Kanavy Group issued an opinion that the financial statements were presented fairly, in all material respects, to the financial position of CABHC and the net assets and its cash flow for the year ended in conformity with accounting principles generally accepted in the United State of America. The Binkley Kanavy group found not reportable findings.

CABHC Monitoring of CBHNP Financial Performance

CABHC's Fiscal Committee is also tasked with monitoring CBHNP's financial solvency and reporting these finding to the CABHC Board of Directors. CABHC's Fiscal Committee monitors CBHNP's solvency by reviewing the following: CBHNP's Capital Region Financial Statements, monthly; Corporate Financial Statement, quarterly; and the AmeriHealth Mercy Corporate Audit including the CBHNP Supplemental Statement, yearly. For calendar year 2010 CBHNP Capital Region, Corporate, and AmeriHealth Mercy Family of Companies all showed a

[2] The Audit conducted by Binkley Kanavy Group used for this report is based on FY 2009-2010.

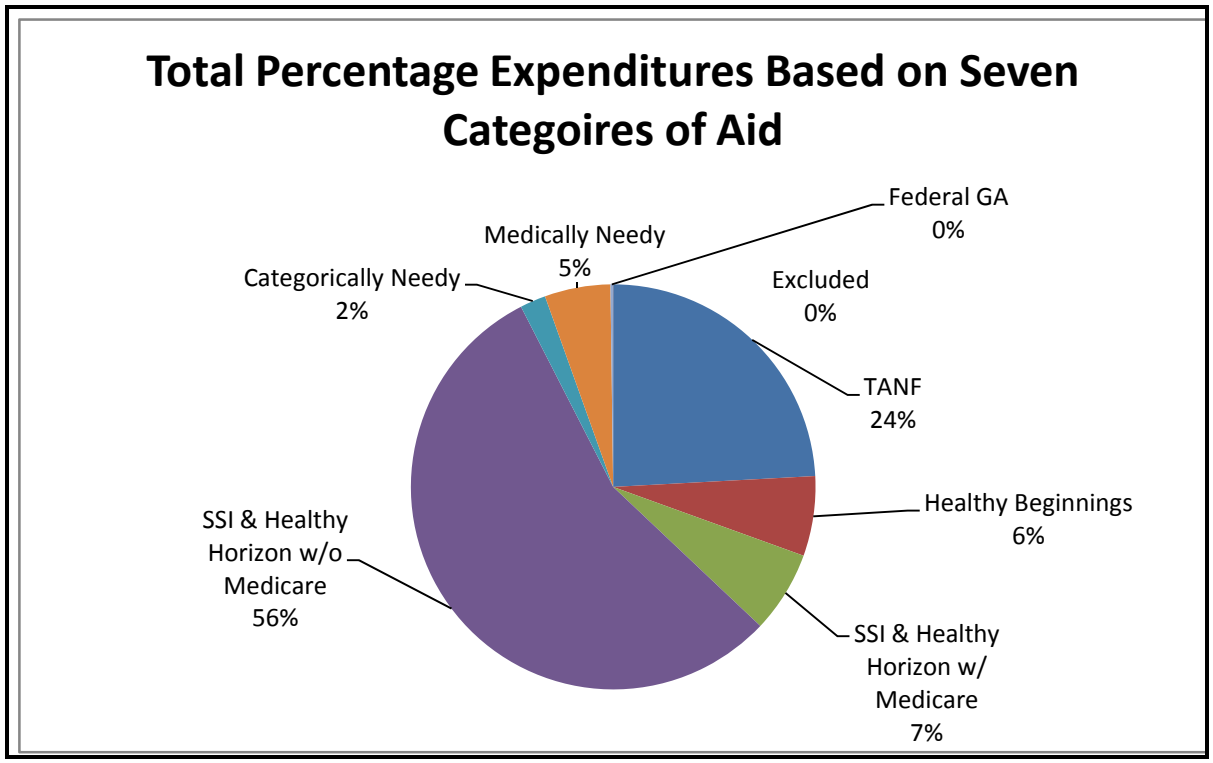
positive outcome for 2010. No problems or concerns were voiced by the committee or CABHC's board about CBHNP's solvency.

HealthChoices Program – Financial Performance

The financial solvency of the HealthChoices Program is closely monitored through reviewing medical expenses for the Territory via the Surplus/Deficit Report prepared by CBHNP's contracted actuary. Also, CABHC's actuary, Compass Health Analytics, provided quarterly risk reports for the bank, and certifies the IBNR estimates that are reported to OMSHAS on the quarterly financial reports. Information is analyzed by County, by month, by dollars, and by cost on a per member per month (PMPM) basis.

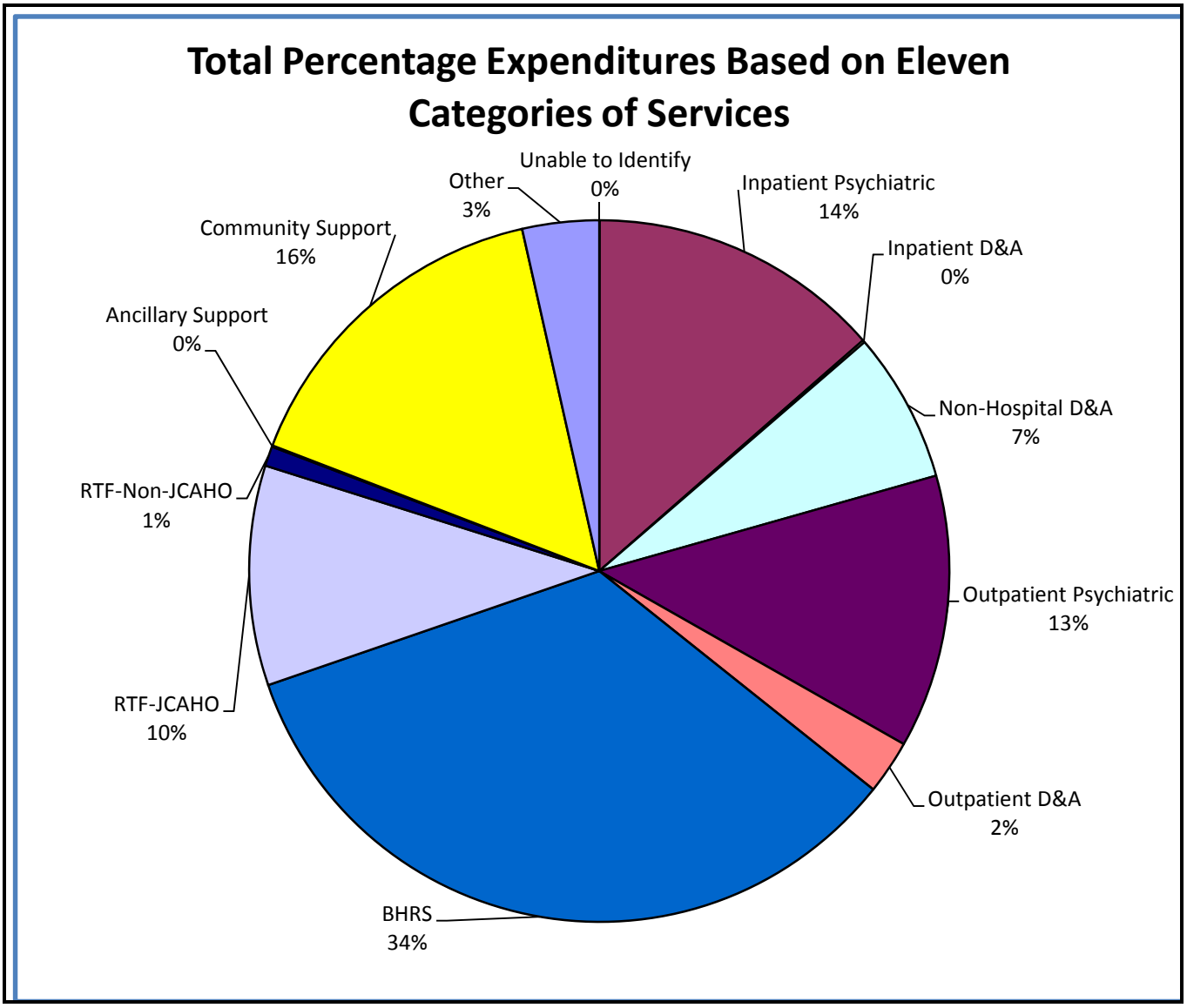
The division of medical expense percentages between the seven categories of aid is presented in Figure 3.

Figure 3: Total Percentage of Expenditures Based on Seven Categories of Aid



Likewise, the percentage of medical expenses between the eleven categories of services is presented in Figure 4.

Figure 4: Total of Expenditures Based on Eleven Categories of Services



During FY 2009-2010, the HealthChoices medical capitation revenue paid by DPW to the Counties' HealthChoices Program exceeded medical expenses. This allowed the Counties to provide Provider rate increases during the contract year, increase risk and contingency reserves, and continue reinvestment services as well as begin the process to develop a new reinvestment plan.

The Binkley-Kanavy Group conducted an audit of various aspects of the HealthChoices Program which included claims processing, MIS/encounter data reporting, MCO subcontractor incentive arrangements, and financial management and reporting for Fiscal Year 2009-2010. The year-long audit included quarterly claims data testing, an annual trip to each County, and several visits to CBHNP. The Binkley-Kanavy Group issued an opinion that the financial schedules were presented fairly, in all material respects, in conformity with accounting

principles prescribed by the Commonwealth of PA, Department of Public Welfare. The Binkley Kanavy group found not reportable findings.

CONCLUSION

This Annual Report provides a detailed summary of the accomplishments achieved by CABHC during CY 2010. These results could not have been achieved without the collaborative effort between CABHC, the Counties, CBHNP and our stakeholders. The results shown in this report highlights our success to provide our Members with the best possible network of providers that offer quality services that are readily accessible.

The fact that this HealthChoices Program is exceptional is attributed to the hard work and dedication of the CABHC and County staff, the commitment of CBHNP, the stakeholders and the network of providers.

Although many achievements have been reported for CY 2010, many challenges lie ahead in the coming year. Many of the areas highlighted in this report will be the foundation for work in CY 2011. They will provide the springboard for continued improvement in all services, provide the impetus for improved quality, and serve as the focus for new initiatives to more effectively serve our Members.

This report would be remiss, if it did not include a note of deep appreciation to all of the CABHC staff who has worked diligently to make 2010 an excellent year.

APPENDIX

List of Tables

List of Figures

Web Sites

Consumer Satisfaction Services, Inc., 4775 Linglestown Road. Building 1, 2nd Floor, Harrisburg, PA 17112, www.css-pa.org

Community Behavioral Health Network of Pennsylvania, Inc. (CBHNP), 8040 Carlson Road, PO Box 6600, Harrisburg, PA 17112 www.cbhnp.org

Department of Public Welfare, Office of Mental Health and Substance Abuse Services. http://www.dpw.state.pa.us/dpworganization/officeofmentalhealthandsubstanceabuseservices/index.htm

CABHC STAFF

Scott Suhring	Chief Executive Officer
Melissa Raniero	Chief Financial Officer
Judy Goodman	Executive Assistant
Deborah Allen	Clinical Director
Aja Orpin	Receptionist/Administrative Assistant
Akendo Kareithi	Accountant
Lynn Novakoski	Member Relations Specialist
Jenna O'Halloran-Lyter	Children's Specialist
Denise D'Addario	Provider Network Specialist
Joe Mills	Quality Assurance Specialist
LeeAnn Edelman	Drug & Alcohol Specialist

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Jack Carroll - Cumberland/Perry Co.	Becky Mohr - Lancaster Co. MH/MR
Robert Count - Lebanon Co. D&A	Lynn Novakoski - CABHC
Jamie Davis - CRME	Jenna O'Halloran-Lyter – CABHC
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Lois Harding - CFFC	Jonathan Sailor - CFFC
Holly Leahy - Lebanon MH/MR/EI	Vivian Spiese - CFFC
Tonya Long - CFFC	Anita Thiemann - OMHSAS

Natasha Lugaro - PRO-A	Denise Wright - CFFC

Peer Support Services Steering Committee

Chris Bilger– Certified Peer Specialist	Doug Smith – Certified Peer Specialist
Diana Fullem – CST of Lancaster Co	Greg Snyder – Lancaster Co. MH/MR/EI
Laura Jesic – STAR	John Stygler – Lancaster Co. MH/MR/EI
Frank Magel –Dauphin Co. MH/MR	Annie Strite – Cumberland/Perry MH/MR
Kim Maldonado – The Dauphin Clubhouse	Scott Suhring – CABHC
Lynn Novakoski, CABHC	

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Kim Biggs – Lebanon Co. MH/MR/EI	Joe Mills – CABHC
LeeAnn Edelman – CABHC	Lynn Novakoski – CABHC
Dan Eisenhauer – Dauphin Co. MH/MR	Jenna O'Halloran-Lyter – CABHC
Judy Erb – Lancaster Co. MH/MR	Matt Rys – Lebanon, Co. D&A OMHSAS Representative
Cheryl Floyd – PRO-A	Rose Schultz – Dauphin Co. MH/MR
Silvia Herman – Cumberland/Perry MH/MR	Helen Shuman,
Denise Holden - RASE	Rhonda Slinghoff – Lancaster Co. MH/MR

Megan Johnston – Cumberland/Perry MH/MR

Christine Kuhn – Lancaster Co. MH/MR

Holly Leahy – Lebanon Co. MH/MR/EI

Kelly Walters, OMHSAS Representative

Vivian Spiese – NAMI, Lancaster Co.

Robin Tolan – Cumberland/Perry MH/MR

Denise Wright – Member

Provider Network Committee

Denise D'Addario – CABHC

Rick Kastner – Lancaster Co. D&A Commission

Holly Leahy – Lebanon Co. MH/MR

Frank Magel – Dauphin Co. MH/MR

Becky Mohr – Lancaster County

Evelyn Reese – Cumberland/Perry D&A

Scott Suhring – CABHC

Denise Wright – CFFC Representative

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