CAPITAL AREA BEHAVIORAL HEALTH COLLABORATIVE, INC.

*Established October 1999*

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# CONTINUOUS QUALITY IMPROVEMENT PLAN 2011

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Capital Area Behavioral Health Collaborative, Inc. (CABHC) is a jointly governed, not for profit business produced out of the partnership among Cumberland, Dauphin, Lancaster, Lebanon, and Perry Counties (Counties) to administer and manage the HealthChoices Behavioral Health Program (Program) contracts for the five member Counties. CABHC also directs the behavioral healthcare contract with the Counties' managed care partner, Community Behavioral HealthCare Network of Pennsylvania (CBHNP). CABHC is under the direction of a Board of Directors composed of county commissioner appointed directors, with each County designating one individual representing Mental Health and one individual representing Drug and Alcohol.

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 territory*.

The Continuous Quality Improvement Plan (CQIP) is a document that identifies key areas that will be monitored by CABHC. It is further designed to outline the content areas which will be the focus in the Annual Report including State measures, initiatives, outcome measures, consumer satisfaction and overall compliance of CBHNP and the Program in adhering to the Program Standards and Requirements. The CQIP provides a systematic, structured approach to the ongoing monitoring, analysis and expansion of the Program, including Member care and stakeholder satisfaction. The CQIP also provides a brief abstract of specific objectives that will be implemented as priorities for CY 2011.

## CHILDREN'S SERVICES

CABHC is committed to assuring access to quality services for children and adolescents throughout the Counties. CABHC strives to form new, integrated partnerships across child serving systems to reduce duplication and increase responsiveness of services to families and their children, including coordination with early intervention and early childhood care and education programs. It is these Members which account for almost 86,000 of Medical Assistance Members, and nearly 70% of all HealthChoices expenditures in the Counties. These Members often present with the most multifaceted symptoms and needs for services across numerous systems of care. CABHC continues to support an array of initiatives to enhance access and delivery of services to children.

### Priorities for Children's Services for 2011

*1. Summer Therapeutic Activities Program (STAP)*

Summer Therapeutic Activities Program (STAP) is a service that applies group treatment as a method to deliver medically necessary mental health treatment. It is designed for children and adolescents under age 21 and provides a range of specialized therapies which may include art, music, dance and movement, play, recreational or occupational therapies, and/or therapeutic

activities, which may include more traditional structured therapeutic group activities, in a group format. These groups are designed to assist in the development of interpersonal relationships, daily living, decision-making, problem-solving and coping skills for children and adolescents meeting medical necessity.

A STAP workgroup was developed through CABHC's Clinical Committee in order to better evaluate this program. The workgroup was composed of representatives from the Counties, CABHC, CBHNP, school districts, Providers, and parents. The major change, based on the workgroup's feedback from the 2010 STAP session, was to alter the start time of STAP so that children could benefit from both the Extended School Year (ESY) and STAP.

STAP has been a significant service to children and their families; therefore as part of our 2011 objectives, CABHC will focus on Providers demonstrating outcome measures to show that STAP has merit and is extremely helpful in transitioning back to school, as well as demonstrate that children are retaining the skills they have learned. We will also be developing outcome measures which separate ASD vs. non-ASD children. Outcomes for non-ASD youth include review of service utilization pre and post STAP to distinguish if STAP was effective in helping children retain skills. CABHC encourages Providers to have a larger focus on community integrated activities. Another outcome that CABHC will review is the choice of settings for the STAP program, particularly utilization of community camps. CABHC will also assess STAP utilization and whether Members who attended STAP in the summer utilized ESY as well. At the conclusion of STAP 2011, the workgroup will reconvene to evaluate the success of the program, Provider outcomes, and address other changes that may be needed for 2012.

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

Behavioral Health Rehabilitation Services (BHRS) provide therapeutic and behavioral treatment interventions for children under age 21. Services are authorized based upon medical necessity. The goal is to diminish or substitute problem behaviors with positive, socially appropriate behaviors, as well as to support the family's movement toward the utilization of a less intensive treatment modality, and increase their use of family and community for ongoing support. All services, with the exception of the evaluation process, are provided in the home and community to include: school, day programs, after school programs, and other community settings. The BHRS model promotes ongoing collaboration between family, Providers, and systems across all settings for the duration of treatment.

In order to address the clinical challenges faced by BHRS Providers, *The BHRS Best Practice Workgroup* developed the Best Practice Guidelines. This is a qualitative set of standards expanding on the existing regulations, and encompassing OMSHAS directives, CASSP best practice recommendations, published best practice guidelines utilized by other professional organizations, academic reviews of literature, and extensive HealthChoices Provider input. The purpose of the Best Practice Guidelines is to create a framework of recommendations for systematic clinical decision making. This document was completed in December 2010 with the target date to present it to OMHSAS in early spring 2011. If the OMHSAS review requires more modification of the document, the workgroup will reconvene to make revisions. The goal is to monitor the implementation of these guidelines and set up a monitoring system to assess their impact.

*3. The Functional Behavior Assessment (FBA) Workgroup*

In response to national and statewide interest in implementing evidence based treatment in the mental health field, A *Functional Behavior Assessment (FBA) Workgroup* formed with the task to develop a best practices guideline for the FBA. The workgroup was composed of CBHNP, CABHC, Providers, Family Representatives and Counties to ensure that all parties were in agreement with the design and content of the document.

The overall goal of developing such guidelines is to support providing the child/family to identify the best BHR Services 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 are intended to incorporate 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. This systematic approach allows an opportunity to ensure the utmost quality of care is provided to Members, and to fully take into account the integration of FBAs into our existing systems of care.

The document was completed in May 2010. It will be presented to OMHSAS in the early spring of 2011 and it is anticipated that once the guidelines are approved, CABHC will monitor their implementation. The goals for 2011 are to monitor the inclusion of FBA in treatment plans and to evaluate their impact on treatment utilization; CABHC will also monitor the inclusion of FBAs into CBHNP's BHRS performance standards.

*4. The Residential Treatment Facility (RTF) Workgroup*

*The RTF Workgroup* was developed out of CABHC's Clinical Committee. One major accomplishment in 2010 includes the development of a completed Community Residential Rehabilitation-Host Home (CRR-HH) Therapeutic Vacation Policy. This was approved in September 2010 by OMHSAS. A second accomplishment was the JPO and C&Y informational sessions presented by CBHNP staff. The presentations include 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.

Focus areas for 2011 include changing the ISPT process to occur prior to an evaluation. The workgroup recommended changing the ISPT meetings to take place before an evaluation is conducted for out of home placements. This way, the treatment team input and recommendations get to the evaluator prior to the evaluation.

The RTF workgroup has also been composing methods to overcome barriers to discharge from both CRR-HH and RTF levels of care. Counties are sent lists from CBHNP via CABHC of Members who are either in CRR-HH or RTF. The list was initially created to monitor RTF admissions and barriers to discharge from RTFs. Through time the list has expanded to include CRR-HH admissions. The focus of the RTF workgroup has been to discuss the barriers to successful discharge by increasing collaboration between Counties and CBHNP. 2011 goals include CABHC's monitoring of the lists to identify trends in CRR-HH and RTF utilization.

Barriers to discharge will be analyzed in detail, with the results shared with the Counties quarterly.

*5. Therapeutic Staff Support (TSS) Schedule Implementation*

In 2009, an initiative was implemented to reorganize how TSS services are managed and delivered. This was driven by concerns raised by various stakeholders regarding the management and delivery of TSS services. As a result of this process, a new TSS Schedule program model was developed by a Stakeholder Workgroup which was then approved by OMHSAS in November 2009. This past year, it was the objective of CABHC to work with CBHNP and the Counties to implement this new program model and to monitor the efficacy of its objectives. 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. Due to continued confusion and concern, it was decided in November 2010 to form the BHRS and Evaluator TSS Scheduling Workgroup which included CABHC, CBHNP, Counties, and Providers where discussion was addressed in making this tool more Provider friendly. This group was not focusing on outcomes per se, but rather the procedural aspects of using the schedule, concerns Providers are experiencing and also what Providers have learned that is useful and beneficial regarding the schedule. As a result, CBHNP will provide TSS Schedule training to BHRS Providers, Evaluators, and TCM Providers. During 2011, CABHC will review the effectiveness of TSS Scheduling with TSS service utilization and delivery.

*6. Multidimensional Treatment Foster Care (MTFC) Implementation Team*

MTFC is a cost-effective 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. The MTFC treatment model can be implemented by providing services to children with serious behavior problems and their families.

The MTFC Implementation Team is comprised of CBHNP, CABHC, Children's Home of Reading (CHOR), Dauphin County Mental Health Staff, Dauphin County CYS and JPO, as well as Cumberland County Mental Health, JPO, and CYS. Their initial meeting took place in April 2010, where the focus centered on discussion of the program description, the timeline for program implementation, CHOR's activities surrounding advertising, and CHOR's training JPO and CYS staff regarding MTFC. CHOR began marketing in June 2010, and the goal for 2011 is for CHOR to have MTFC up and running in Cumberland and Dauphin counties. During 2011, CABHC will monitor the progression of this service and it effectiveness with participating families.

*7. Efficacy of Children and Adolescent Services*

In an ongoing attempt to monitor the efficacy of children and adolescent services, CABHC composed a report, *BHRS After 18 Report* which 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 BHR service. 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 BHR services most often.

When considering Members still receiving BHR services who do not have an Autism Spectrum Diagnosis, the data provided some contradictory evidence to the assumption that children and adolescents "age out" of BHR services once they are no longer school age. This population should be more closely monitored to determine why they continue to need BHRS and what benefits they are experiencing. For 2011, CABHC will be reviewing the impact services have on transition aged youth, services they are receiving, monitoring the expansion of services for both youth and adults, and evaluating the utilization of other services by 18-21 year old Members.

## PHYSICAL HEALTH/BEHAVIORAL HEALTH (PH/BH)

The PH-BH Workgroup was developed out of CABHC's Clinical Committee, and commenced on October 19, 2010. This is a group of nine individuals composed of CABHC, CBHNP, Counties, and individuals in recovery. 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 behavioral and physical well being and overall recovery of HealthChoices Members.

The 2011 goal for this initiative is to encourage the development of pilot projects in the Counties, and then, monitor their benefit for HealthChoices Members.

## PEER SUPPORT SERVICES (PSS)

Peer support for individuals with similar life experiences has proven to be tremendously important toward 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 reinforce that recovery is possible and provides a very strong message of hope for the peer, family, and other Providers on the team. PSS can assist individuals rebuild their sense of community when they have had a disconnecting experience.

CABHC is committed to maintaining the growth, development, and success of PSS through its support of the Peer Support Services Steering Committee (PSSSC).

**PSSSC Priority Goals for 2011**

*1. Expansion of Billable Services*

Peer Support Services were added in November 2006 as covered services for adults aged 18 or older who have a serious mental illness and for others by exception. As of January 1, 2010, Peer Support Services provided via telephone are reimbursable in Medical Assistance (MA) Fee-for-Service and HealthChoices programs. This expansion of billable services was a result of strong advocacy by Certified Peer Specialists, Providers, Pennsylvania's Community Provider Association (PCPA), and many others. During the coming year, CABHC will encourage the PSSSC to explore additional ways to expand billable services and to increase the number of Members using PSS. During 2011, CABHC will continue to monitor the expansion of billable services. In addition, CABHC will sponsor a PSS certification training session in the Counties. This will increase the number of Certified Peer Specialists available for employment to providers, which will expand the system capacity to serve more Members.

*2. Retention of Certified Peer Specialists*

There has been an ongoing interest by the PSSSC in reviewing turnover rates. During 2010, this committee utilized the 2009 survey on retention of CPS to conduct further analysis of the retention of CPS. The PSSSC examined different PSS models that may render better retention rates. The committee will continue their focus related to CPS retention in 2011. CABHC will continue to provide support to the PSSSC as they develop new, innovative ways to increase the retention of CPS.

*3. Peer Support Services Website Page*

The Peer Support Services page on CABHC's website was completed in July 2010. Areas that are monitored each month include Peer Support Provider Job Posting Requests, as well as Peer Specialist Registration approvals. For 2011, CABHC will closely monitor matches that are made between Providers and Peer Support Specialist, and this will be reviewed at the Certified Peer Specialists Steering Committee and then reported to the Consumer Family Focus Committee (CFFC) on a bi-yearly basis.

## 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 Family Focus Committee (CFFC) is no exception, and includes stakeholders in this process.

During 2010, the CFFC accomplished a number of goals toward the recruitment of Members to serve on committees and to provide educational opportunities for its Members. Among their accomplishments for the recruitment of Members was the development of a smaller workgroup

that conducted presentations to local Clubhouses, drop-in centers, and psychiatric rehabilitation programs. Through these efforts five individuals were recruited to participate on various committees and workgroups.

In addition, six educational presentations were offered during CFFC meetings. These topics focused on various issues in order to provide information that would be helpful in educating committee participants. The presentations comprised of a broad range of topics around Understanding Autism, Addiction/Recovery, Lancaster County Mental Health Court System, and Dauphin County Mental Health Disposition Programs. CABHC's priorities for 2011 include providing ongoing support so that CFFC is able to accomplish its goals of additional Members serving on committees.

**CONSUMER SATISFACTION SERVICES**

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 to reveal whether they are being provided behavioral health services that are high quality, culturally sensitive and effective. Additionally, CSS seeks to ensure consumers of these services have a strong voice in evaluating the services that are being provided. CSS is a consumer-driven and consumer-operated organization.

During CY 2010, CSS underwent internal reorganizaiton 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, and CSS has also completed more face-to-face suveys than in previous years. In order to ensure continued performance, CABHC developed a corrective action plan to monitor CSS performance.

The System Improvement Committee (SIC), composed of CABHC, CBHNP, CSS, the Counties, consumers, family members and persons in recovery was formed to discuss system or global issues that are identified by Members as part of their responses to satisfaction surveys. The committee will discuss these issues and when appropriate, develop action steps that are intended to help alleviate such issues.

A recent issue identified was a need for better discharge planning. Stakeholders of the SIC are interested in readmission and what steps can be taken to minimize hospital readmissions. In order to address this concern, the SIC requested that CSS develop and administer a survey in 2011.

Throughout 2011, CABHC will monitor CSS's performance as a result of changes they have implemented and will review the satisfaction survyes to ensure that they meet C/FST requirements. Additionally, CABHC will monitor the development and implementaion of the speical survey, review the findings and report those findings to the SIC and the Board.

## PROVIDER RELATIONS

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; developing and monitoring annual Provider satisfaction surveys; monitoring CBHNP Provider profiling reporting including identification of Best Practices; and monitoring CBHNP Credentialing Committee activity.

### Priorities for Provider Relations for 2011

*1. Service Access Standards*

The Provider Network Committee facilitates collaboration with the Counties and CBHNP in the continued assessment of network capacity through outreach to potential new Providers and expansion of services with existing Providers. CABHC reports annually to OMHSAS the status of the CBHNP Provider network in relation to HealthChoices standards of maintaining choice and timely access to in-plan 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 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. Any required access standard exception requests for fiscal year 2011-2012 will be submitted to OMHSAS by June 2011.

*2. Provider Profiling & Performance*

CABHC continues to monitor CBHNP's Provider profiling. This is an ongoing process that results in identifying capacity and network needs, educating and providing feedback back to Providers, as well as providing data in areas such as readmission rates, claims denials for non-administrative reasons, complaints and grievances.

As a part of the profiling process, the Provider Network Committee, in conjunction with CBHNP, is evaluating updates to CBHNP's Provider performance tracking and reporting system. It is anticipated that this will lead to upgrades in the Provider profiling system early in 2011. The

upgrades will include performance indicators for the assessment of co-occurring disorder competency, appropriate aftercare planning, coordination of care, and timeliness of submission of treatment information. During 2011, the CABHC Provider Network Committee will utilize the CBHNP report data to evaluate the upgraded profiling measures used by CBHNP. The upgraded profiling system will be used as a tool by CBHNP to hold Providers accountable for their performance.

*3. School Based D&A OP 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 and the School-based D&A Workgroup is to assist in the development and monitoring of school-based drug and alcohol outpatient services as a HealthChoices Supplemental Service. This will include monitoring of CBHNP outreach to Providers to offer this service, and to increase community awareness in order to create referrals and effective utilization of this service. The service began in the fall of 2010 with two Providers (Diakon Family Life Services and Gaudenzia West Shore). Utilization reporting will be monitored by the Committee. Additionally, School Based D&A OP Services is a recommendation in the Performance Incentive Plan to Improve Access for Youth Receiving Substance Abuse Services which is monitored quarterly by CABHC.

The workgroup discontinued official meetings in October 2010, after the above goals were accomplished and Supplemental Provider Enrollment Applications were submitted to OMHSAS on behalf of the existing school based Providers in the Territory. 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. During 2011, school based services will be expanded with the addition of at least one additional Provider.

*4. Network Development*

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. CABHC monitors the utilization and effectiveness of new MA services.

In January 2011, Members will be offered telepsychiatry as a new service in Dauphin, Cumberland, and Perry Counties. 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 quality psychiatric evaluation and medication management. CABHC's 2011 goal is to monitor the effectiveness of Telepsychiatry services. Monitoring will include distinguishing if there is increased psychiatric time and improved access to psychiatric services. CABHC will work with CSS to identify and compose a satisfaction survey for individuals who used Telepsychiatry to see if they were satisfied with this service in 2011.

*5. Assertive Community Treatment (ACT)*

In 2010, CABHC began the process of bringing Community Treatment Team (CTT) services into compliance with the 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 June 2010, CABHC convened an ACT workgroup consisting of CABHC, Counties, and Providers. The workgroup began developing five outcomes measurements in the areas of vocation and education, community, housing, readmissions, and legal involvement which will be used for these programs beginning in July 2011. CABHC will conduct annual monitoring site visits to Providers using the TMACT for monitoring fidelity in 2011. CABHC will also evaluate the results of the outcome measures used by the ACT Providers.

## 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.

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 the HealthChoices Program start up, the CABHC Board evaluated the continued need for a standing MIS Committee. As a result, the Board decided the MIS Committee would cease and disband, and was not needed as a standing committee. 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 Members to reconvene if any pertinent matters arise that would warrant more technical advice. Goals for 2011 include CABHC contracting with offsite storage of servers, as a backup system, which is targeted for January 2011. Other goals include monitoring of ACA's Performance Objectives and developing a CABHC disaster plan. CABHC will also redesign the website which is targeted for completion in February 2011.

## FISCAL STABILITY

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

Throughout 2010, financial solvency of HealthChoices and CBHNP was maintained through monitoring financial reports and reviewing them with the CABHC Finance Committee and CABHC Board of Directors. CABHC additionally reviews the Capital Region and Consolidated CBHNP Financial Statements.

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

## CABHC Financial Priorities for 2011

*1. Financial Solvency*

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

*2. Financial Reporting to OMHSAS*

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

*3. Monitoring of Reinvestment Programs*

A plan to monitor the fiscal payments for Reinvestment Programs was discussed, and policies and procedures are in the planning phase. The goal will be to implement and begin the monitoring process in detail throughout 2011. This monitoring was recommended by the HealthChoices auditors. Further, the goal is to work collaboratively with other CABHC committees to develop a plan that would determine if Providers are providing the contracted services and if they are achieving the stated outcomes.

*4. Monitoring of Behavioral Healthcare Expenses*

CABHC will monitor the Behavioral Healthcare expenses for the HealthChoices Program to determine actions that may need to be taken in a surplus or deficit situation. This will be ongoing throughout 2011. This will include the need to shift risk reserve funds to pay claims, assuring that the equity reserve meets minimum standards, that all reporting required by the bank for the Letter of Credit are maintained and designation of potential clams surplus is tracked for Board action.

*5. CABHC Financial Position*

Monitoring and reporting on the financial position of CABHC is key to assuring CABHC maintains a strong financial position. The Fiscal Committee will review monthly CABHC's Financial Statements to determine solvency and compare administrative budget to actual expenses and revenues. All findings will be reviewed and presented at the Board's monthly meetings.

## PERFORMANCE IMPROVEMENT PROJECTS (PIP)

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

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

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

The second PIP report is to Increase the Rate of Follow-Up after Hospitalization for Mental Illness. Overall, the data during CY 2010 has shown a slight decline in the Territory rates, from the CY 2009 data. CBHNP conducted a Root Cause Analysis of this PIP and has established short and long term goals for the four indicators. The PIP is then submitted to IPRO, who is the independent external quality review agent for Pennsylvania's Department of Public Welfare. Prior to its submission to IPRO, CABHC has analyzed and reviewed the final Root Cause Analysis (RCA) addressing the Rate of Follow-up after Hospitalization. The Root Cause Analysis was approved by IPRO, and the impact of the interventions will be followed by CABHC during 2011.

**Objectives for 2011 PIP Reports:**

*1. Objective for Youth Receiving Substance Abuse Services*

CABHC will meet quarterly with CBHNP's QI Department to review the Objective for Youth Receiving Substance Abuse Services to evaluate the quarterly results and to ensure that the data, the analysis, and the interventions are based on the data results. The objective is that each County meets or exceeds the HealthChoices Average of 1.54% this year. CABHC will monitor the implementation and results of CBHNP's Corrective Action Plan as identified in the Root Cause Analysis.

*2. Increase Rate of Follow-up after Hospitalization*

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

The short term goals in the RCA for this PIP are that the four quality indicators (QI) improve as follows: QI 1 (HEDIS) 7-day follow-up after discharge and QI B, 30 day follow-up, each improve 10% and that QI 2 (PA Specific), 7 day follow-up improves 5%.

CABHC will meet regularly with CBHNP's QI Department to review and analyze CBHNP's implementation of the Root Cause Analysis for Follow-Up After Hospitalization for Mental Illness, and its impact on the follow-up rates.

## 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. CABHC monitored all activity of the CBHNP 2010 Action Plan. Highlights for 2010 included:

1. Changes in practice so all clinical information for prior authorization of any higher level of care is gathered by a Clinical Care Manager 24/7.
2. Ensure adequate care management resources are available by review of caseloads to hire needed UR & Children's Care Managers, identification and management of quality of care concerns.
3. Revise Staff to Physician Consultation Event and the Peer to Peer Event in the eCura system.
4. Additionally, CBHNP targeted steps to "Increase active care management". These included additional children's services Provider trainings to address: Provider performance monitoring to include additional clinical information in treatment plans, and incorporation of recovery and resilience in assessments and treatment plans.
5. Encourage increased school involvement with delivery of ASD services and address discharge planning in treatment that includes a plan to transfer skills to school staff.
6. Several system level initiatives were identified: more effective monitoring of crisis system to identify consumers who frequent crisis services; develop coordinated Provider development and CCM monitoring for children with ASD to ensure network compliance with inclusion of FBA in treatment plans and updates.

### Objectives for PEPS Monitoring for 2011

*1. Monitor PEPs CAP Monitoring Plan*

Complete all monitoring activities as identified in the PEPS CAP Monitoring Plan. A number of initiatives in the CBHNP 2010 Action Plan are on-going or have completion dates in 2011. CABHC will continue to monitor all activities related to the action plan.

CABHC will conduct all identified monitoring activities per the monitoring plan and report the findings to CBHNP, OMHSAS, and CABHC's Board of Directors at least quarterly. If CBHNP is not achieving the stated goals, CABHC will discuss with CBHNP any further action that may need to be taken to assure CBHNP completes all objectives in the CAP.

## REINVESTMENT

Reinvestment Projects are developed from available 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.

### Priorities for Reinvestment Projects for 2011

*1. Respite Care*

On June 14th, 2010, Youth Advocate Programs, Inc. (YAP) submitted a proposal in response to the RFP composed by CABHC and CBHNP requesting a new Provider to manage the Respite Management Agency (RMA). On June 25th, 2010, YAP was selected as the new Provider for the Respite Management Agency. They began management of the Respite Program on September 1, 2010.

During the past four months, CABHC has directed YAP in the following areas that have been proven accomplishments. During this time, YAP has developed policy and procedures, recruited new Providers, and connected to a variety of respite Providers and organizations as a way to network and gain additional knowledge in respite services.

Looking ahead to 2011, CABHC will monitor YAP's efforts to contract with additional Providers, expand services to include the adult population, develop direct contracts with family members and neighbors who could provide respite care, and their development of marketing materials. In addition, CABHC will monitor all respite outcomes of Members utilizing respite services. The results will be discussed monthly with the Respite Committee, and be presented to the Clinical Committee on a quarterly basis.

*2. Specialized Transitional Support for Adolescents*

NHS Stevens Center and The Jeremy Project (Joint Efforts Reach & Energize More Youth) provide the Specialized Transitional Support Program for Adolescents serving Members in Dauphin, Cumberland, and Perry Counties. Support is provided to adolescents ranging from sixteen (16) to twenty-one (21) years of age and focuses on areas such as employment, education, housing, and community life.

Individuals who succeed and/or graduate from these programs should be better equipped to handle their life needs, and will hopefully become productive citizens. During 2011, CABHC will monitor the programs' development of personal outcome measures for their participants, and the tracking of claims data that could illustrate that successful participants have a reduced need for services.

CABHC will monitor the Jeremy Project's goals to reduce the waiting list and expand employment opportunities for participants who are prepared for work through their networking with AHEED. CABHC will monitor NHS's 2011 Program goals in increasing program

attendance and networking so they may be able to obtain more referrals for the program. In addition, CABHC will monitor both programs' goals related to Member outcomes.

*3. The Recovery House Scholarship Program*

Upon completion of D&A non-hospital rehabilitation or halfway house treatment services, some individuals may require transitional housing services that are specifically designed to support their recovery. CABHC's Recovery House Scholarship Program provides scholarships to individuals from Cumberland, Dauphin, Lancaster, Lebanon, and Perry Counties who require financial assistance to enter a Recovery House as part of their journey of recovery from substance abuse. This may be because someone is homeless, or because their previous living arrangement would undermine recovery to abstain from drug and alcohol use. CABHC can provide scholarships to fund up to two (2) months' rent (not to exceed $300/month) for persons who qualify for this program to move into a Recovery House that participates with this program.

To assure certain standards of quality, Recovery Houses interested in serving individuals receiving scholarships from this program must submit a written application and complete a site visit conducted by CABHC staff. As of the end of October 2010, 20 agencies from both within and outside of the five county area are participating in the Recovery House Scholarship Program. Many of these agencies operate numerous sites throughout the area, affording those in need ample opportunity for housing assistance. CABHC maintains a directory of Recovery House facilities on its website to keep substance abuse (SA) Providers up to date with available Recovery Houses.

In 2011, CABHC will focus on collecting and analyzing data related to grant expenditures, and present its findings quarterly to the CABHC Clinical Committee and the CABHC Board of Directors. CABHC will monitor the Member outcomes by reviewing and analyzing data collected on Scholarship recipients from the participating Recovery Houses. It is expected that this will assist us in identifying ways to continue providing aid when available to this population. CABHC looks forward to continuing to assist those in need of this support throughout the next year.

*4. 2009-2010 Reinvestment Plan Development*

The Reinvestment Plan Development Workgroup met on December 21, 2010 and will meet again on January 21, 2011. The task of this group is to brainstorm ideas as we develop the 2009-2010 reinvestment plan (Plan) that will designate how we expand services using funds retained from our 2009-2010 HealthChoices Behavioral Health Program contract year. This group will make the final recommendation for Board action on how we can best invest the reinvestment funds. The plan is due to OMHSAS by the end of March 2011.

## CONCLUSION

Each year encounters various visions and challenges ahead. Together, the *Continuous Quality Improvement Plan* and the *Annual Report* outline and identify the success of the program. CABHC will persistently monitor, and collaborate with distinctive organizations, agencies and systems of care to meet the needs of its Members. Our priorities for the upcoming year accentuate innovation in service delivery based on ongoing monitoring to ascertain the continued stability of the Program. The results of these goals stated in this Annual Plan will be revisited and reported as part of the 2010 Quality Improvement Annual Report. Our priorities for the upcoming year emphasize further innovation in service delivery balanced by ongoing monitoring to ensure the continued stability of the Program. Our success depends upon our ability to collaborate within our own organization and with other individuals and agencies vested in the care of our Members. We have engaged county government with the private sector behavioral health care industry, while also including stakeholders in our growth and development of the Program. We have developed a competent, locally managed Medicaid Behavioral Health Program that supports recovery and resiliency while moving services to be more accountable and outcome focused. We extend our appreciation to all those who have embarked upon making HealthChoices a success within the Capital Region and we look forward to continuing our work collectively in the year ahead.