CAPITAL AREA BEHAVIORAL HEALTH COLLABORATIVE, INC.

Established October 1999

2011

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 **2011 Annual Report** reflects the status of the Capital Area Behavioral Health Collaborative (CABHC) has shown in the Continuous Quality Improvement (CQI) Plan for Calendar Year (CY) 2011. There are two major headings in this year's report: **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 2011 Annual Report represents the fifth 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 2011 are as follows:

CLINICAL SERVICES

The **Children's Services** is committed to the services for children and adolescents. Children and Adolescent Members make up over 50% of the total number of Members and accounts for 64% of all HealthChoices medical claims expenditures in the five counties. CABHC continued to review the **Summer Therapeutic Activities Program (STAP**) comparing STAP 2010 to 2011 finding that the majority of individuals utilizing STAP were 06-12, with 13-17 representing the next highest. It was noted that in the 18-20 age range, only those with an Autism Spectrum Disorder participated. The **Best Practices Work Group** continued to review the BHRS Best Practice Guidelines (BPG), which included considerations for Members who have been impacted by an ASD. The BPG are being incorporated into the CBHNP BHRS Redesign which will be completed next year. The **Functional Behavior Assessment (FBA) Workgroup** oversaw the development of a Quality Audit tool to assist in the rating of critical components of FBA's and to assess the overall quality of FBA's.

The **Residential Treatment Facility (RTF) Workgroup** focused on two additional programs: Community Residential Rehabilitation – Intensive Treatment Program (CRR-ITP) and a Short Term Residential Treatment (STRT). The CRR-ITP will serve youth (5-21) who have severe emotional and behavioral disturbances. The STRT will provide services for youth (11-21) who have had multiple treatment placements and have experienced problems over a variety of life domains. The Children's Home of York (CHOR) is the provider of the **Multidimensional Treatment Foster Care (MTFC**) services. In August, CBHNP approved the first referral for MTFC services. Services in Cumberland and Dauphin Counties continue to be developed. CBHNP conducted a study on the **Efficacy of CBHNP's Treatment Planning** to evaluate CBHNP's review of the quality and appropriateness of initial BHRS treatment plans. CABHC conducted data analysis on treatment plan scores before and after the training to assess the overall impact of the training on treatment planning scores. It was CABHC's assumption that the scores would improve after the training, thereby verifying the trainings value. CABHC analysis of the audit scores found that although the scores generally remained lower than anticipated, the end result was collaboration between CBHNP, Providers, and CABHC leading to system improvements which enhanced service to our Members.

CBHNP conducted a random review of the CBHNP treatment plan record review audits and found that scores improved over time.

The **Peer Support Services (PSS)** program was bolstered this year when CABHC sponsored certification training in August with eight new Certified Peer Specialists registering on the website. CABHC will continue its ongoing support of PSS by sponsoring training for supervisors.

Consumer and Family Focus Committee (CFFC) conducted several efforts to recruit new members for the committee and to serve on CABHC committees. One of the efforts was through participation in the CBHNP Provider Fair. CFFC continued to provide a variety of educational opportunities for their members.

The Provider Network Committee continued to evaluate the CBHNP development of performance indicators related to provider profiling and performance. This year saw CBHNP establish a baseline score of 72% on their treatment record reviews. Providers falling below the baseline will be requested to complete a corrective action plan to address identified areas of need. School Based Outpatient Programs now have a new service location codes for billing that will enable CABHC to more clearly track services provided in schools. Network services continued to be enhanced as Telepsychiatry services demonstrated a positive impact to reduce wait time for Members to see a psychiatrist for an evaluation or medication. The monitoring and development of Assertive Community Treatment Team (ACT) continued as this year saw the full implementation of the fidelity Tool for Measurement of ACT (TMACT). TMACT was used to evaluate the fidelity of all ACT programs this year. The results of the reviews were positive.

CABHC continued monitoring two **Performance Improvement Projects (PIP)** during the year. Due to continued low rates for Follow-up after Hospitalization, CBHNP conducted a root cause analysis to identify barriers to achieving higher rates. CABHC will monitor the action recommendations identified in the RCA. Additionally, this PIP has been incorporated into the CBHNP Incentive Performance Objectives and will be one-third of the total performance score. The score will be based on the HealthChoices average for all BH-MCO's. The Youth Receiving Substance Abuse Services PIP continued to rate above the HealthChoices average scoring 2.46% for the year; however, that score is slightly lower than last year's final score of 2.44%. **Program Evaluation Performance Summary (PEP)** continued in 2011. CABHC continued monitoring the corrective action plan (CAP). Areas being monitored include: Clarification of roles of Member Services Specialists and Clinical Care Managers, Identification and Management of Quality of Care Concerns, and the Increase Active Care Management.

Reinvestment Projects continued to have positive results in 2011. The **Respite Management Agency** (RMA) operated for a full year providing respite services for both children and adults throughout the Counties. The Program served 235 children and 19 adults providing both in home and out of home services. RMA is seeking to expand services to adults and to add additional providers. **Specialized Transitional Support for Adolescents,** The Jeremy Project, Dauphin County, reported serving 65 Members ranging from 14 to 22 years old. NHS Stephens Center reported serving 15 Members in Cumberland and Perry Counties. The **Recovery House Scholarship Program** served over 100 individuals. The **Housing Initiative Program** in Cumberland and Perry Counties continue to serve individuals through two programs and reported that 85% of those served were homeless. The Lancaster County Home Choices Program supported 15 individuals in need of more permanent housing. Lebanon County provided support through their Bridge Subsidy Program to provide temporary assistance helping

people relocate or improve their housing situation. The Housing Contingency Funds provided consumers funds for their existing or newly acquired community living arrangements.

ADMINISTRATIVE OVERSIGHT

The results of the **CBHNP Performance Objectives** revealed that CBHNP scored 76.7 points for the year, to earn the right to retain 60% of the available funds. This score declined for the second year.

Community Satisfaction Services, Inc. instituted several administrative changes during the year, although the number of interviews declined, the number of individuals interviewed face-to-face significantly increased. 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 Counties. During the year, they presented 14 "In My Own Words" presentations to over 1,000 students in two different school districts.

Through the coordination **Between Systems of Care: Physical Health and Behavioral Health (PH-BH) Initiatives** several projects were completed. Specifically training for Targeted Case Managers emphasized physical health issues such as diabetes.

Readmission rates for **Adult Mental Health and Drug and Alcohol Services** were slightly higher for MH IP while slightly lower for D&A.

Enrollment rates generally increased for the year; however, **Penetration** rates showed slight declines.

In the area of consumer safety, the number of **Critical Incidents** filed saw a slight increase this year. The total number of restraints/seclusion experienced a slight increase.

The number of Members experiencing **Treatment Denials** declined to 748 this year and the total number of denials declined from 1,324 to 1,032. For the CY, there were four treatment denials per 10,000; significantly below the target of twenty. A total of 65.3% of Members with a denial for requested services were authorized to receive other services or a different duration of the same service. OMHSAS conducted a review of denial letters in May 2011. OMHSAS found that a large percentage of denial letters did not include the credentials of the Peer Reviewer, nor did they cite a full explanation for the reasons for the denial. As a result of their review, OMHSAS requested a corrective action plan from CBHNP addressing the findings. CABHC developed a monitoring plan to ensure that CBHNP completes the necessary requirements of the CAP.

For Complaints and Grievances, the data for complaints shows that there was a decline in the number of complaints this year compared to last year. There were 0.66 Level I grievances per 10,000 Members for the year; significantly lower than the target of 3.5 per 10,000. Data showed that 90% of Members were satisfied with the complaint resolution. Outcomes for Level I grievances found that 65% were upheld for the MCO/Provider while 34% were overturned for the Member, which is down from 47% last year.

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 935 surveys this year, although a decrease from last year, the percent of face-to-face interviews increased to 93%, a dramatic increase over the 36% last year. Members rated their overall satisfaction with services as 94.7%, slightly lower than last year. CSS took the lead with the Systems Improvement Committee and identified two areas for review: develop a five year study of survey results and to conduct a survey focusing on consumer involvement of the discharge process from inpatient hospitalization. The results of those projects will be available in 2012. The CABHC Provider Survey was revised this year adding 10 new questions. The survey results saw scores for four sections decrease and four sections increased. Although the overall satisfaction score slightly declined over the past three years, the change is less than one point.

The **Financial Overview** of CABHC's financial performance remained strong this year. The Binkley-Kanavy group conducted audits of various aspects of the HealthChoices Program, including claims processing, MIS/encounter data reporting, MCO subcontractor incentive arrangements, and financial management and reporting. After the yearlong audit, Binkley-Kanavy Group issued an opinion that the financial schedules were presented fairly, in all material respects, in conformity with accounting principles.

This **Executive Summary** is only a snap shot of the entire Continuous Quality Improvement 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 2011 CY and will allow the reader to gain a better understanding of the services and quality management that was realized. We have made every effort to ensure continuity of tables for the reader by minimizing tables split between pages. Therefore, some pages have large sections space at the end of the page.

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 2011 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 Counties. 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 analyzes best practice guidelines and developments, monitors activity of Reinvestment Services, and as needed conducts additional studies of matters related to providing and delivering services to Members.

Consumers and family members comprise the majority of the Consumer and Family Focus Committee which is responsible for 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.

Financial matters are monitored by the Fiscal Committee which is responsible for providing oversight regarding the financial matters associated with our HealthChoices program and the Corporation.

CABHC's 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 includes monitoring 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 the need for additional existing service locations and for new services, develop and monitor provider satisfaction surveys, monitor provider profiling reports, and 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 SERVICES

CHILDREN'S SERVICES

CABHC is committed to the services for children and adolescents throughout the Counties. 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 33,296 consumers receiving services, 14,509 fell into the 0-17 year old category. It is noted that 0-17 year olds utilizing services during the year account for 64% 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 goals and initiatives 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.

Comparison of STAP 2010 and 2011

CABHC conducted an analysis on utilization rates of STAP and Therapeutic Staff Support (TSS) in the summer of 2011 to assess whether utilization for STAP was comparable to the 2010 rates. In addition, since the start date of STAP was changed again in 2011 to June 27th rather than July 19th in 2010, CABHC looked to see whether the earlier start time of STAP impacted the utilization rates of this service. Also, since some providers reported stricter criteria for STAP in 2011, CABHC examined claims data to see if the clinical make-up of STAP changed this summer. One additional feature of the analysis is Member's age. Member's age is included in this report in order to ensure providers are serving those Members they identified to serve.

CABHC used person level encounter (paid claims) data to review STAP services. The total number of consumers increased from 624 in 2010 to 662 in 2011. Of those, the number of consumers with Autism Spectrum Disorder (ASD) increased from 353 in 2010 to 383, while those without ASD showed a minimal increase of 8 going from 271 last summer to 279 this summer.

The notable changes in the area of primary diagnosis were a reduction in the number of Members with a primary diagnosis of Disturbance of Emotions and an increase of those diagnosed with Childhood Hyperkinetic Syndrome. A review of the criteria based on diagnostic category found that the criteria were similar for both summers.

A review of age of Members utilizing STAP found that during both years, the majority of individuals were between 06-12 years old, with 13-17 the next highest. STAP was not utilized by older youth ages 18-20 with no diagnosis of ASD; however, those diagnosed with ASD in that age group participated in both years.

Due to the change in start time for STAP, CABHC was unable to compare last year's TSS utilization with the current year. Therefore, utilization of TSS among Members who attended STAP in 2011 was included in the study. Person level encounter data was analysed for Members who received TSS and STAP in the summer. Members had to have attended 3 of the 5 weeks of STAP, and all TSS services in the school setting were excluded. If a Member received TSS services in the school and in another place of service, they were included. The study also examined Members with an ASD diagnosis and Members without an ASD diagnosis. There were 573 Members who received three of the five weeks of STAP who received services outside of the school setting. Of the 287Members, 38 received TSS in the two weeks before STAP started, 29 received TSS during STAP, and 53 received TSS in the weeks following STAP. There were 286 Members with an ASD diagnosis. Of these 72 received TSS before STAP, 60 received TSS during STAP, and 89 received TSS after STAP ended. Reviewing the data, it appeared that more Members, in general, utilized TSS services more frequently after STAP ended than before or during STAP.

Overall, the study found that Members appear to need more support towards the end of the summer than at the beginning. This may be due to the conclusion of other community activities, ESY, or additional need for TSS services to prepare the child for the transition back to school.

Best Practice Guidelines

CABHC established a Best Practices Workgroup to review the BHRS OMHSAS Best Practices Guidelines (BPG). The OMHSAS Best Practice Guidelines are intended to be used as recommendations for quality clinical practice. As part of the review, 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 BHRS Workgroup continued to work on the development of the Best Practice Guidelines, which included considerations for our Members who have been impacted by an Autism Spectrum Disorder. However, BPG were expanded into the CBHNP BHRS Redesign process with various workgroups addressing the BHRS redesign. The BHRS Redesign workgroup is reviewing a number of suggestions for implementation. Some of the suggestions are: Consideration of ISPT meetings occurring prior to the Best Practice Evaluation, encouraging co-occurring competency among network providers, enhanced focus on discharge planning and identification of barriers to treatment progress, and coordination of FBA and Treatment Plan Submission. It is anticipated that the redesign will be completed in the next year.

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.

Residential Treatment Facility (RTF) Workgroup

The RTF Workgroup focused on two additional programs: Community Residential Rehabilitation- Intensive Treatment Program and Short Term Residential Treatment. Both of these programs would serve children and adolescents in residential services.

During the current year, the CABHC/CBHNP received approval from OMHSAS to establish a new Community Residential Rehabilitation Intensive Treatment Program (CRR-ITP). The CRR-ITP is a type of licensed CRR Host Home, but has a distinctive and separate service than currently approved CRR Host Home and is a comprehensive community based service design that incorporates elements of the CRR Host Home program with added elements and treatment standards. The CRR-ITP is a unique and individualized service that teaches children and families the skills necessary through enhanced clinical treatment to function appropriately in their natural home environment, and lead healthy productive lives.

This program will serve youth age individuals (5-21) who have severe emotional and behavioral disturbances. The CRR-ITP is a comprehensive service that provides individual and family therapy, access to psychological evaluations, assures access to psychiatric services and provides direct clinical support and consultation with schools or other day programs that the youth age person may be involved in during the course of treatment. It is anticipated that these services will begin in 2012.

The Short Term Residential Treatment services will provide services for males and females between the ages of 11-21. The goal of this program is to work with youth who have had multiple prior treatment placements and have experienced problems over a variety of life domains, such as home, school, and community. The program will address the needs of youth with multiple problems in a non-inpatient setting with the opportunity for progressive increases of independence and freedom as treatment and personal growth continues.

The goals of the program are to provide individualized, culturally-relevant residential psychiatric treatment for each youth near their community so that family and community may actively be involved in the treatment process. It will provide an intensive, multi-level treatment environment designed to promote skill and goal attainment. It will provide 24-hour supervision and a highly structured, treatment-intensive, non-inpatient environment to enable the youth to develop a level of functioning that will allow a safe and successful transition to a less-restrictive, community-based setting.

The program will serve 10 youth for a period of up to four months. Youths served will typically experience chronic distress and severe psychosocial dysfunction covering a full spectrum of child/adolescent psychiatric disorders. It is expected that parents/guardians, home school districts, and community agencies will actively participate in the treatment. These services will begin in 2012 with Philhaven as the service provider.

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

Communication and coordination of services is critical to effective treatment. Therefore, CBHNP continued to conduct training for Children Youth Services and Juvenile Probation Office (CYS/JPO) staff from the Counties. The trainings focused on improving understanding and foster cooperation between the two agencies. The informational sessions covered topics such as the complaint and grievance process, medical necessity criteria, and different levels of care funded by CBHNP. This year training was held in Cumberland/Perry, Lancaster, and Lebanon counties. Dauphin County rescheduled their training to next year.

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 2011 was for CABHC to work with CBHNP and the Counties to continue to review the effectiveness of TSS Scheduling and its impact on the delivery of TSS services. The TSS Workgroup met during the year to monitor the TSS Scheduling process. During the year, CBHNP continued to provide quarterly reviews of high volume providers and discuss expectations for initial service delivery.

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-model treatment approach is compelling.

MTFC services are being developed by the Children's Home of York (CHOR). CHOR identified one family in Dauphin County that is eligible to provide MTFC services, and have identified additional families to provide services in the future. In August 2011, CBHNP approved the first referral for MTFC services. Service in Cumberland and Perry counties continues to be developed.

Efficacy of CBHNP's Treatment Plan Training

As part of CBHNP's identified steps to remove barriers to accessing BHRS services, every quarter BHNP evaluates initial BHRS treatment plans for quality and appropriateness. CBHNP's review consisted of a random review of treatment plans and evaluates them using a scoring tool. Additionally, CBHNP conducted training on treatment planning with BHRS providers.

In an ongoing effort to improve the quality and efficacy of children's services, during 2011 CABHC conducted data analysis on treatment plan scores before and after the training to assess the overall impact of the training on treatment planning scores. It was CABHC's assumption that the scores would improve after the training, thereby verifying the trainings value.

CABHC reviewed the results of the initial treatment record reviews, conducted by CBHNP staff, prior to and after the plan training. The review consisted of only BHRS providers who attended the training and who CBHNP audited in both Quarter 4, 2009 and Quarter 3, 2010. CABHC reviewed sign in sheets from both sessions which involved 130 individuals from various providers attending the training. There was a net of 10 BHRS providers who qualified for the review. Therefore, CBHNP reviewed treatment plan audit scores from CY Q4, October-December 2009 (pre-training), and CY Q3 2010, July-September (post-training). Fifty-two treatment plans from 10 providers were reviewed from Q4, 2009 and 67 treatment plans from 10 providers from Q3, 2010. Following up after the training, CABHC contacted providers to see how they disseminated the training information to their staff. The providers responding to the poll indicated that they utilized a train-the-trainer approach to disseminate the information.

CABHC analysis of the audit scores found that treatment plan scores improved following the treatment plan training held in December 2009; thereby, providing evidence for the value of the treatment plan training. The study found that the average score improved slightly from 55.8% to 61.7% out of a possible 100%. Although the scores improved, the results of the CABHC review found that even with the training the scores, on average, were still very low. Based on the results, CABHC recommended that CBHNP offer additional training to providers in several areas: Discharge Criteria, Recovery/Resiliency, Crisis Planning, and Criteria.

CBHNP reviewed the results of this study responding that they had taken a number of steps to reinforce the training and provided additional information that was not available to CABHC at the time of its study. CBHNP reported that the initial treatment plan tool was revised, and four items were removed in order to make it a more effective audit tool. They also reported that CBHNP had begun consulting individually with providers in order to discuss treatment planning. Additionally, CBHNP began requiring a Corrective Action Plan (CAP) if scores fall below 72%. Since the initiation of the CAP requirement, several providers have been requested to complete a CAP.

The end result of the CABHC study, and the CBHNP review, has led to further collaboration between CBHNP, Providers, and CABHC which has led to improvements in treatment planning, which translate into improved quality of service to our Members.

PEER SUPPORT SERVICES

The development and utilization the Peer Support program continues to play an important part in service delivery to our Members. Individuals who become Certified Peer Specialists (CPS) provide a valuable service to Members seeking to maintain their recovery. Their role is crucial in assisting individuals rebuild their sense of community when they had a disconnecting experience.

CABHC continues to support the development of PSS throughout the network by sponsoring PSS certification, providing space for ongoing CPS and CPS Supervisory Professional Development meetings, through the Peer Support section of the CABHC website, the Peer Support Services Committee, and through ongoing advocacy of PSS through participation on

various committees and through Member Relations participation in various activities throughout the network.

Peer Support Certification Training

This year, CABHC sponsored a Peer Support Training which took place in August 2011. As a result of the training, 8 individuals were certified and have registered as Certified Peer Specialists on the CABHC Peer Support webpage.

In an effort to provide ongoing support of the PSS program, CABHC identified the need to provide certification for peer support supervisors. This training will take place in June 2012.

Table 1shows that the total number of units of service delivered increased 46% during CY 2011. Telephonic support increased 37% from 617 units to 846 units. CABHC will continue to monitor this service in for its effectiveness in providing support to our Members.

Table 1: Utilization of PSS Telephone Supportive Services 2009 to 2011

	CY 2009			CY 2010			CY 2011		
	Consumers	Units	Dollars	Consumers	Units	Dollars	Consumers	Units	Dollars
Peer Support Services	189	24,023	399,267	223	24,798	416,516	278	36,297	629,417
PSS Telephonic Support				79	617	10,267	105	846	14,749
Totals	189	24,023	399,267	225	25,415	426,783	282	37,143	644,167

Peer Support Webpage

The Peer Support page of the CABHC website provides an opportunity to link Certified Peer Specialists with providers who have job openings for CPS. Since the inception of the PSS website, 16 CPS's have registered, with six of those registering during 2011. During the year, four providers posted a total of five available positions on the website. Provider postings remained on the website for an average of 59 days. CABHC is developing a methodology to be able to monitor the impact of the website process for CPS to secure employment through the postings.

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) provide CABHC valuable input from Members and families. Consumer participation in the oversight process is vital. Consumers provide insights into the recovery and resiliency that makes a positive impact on the quality and responsiveness of services of providers.

Recruitment of Members

In 2011, the CFFC focus for recruitment continued throughout the year with CFFC members exploring committee membership possibilities with their peers. Additionally, the CABHC Clinical Director and Members Relations Specialist held individual orientation sessions throughout the year. The efforts of the committee were positive with five new members joining the committee.

Educational Presentations

Continuing educational opportunities took place throughout the year as CFFC held presentations on Paxton Ministries, Lodge Program, Supported Employment Services and Peer Support Services, Community Satisfaction Services, and Latest Legal Drugs of Abuse. Future presentations will include Multi-Cultures and matters related to behavioral health and LGBQTI issues.

PROVIDER NETWORK

The Provider Network Committee is responsible for the oversight of the provider network developed by CBHNP, who is the contracted Behavioral Health Management Organization (BH-MCO). Areas of focus include: Monitor the BH-MCO provider network to assure access standards are met, choice is provided, and specialty needs are available for Members, Develop and monitor need for additional existing service locations for new services, Develop and monitor provider satisfaction surveys, Monitor provide profiling reports and Monitor CBHNP credentialing committee activity.

Service Access Standards

The Provider Network Committee facilitates collaboration with the Counties and CBHNP in the continued assessment of network capacity in order to identify potential new providers and expansion of services with existing Providers. CBHNP uses a program called GeoAccess® which is the industry standard for producing reports on accessibility. All providers with a contract for a given county are included in the provider listing regardless of their location. The GeoAccess® program then plots provider addresses against actual member addresses to determine how many members have access within designated requirements by service type. Pennsylvania HealthChoices standards and require the following access standards to be met or an access waiver must be requested:

Ambulatory services – 2 in 20 miles (urban counties); 2 in 45 miles (rural counties)
Inpatient services – 1 in 20 miles (urban counties); 1 in 45 miles (rural counties)

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 2011-2012 fiscal year. It should be noted that changes to the exception request from the prior year are due to population shift and not a change in the Provider network. 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; NW quadrant of Cumberland County; and NW quadrant of Perry County.

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

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

Residential Treatment Facility (Child/Adolescent): Access standard of distance for the NW quadrant of Dauphin County; and the SW quadrant 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. CBHNP utilizes a variety of profiling indicators that vary among services. Some of these indicators include data from utilization ratios, case mix severity index, service delivery percentages (for BHRS), Member satisfaction, treatment record reviews, administrative compliance, and provider performance indicators. It is important to note that all of the profiled providers are fully credentialed network providers in good standing with CBHNP. CBHNP provides the results of provider profiling on their website. The results of are presented for informational purposes only for Members.

CBHNP established a baseline score of 72%; providers scoring below are required to provide a corrective action plan. During the year, the Providers made positive improvement in their scores. CBHNP reviewed the scores by level of care and found all of the levels scored well in one or more specific section such Recovery Orientation indicators or Coordination and Continuity of Care sections. CBHNP reported that all providers that were required to complete a corrective action plan addressed the needs identified from the record review. It is anticipated that with continued use of this process, provider's scores will continue to improve and the number of corrective action plans will decrease.

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). CBHNP established a baseline score of competency for four levels of care: RTF, CRR HH, MH IP and Partial Hospitalization Programs. Co-occurring competency results varied within each level of care. CBHNP reported that the audits were completed by each provider. The scoring ranges for the various levels of care are: RTF 33% to

97%, CRR-HH 33% to 82%, MH-IP 0% to 99%, and MH-PH 33% to 93%. 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

School based D&A services continued throughout the year and saw the creation of billing code modifiers that will provide a method to more effectively track services provided in schools. Throughout 2011, CABHC continued to use county provider meetings to highlight the need for school-based D&A services throughout the network. Discussion focused on the steps necessary for providers to follow in order to provide such services. At those meetings, there has been minimal interest expressed by the providers to provide D&A services in the schools.

Telepsychiatry

Telepsychiatry services at NHS began in March 2011 as one way to alleviate the waiting time for Members to receive psychiatric services. The service includes both psychiatric evaluation and medication management. The benefits to this service will allow Dauphin and Cumberland/Perry County Members to access psychiatric services; however, it does not replace existing access to site based services. Utilization of the service has grown from the beginning and NHS anticipates adding a second psychiatrist early in 2012. Expanding available psychiatric time and OP clinic hours, will reduce the waiting time for these services from the current six months to less than a month.

Since Telepsychiatry services began in March 2011, NHS-Stevens Center served a total of 61 child/adolescent (0-17) and 109 adult (18+) Members. NHS conducted a satisfaction survey as Members competed their sessions. A total of 405 surveys were returned with the results shown in Table 2 below. The data shows significant levels of satisfaction with these aspects of the service.

Table 2: Telepsychiatry Consumer Satisfaction Survey. March – December 2011

Telepsychiatry Consumer Satisfaction Survey N = 405[1]	**Extremely/Very Much**	**Moderately/Slightly**
How much has telepsychiatry helped you?	91%	8%
Are you treated with respect?	99%	1%
How satisfied are you with telepsychiatry?	97%	3%
I feel as though my doctor truly listens to my concerns.	98%	2%
Would you recommend telepsychiatry to others?	100%	

[1]This number is duplicated Members as they could have participated in multiple surveys.

Assertive Community Treatment (ACT)

In 2011, 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 2012. This information will be evaluated and reported on in the next Annual Report.

PERFORMANCE IMPROVEMENT PROJECTS (PIP)

Follow-Up after Hospitalization: Root Cause Analysis

During CY 2010, the performance measure for 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 four 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 Num 1 (HEDIS) 7-day follow-up after discharge to improve 7% to 46.2% by the end of 2011, with the long term goal of 57.4% by the end of 2013. The short term goal for Num A (PA Specific 7 day) is to improve by 7% to 60.2% by the end of 2011, with the long term increase to be 65.4% by the end of 2012.

Throughout the year, this PIP was submitted by CBHNP, reviewed by CABHC, and then submitted to OMHSAS each quarter. The rates for the first three quarters of 2011 reflect that three of the four measures are higher than for Measurement Year (MY) 2010. While they show improvement, scores for all four indicators remain lower than the HEDIS–OMHSAS goal. Table 3 provides a summary of the scores over the past three years.

Table 3: 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	40.3%	62.4%	53.7%	70.6%
CY 2011[1]	41.4%	60.1%	55.2%	71.7%
OMHSAS Goal	53.9%	74.6%	68.3%	82.6%

[1]Data is for the first three quarters of CY 2011 as the fourth quarter data will not be available for this PIP until May 2012.

CBHNP identified a number of root causes in addressing why follow-up rates were not meeting standards.

- Limited data in meeting 7 day HEDIS standards. Minimal actions can be taken to focus on correlation that may be preventing follow up within 7 days. CBHNP is addressing through their IT department with the enhancement of their comprehensive mechanized report. At the close of 2011 this item remains pending.

- Some providers are reporting limited capacity for MH OP and children services preventing follow-up within 7 days. Action taken by CBHNP included a survey of the current MH OP providers' capacity in order to assess the correlation between capacity and providers offering appointments within the 7 day standard. Analysis of the survey proved inconclusive. CBHNP modified the survey and will repeat it periodically throughout the year.

- A lack of communication and collaboration with family/friends and other MH OP providers has impacted Member attending within 7 days after discharge creating an additional barrier to treatment. CBHNP repeated follow up responses from previous educational opportunities in 2010 with MH IP providers to determine success or need for further interventions and implement new procedures to enhance collaboration and lessen barriers. CBHNP repeated the review of discharge planning/process documentation audit of MH IP. Their findings were that many of the facilities were showing improvement in their results of improved discharge planning.

- Although MH IP providers are educating Members on the significance of aftercare and report they are addressing barriers while on the unit, barriers continue to exist for Members and the no show rate remains too high. Additionally, referrals to TCM/Peer Support and Mobile Psych Nursing (MSN) are not always included in the discharge planning process. Also, MH OP providers are not always able to offer appointments in 7 days. CBHNPs action is to focus Member education and the significance of aftercare needs and address the barriers prior to discharge by relying on community resources and natural supports. Additional

emphasis for 2011 was that CBHNP Follow up Specialists will include a question about barriers to treatment and whether or not they were addressed on the inpatient unit. The summary of the results of the Follow up Specialists survey is pending. CBHNP provided educational opportunities on the use of TCM/Peer Support and MSN when appropriate. CBHNP noted that their audit found that PSS was not always available and noted that the oversight provided funding to hold additional peer support training. Also, MSN services will be expanding into Cumberland and Dauphin Counties in 2012.

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

Data for the first three quarters of CY 2011 shows a slight decline in the rate to 2.42%, compared to 2.44% at the end of CY 2012. Although the rate is lower than last year, it exceeds the HealthChoices average of 1.35%. Four of the five counties also exceed the HC average, with Perry only slightly lower at 1.29%. The demographic breakdown of the data shows that 16 and 17 year olds (62%) are the largest groups receiving treatment. Males utilize 79% of the services and 21% females. Regarding race, 56% were Caucasian, 35% African-American, and 9% Hispanic.

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, partially 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. CABHC received notification from OMHSAS that in October they completed their review of the Final Completed Corrective Action Plan (CAP) for the 2008 Program Evaluation Performance Summary (PEPS) Triennial Review of CBHNP. OMHSAS reviewed reports from September 2009 and August 2010. Although all of the items from the review were seen as "complete" by OMHSAS, several areas included recommendations for further action. Due to the review dates, most of the recommendations have been acted upon by CBHNP.

REINVESTMENT PROJECTS

Reinvestment Projects utilize HealthChoices County discretionary funds that are not 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, an OCYF representative, CABHC, and CBHNP discussed services that would benefit Members served under the HealthChoices program in the Counties using reinvestment funds (surplus medical claims and administrative dollars that are designated for reinvestment by the Counties). Once the projects become operational, CABHC actively reviews all reinvestment projects throughout the year and reports their status to the Board and OMHSAS.

Respite Care

Respite services offer planned and short-term respite services to children, adolescents, and adults. Respite services are designed to provide a temporary relief for caregivers. These services can help parents and caregivers by giving them a rest or a break for caring for child and/or adults with behavioral/emotional health concerns.

Respite services offer two types of respite: In-Home are provided in the family's home or in the community. Respite workers' will supervise and interact with the identified child or adult while the family members are able to take a break. The Respite Management Agency (RMA), Youth Advocate Program (YAP) authorizes 15 hours of service over a two month period, with the opportunity to be reauthorized. The billable rate to providers is half hour units.

Out of home services are typically overnight or weekends, but may be scheduled for any time. The service is provided in a qualified home. A typical authorization is 2-3 nights over a one month period, with the opportunity to be reauthorized. The billable rate for this is one night service equals one unit.

Over the past year the RMA has been able to facilitate respite services via contracts with eight providers, and four staffing agencies which will provide actual "staff" in all counties served. Additionally, RMA has contracts with two individuals providing services.

Tables 4 and 5 provide data for the first full year of operation. The overwhelming amount of respite was provided to children, 93% with 7% of adults receiving respite care. Dauphin County received 48% of all services, with Lancaster next with 28%. The total number of units provided was 15,002, with a cost of $238,792.

Table 4: Service Summary by County[1]

County	# Members Served	In Home Hours	Out of Home Days
Cumberland	33	787.5	5
Dauphin	121	4,035	164
Lancaster	71	1,801.5	34
Lebanon	20	648	0
Perry	9	123.5	8
Totals:	254	7,395.5	211

[1]Data from YAP 2010-2011 Respite Management Annual Report (9/1/2010 – 8/21/2011**)**

Table 5: Children Served vs. Adults Served by County[1]

County	# of Children Served	# of Adults Served
Cumberland	29	4
Dauphin	111	10
Lancaster	66	5
Lebanon	20	0
Perry	9	0
Totals:	235	19

[1]Data from YAP 2010-2011 Respite Management Annual Report (9/1/2011 – 8/21/2011)

During the year, YAP sought to increase services to adults by presenting an overview of respite services to various groups throughout the Counties. Presentations were made to Dauphin County's CMU, Lebanon, Lancaster, and NHS. Additionally, YAP contracted with four new staffing agencies to serve the adult population. Another resource for respite service is the use of family and friends as respite providers. This resource became available as a resource on April 1, 2011. Before family and friends can qualify as a provider, they are interviewed by the Program Coordinator. Additionally, they must have their FBI Clearance, PA Background Check, Childline Clearance, First Aid/CPR certification, and complete a review of the training manual.

Looking ahead to the coming year, RMA is hoping to add at least two new providers, with one of these serving the adult population, continue to make presentations at provider meetings, meet with county representatives, and create a compact disk containing their respite manual. The compact disc will make training easier for providers and direct contractors.

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 14-22 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. The transitional program focuses on four target domains which assist individuals to gain knowledge and skills needed to become successful adults. The four target domains are: Employment, Education, Independent Living, and Community Involvement/Socialization.

There are two providers for transitional services, The Jeremy Project (Joint Efforts Reach & Energize More Youth) in Dauphin County and NHS, Inc., The Stevens Center in Cumberland and Perry Counties. The data for FY 2010 – 2011 shows that the number of Members served increased from 58 to 65.

In Dauphin County, the CMU's Jeremy Project assisted over 50 adolescents and their families, with an average number of 48 served monthly. The age range of participants was 14-22 years old. The Jeremy Project consists of a set of specialized services designed in the form of Independent Living Resources designed to maximize their transition to independence through person-centered planning. These services are provided in a group setting with an average of 14 unique groups held each month. Additionally, individual sessions are held to assist the participants to be successful in their transition.

One of the highlights of the FY was eight participants graduating from high school. Two graduates will pursue post-secondary education; one will explore technical/trade school. Four will explore their options by obtaining part/full-time work, and one individual has been employed on a part time basis for over a year and will move on to full time status. Jeremy participants were involved with AHEDD, an additional resource for employment opportunities for those with disabilities, with 28 participants attending at least one employment session. In the area of Independent Living, 36 participated in the cooking skills class, and 10 participants completed the Jeremy Mobility Training by developing a "Mobility Plan" to utilize public transportation at designated destinations throughout Harrisburg. Twenty-seven participated in Independent Living Skills and reported they had made progress in two out of three independent living goals. Finally, Community Involvement/Socialization Outcomes saw 100% of the participants involved in at least one mental health service.

Cumberland and Perry Counties are served by NHS, Inc. (The Stevens Center). NHS-Stevens Center Transition served a total of 15 consumers during the FY. In the target area of employment, NHS reported that all participants were employed at least part-time. In the area of education, 20% of those who have graduated high school, and 100% of those currently attending the program have plans for continuing education. NHS reports that 75% of consumers living independently utilized transition supports to help them move into independent living situations. In order to foster greater independence, 77% of program participants obtained their driver's license, have a learners permit, or are currently working on permit goal.

Overall, both of these projects provide needed services to individuals transitioning from adolescence to adulthood. CABHC will continue to support these projects in 2011-2012.

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**.**

The Recovery House program continued to expand during the year. Two new organizations were added, bringing the total to 21 and increasing the number of sites from 44 to 53.

Through the close of FY 2010-2011, 134 Members received Recovery House scholarships which were paid to 21 organizations, with a total of 53 sites. There was a total of $68,002 in scholarships paid out during the year.

Table 6: Recovery House Members and Scholarships FY 2010-2011

FY 2010-2011		
County	Individuals Served	Total Expenditures
Cumberland	7	$3,508
Dauphin	36	$118,224
Lancaster	73	$37,310
Lebanon	16	$8,100
Perry	2	$860
Total	134	$68,002

Two Outcome Analysis have been completed. The initial survey period was March 2010 to June 2011. Fourteen months were chosen as the project was restarted following some financial difficulties, and the reporting period was converted from CY to FY. The second analysis was completed for the period of July – December 2011. The survey is administered every six months; thus, monthly data is not available in order to cover the CY of this report.

The surveys are administered reviewing for areas: Activity status of residents looking at productive measures such as looking for employment, pursuing education. A second area examined efforts residents were involved in order to maintain sobriety. The third area looked at length of stay, and the last area focused on reasons for discharge.

The data for the activity status shows during the initial analysis, 76% of residents were either employed, looking for employment, or pursuing education/job training. However, the activity focus declined to just 53% during the second analysis. The data for residents' efforts to maintain

sobriety was similar in both analysis as 67% reported maintaining sobriety in the initial analysis, declining slightly to 55% in the second analysis. The outcomes for participating in house activities (44% to 72%) or 12 Step/External resources (74% to 72%) were similar.

The average length of stay was almost identical in both surveys with 19% and 18% respectively staying six months or longer and 81% to 82% staying less than six months. Reasons for discharges also showed similar results from the initial to second survey. In the initial survey 38% left voluntarily, 27% left involuntarily, 26% were asked to leave, and 9% left for other reasons. The follow up survey was similar with 43% leaving voluntarily, 28% leaving involuntarily, 30% were asked to leave, and 0% other. The overall results for the Recovery House Scholarship Program this year is very positive**.**

Recovery House Project

This project provided funding for the start-up of three new Recovery Houses located in the Counties. Through this initiative, 19 new beds at three new Recovery Houses have been made available to assist males in need of support as they transition into their new life of sobriety. Annual follow-up site visits at each of the new recovery houses under this initiative (Daystar in Harrisburg, Just for Today in Mechanicsburg and Nuestra Vida in Lancaster) have occurred. All three houses continue to meet the terms of their contract, and will continue to undergo annual site visits.

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 Counties, CBHNP plays a significant role in the management and delivery of services. The 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 2010-2011 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 score is used to determine the percent of available incentive funds that may be retained by CBHNP.

[1] The information and data related to the CBHNP Incentive Performance Objectives will be reported using FY -2010-2011 data. Utilizing FY data rather than CY will provide a more accurate report of CBHNP performance.

The **D&A Readmission** rate for the 2010-2011 is 9.98%, slightly lower than the 10.14% reported for 2009-2010. Reviewing the data across the quarters shows that the lowest score, 8.33%, was achieved in the second quarter, and the highest, 10.86%, during the fourth quarter. Examining the service categories finds that two of the three areas were higher than reported last year. Non-Hospital Detoxification increased slightly from 5.97% last year to 6.53% this year. Non-Hospital Residential Rehabilitation is 11.29%, slightly higher than last year's 11.05% rate. Non-Hospital Halfway House was considerably lower at 13.02% compared to 17.82% at the close of last year. The aggregate score declined from 10.14% to 9.98%, which increased the total points earned from 26.6 last year to 30.0 for the current year.

The aggregate total for **SMI MH Inpatient Readmission** is slightly lower than last year. The data across quarters shows mixed results. The first quarter had the highest readmission rate (21.17%) with the second (16.53%) and third quarters (16.14%) experiencing declines. However, the fourth quarter showed an increase to 17.47%. Three of the five counties scored lower this year. Lancaster scored 18.06% compared to 22.57%, Lebanon is 14.12%, down from 15.96%, and Perry scored 12.82% this year and 17.39% a year ago. Cumberland's score increased from 10.81% to 15.92%, while Dauphin increased from 17.43% to 19.37%. Lancaster is the only county to show declines in each quarter throughout the FY. The score of 17.73% for SMI MH Inpatient Readmission exceeds the maximum target score of 21.0% or less; therefore, CBHNP earned the maximum number of points (33.3), unchanged from last year.

BHRS Access data for the FY shows a decrease in the points earned for 2010-2011, 13.4, down from the last FY. During the FY, two of the three areas earned points, whereas all three areas earned points last year. The quarterly totals for each of the categories revealed mixed data with some data declining one quarter, and then increasing in another. When compared to last year, both TSS and MT experienced declines. TSS had the greatest percent of decline, to 13.55% compared to 32.51% last year; therefore, earning zero points. MT experienced a slight decline from 34.40% to 32.93% to earn 6.7 points. BSC improved from 32.66% last year to 35.38%, earning 6.7 points.

Overall Scoring for Performance Objectives FY 2010 - 2011

The total score for this report period is 76.7, a slight decline from the 80.0 points earned a year ago. This score would result in CBHNP earning the right to retain 60% of the available funds. Table 7 provides a look at the CBHNP Performance Incentives for FY 2010-2011.

Table 7: CBHNP Incentive Performance Objectives 2010-2011

Performance	Standard	Score[1]	Points Earned
D&A Readmission Rate	9.4% or less	9.98%	30.0
SMI MH IP Readmission Rates	21.0% or less	17.73%	33.3
BHRS Access			
TSS	50.0% or greater	13.55%	0
MT	50.0% or greater	32.93%	6.7
BSC	50.0% or greater	35.38%	6.7
COMBINED BHRS			13.4
Total			76.7

[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 ranges 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 Counties. The contract with **Community Satisfaction Services Inc. (CSS)** fulfills the HealthChoices requirement for having Consumer/Family Satisfaction Teams, to conduct consumer satisfaction surveys. Their work is summarized in the Consumer Satisfaction section of this report. CABHC also contracts with **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)

CSS instituted several changes during the year to strengthen their team, and gain rapport with area service providers and the recovery community.

CSS strengthened its relationship with the behavioral health and drug and alcohol communities with seven presentations at "Level of Care" meetings at CBHNP and to the CBHNP Stakeholder Steering Committee. Additionally, they attended the Community Support Program of Lebanon and Dauphin Counties. CSS also regularly attends drug and alcohol provider meetings hosted by each Single County Authority. These efforts resulted in positive feedback and many good suggestions that will enable them to provide more effective surveys.

Another improvement made is the use of new software to gather and report data. CSS began to use SNAP (a software data manipulation tool) as its primary tool for creating reports. They report that there are two major advantages from the software. They now have the capacity to

create all reports internally and the software allows their staff to utilize PDAs to enter survey results directly into their computer system, reducing paper work and the cost of data entry. The update of technology benefits CSS by eliminating the cost of data entry and reducing time spent to gather/organize paper surveys.

CSS also takes the lead in the System Improvement Committee (SIC). SIC is meant to identify specific improvements needed in services for consumers utilizing the data gathered by the CSS surveys. The SIC identified two areas for review: to conduct a comparative study of five years of survey results, and to conduct a survey focusing on consumer involvement of the discharge process from inpatient facilities. CSS developed a mini survey that will be administered for individual who have been readmitted within 30 days of their discharge. It is anticipated that the results of that survey will be available early in 2012.

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, positive social events, and conscience raising activities.

CABHC specifically contracts with RASE to provide representatives at various CABHC Committees (i.e., Clinical and CFFC), who then disseminate relevant information throughout the Counties. 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.

RASE conducted a number of community presentations for FY 2010-2011, which included 14 "In My Own Words" speaking engagements at two different school districts, with a total of 1,007 in attendance. RASE also facilitated nine additional trainings with a total of 228 present. The focus of the trainings included: *Addiction & Recovery 101, Addiction, Recovery & the Family, The Value of Storytelling, and What is Recovery Oriented System of Care.* 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 continues to provide representation on local, private, county, state and federal levels by 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 recovering populations in the five county region by taking part in meetings and rallies on Capitol Hill in Harrisburg, PA and Washington DC. RASE staff members attend the CABHC Clinical, and Consumer & Family Focus Committees.

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

The PH-BH Workgroup continued the development of developing opportunities to promote the integration of PH-BH throughout the Counties. CBHNP engaged the Lily Foundation to present training for Targeted Care Managers to expand their knowledge of physical health issues such as diabetes and heart disease. Four three hour training sessions were held in each of the five counties.

CBHNP also developed two new tools: 1. Doctor Appointment Tool and 2. Wellness Toolkit for Members. These tools will enhance Members to more effectively participate in their sessions with their doctors.

CBHNP participated 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. During 2011, CBHNP expanded their website library by incorporating the Health Education Answers ^{TM}. In addition to information related to the above areas, this module provides information about specific diseases such as diabetes, cardiovascular disease and men's health. It also includes information on behavioral health diagnoses such as ADHD, depression, and schizophrenia. A Health Risk Assessment is available to everyone utilizing the CBHNP website. The Wellness Library link offers a comprehensive approach to multiple health topics from stress to sleep. Future expansions to the Wellness Library will enable CBHNP to make even more information available to our Members.

The CBHNP Perinatal Depression Project, which began in November 2008, was completed this year. This 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. Twenty-four of the forty-eight women reached by CBHNP agreed to participate in additional outreach efforts to reassess their Behavioral Health and Physical Health needs. CBHNP reported that a number of the 24 women continue with the program being reassess by completing a postpartum AMSA at 7-8 weeks post-delivery and then are discharged unless the Member has need for further outreaches.

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. 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 2011.

Table 8: School Participation in Initial ISPT Meetings

	Total Number of Initial Meetings				Percent of Schools Participating in the Initial ISPT			
	2008	2009	2010	2011	2008	2009	2010	2011
Participation in Initial ISPT Meetings	2064	2477	2461	2408	24.5%	17.7%	15.7%	11.10%

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 BHRS 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. Effective June 2011, CBHNP revised the reporting methodology for BHRS service separating BSC, MT, and TSS; therefore, the data below reflects only the second half of CY 2011 and no comparison to previous years can be made. The data shows that just over 50% of BSC and MT services authorized were delivered; with only 38.5% of TSS services were delivered. Table 9 shows the average monthly data for the second half of CY 2011.

Table 9: Average Monthly Data for BHR Services Delivered Compared to Authorized

Service	Monthly average number of Members with open BHRS authorizations[1]	Monthly average number of authorized BHRS hours[1]	Monthly average number of BHRS hours claimed[1]	Monthly average percent of BHR services delivered[1]
BSC	1,744	17,515	8,876	53.2%
MT	1,600	16,353	9,119	57.1%
TSS	1,839	139,345	49,150	38.5%

[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:

- CBHNP conducted quarterly performance reports for BHRS providers which incorporate discussion of the expectations for initial service delivery within 50 days of evaluation and utilization. If a provider is not achieving this goal for two consecutive months, corrective action is implemented. CBHNP changed the report in Q2 of 2011 to include in the performance reports monthly service delivery percentage needed in order to provide for more effective monitoring.
- CBHNP conducted individual meetings with BHRS providers comparing their scores in to other providers. CBHNP will continue peer to peer outreach with the initiation of a toolkit for network psychiatrists.

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 target is 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 FY 2010-2011 showed small changes for BSC and MT; however, TSS scored considerably lower than in the previous year.

Table 10: Percentage of Initial BHRS Delivered within 50 Days

Fiscal Year	BSC	MT	TSS
2008 - 2009	34.43%	25.64%	31.10%
2009 - 2010	32.66%	34.40%	32.51%
2010 - 2011	35.38%	32.93%	13.55%

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, improvement has not met expectations. Due to the continued low scores for Initial BHRS Access, CABHC contracted with Susan Signore-Smith to conduct a *50-day Access for Initial BHR Services Root Cause Analysis.* The analysis was completed in November 2011. The RCA consisted of conventional RCA tools such as Fishbone diagramming, data analysis and document review, interviews, and brainstorming sessions. It is the intent of the RCA to uncover the root causes through a systemic review and will likely identify actions and processes that may improve access to BHRS. The RCA found two key areas that were causes for delays in the 50-day access: Delays within the BHRS workflow and timeframes, and Long-standing and persistent BHRS Provider recruitment/retention difficulties.

The results of the RCA included the following recommendations:

1. Enforce timeframes for scheduling ISPTs. This recommendation focuses on the accountability of Providers to adhere to timeframes established by CBHNP.
2. CBHNP address the lag between the Evaluation date and the time a CBHNP CCM is notified that an initial BHRS case is open. It is recommended that CBHP develop procedures for CCMs to be involved as soon as the Evaluation is completed and for CBHNP or a County case manager to coordinate the ISPT activities.
3. CBHNP should continue their BHRS Re-Design process which could have a positive impact on BHRS access.
4. CBHNP should give consideration for a TSS/MT/BSC Forum on at least an annual basis. The Forum would provide the opportunity to support among BHRS workers and enhance their job satisfaction.

In addition to the RCA, CABHC initiated a BHRS Access Workgroup to evaluate this area and return its findings to the CABHC Clinical Committee. The results of these efforts will be closely monitored in 2012.

Critical Incidents for Children/Adolescents

The Critical Incident Reporting section 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 2011, the number of critical incidents for the 0-17 year-olds, 3,285, was 10 less than a year ago.

CBHNP reports that during 2011, the overall number of restraint episodes increased by 8.4% from 1,184 episodes in 2010 to 1,293 in 2011. The number of unique Members restrained while in an RTF was slightly less this year, 194 compared to 199 in 2010. During 2011, 16 facilities which served CBHNP members in RTF were following the Sanctuary Model to reduce restraints. CBHNP also utilized Treatment Record Reviews and the RTF Toolkits to encourage Providers to review how they used restraints and what was needed to eliminate or reduce restraints in treatment.

CBHNP will continue to focus on Member safety in 2012, expanding their emphasis in a variety of areas. The focus will be on clear documentation of safety concerns that require use of restraint, de-escalation and other treatment techniques used to avoid restraint, medical assessment of Members following a restraint with indication of whether the Member was injured, and debriefing of the member following the restraint as a preventative measure to be used in ongoing treatment planning.

SUBSTANCE ABUSE SERVICES UTILIZATION

Substance abuse utilization rates are significantly lower than mental health services. In addition to the penetration rates reviewed in this section, CABHC monitors 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 27. Youth Receiving Substance Abuse Treatment is examined in the Performance Improvement Project (PIP) on page 22. CABHC also contracts with SASI/RASE to provide Members with ongoing advocacy services via presentations and the dissemination of D&A information throughout the Counties. Additionally, RASE provides a variety of training opportunities to the Members. These are discussed in the Contracts section, beginning on page 30.

During CY 2011, two of the four services declined, one increased slightly, and one remained the same. Outpatient D&A Clinic decreased slightly from 1.90% to 1.84% and Outpatient D&A – Targeted CM declined .01%. Non-Hospital based D&A Detox/Rehabilitation increased from .34% to .37% and Hospital Based D&A Rehab showed no change from last year.

Table 11: Child/Adolescent Penetration Rates: Substance Abuse Services

Category	CY 2007	CY 2008	CY 2009	CY 2010	CY 2011
Hospital-Based D&A Rehab	.02%	.02%	.01%	.02%	.02%
Non-Hospital D&A Detox/Rehabilitation	.02%	.28%	.37%	.34%	.37%
Outpatient D&A Clinic	1.23%	1.46%	1.75%	1.90%	1.84%
Outpatient D&A - Targeted CM	.05%	.04%	.03%	.04%	.03%

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. 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, and Non-Hospital D&A Halfway House.

The OMHSAS goal for the MH readmission rate is to be below 10%; however, the overall readmission rate for MH Inpatient services was 13.66%. This is a slight increase from last year. Data for Readmission rates for D&A show a slight decline in the total percent for D&A. As noted in Table 12, three services increased in the year, while two declined.

Table 12: Readmission Comparison by Year

Service Category	CY 2008	CY 2009	CY 2010	CY 2011
IP Psych	14.68%	13.28%	13.34%	13.66%
IP Psych- EAC	3.77%	15.31%	9.76%	7.58%
Total MH	14.49%	13.31%	13.29%	13.54%
IP D&A Detox	8.00%	4.17%	0.00%	5.26%
IP D&A Rehab	7.69%	27.78%	5.88%	14.29%
Non-Hosp D&A Detox	6.63%	6.58%	5.86%	4.42%
Non-Hosp D&A Rehab	6.28%	13.00%	7.30%	9.46%
Non-Hosp Res Halfway	9.05%	8.50%	12.86%	8.49%
Total D&A	8.14%	8.44%	7.48%	7.39%

Utilization of Services: Child/Adolescent and Adults

As part of our oversight, CABHC monitors the service utilization via claims submitted by Providers for both adults and children/adolescents. The data is analyzed by level of care, services paid, and number of Members served with the current data compared to the previous year. Tables 13 and 14 show the Counties results for these areas.

Data related to children/adolescents services paid for 2011 shows that four different levels of care with the highest percent of services paid are: BHRS (MT, TSS, BSC), 37.8%, Residential Treatment Facilities (RTF) and CRR-HH, 17.3%, Family Based Mental Health (FBMH), 13.1%, and BHRS/Exception Services, 10.0%. When comparing these amounts paid to last year, the data shows that BHRS experienced a 14.5% increase, while the other three experienced decreases; RTF/CRR HH declined 12.8%, BHRS/Exception Services, 3.1% and FBMH, 5.7%. Three other services with significant changes in the amount paid were MH Inpatient, 27.5% (increase), and decreases in D&A Residential 11.2%, and Targeted Case Management, 14.8%. The increase in Crisis Intervention (29.3%) is largely attributable to the change to the Alternative Payment Arrangements used by most Providers. During the year, the total amount paid for services increased 2.8% after showing an increase of 0.5% last year.

In terms of the actual number of children/adolescents served in 2011 compared to 2010, the data shows that of the 12 service categories, the number of children/adolescent served increased in seven, with the largest increase in D&A Other Services, 110.8%. It is noted that the percent of children in this service is only 1% of all children/adolescent served, which could account for the greater variance in the percent of change. BHRS, 31.2%, and BHRS Exception, 40.2% had the highest percent of all children served. These two categories increased by 6.4% and 3.3% respectively. Three services recorded declines this year, RTF and CRR-HH declined 12.2% and Targeted Case Management declined by 11.1%. Mental Health Outpatient remains the most

highly utilized at 77.3%. Overall, the increase in children/adolescents served was 5.1%, slightly less than last year's increase of 9.5%.

Table 13: Utilization Data for Children/Adolescent Services

Services[1]		Child/ Adolescent Services Amount Paid	Percent of All Child/ Adolescent Services Paid	Change in Child/ Adolescent Services Paid 2010 to 2011	Children/ Adolescents Served[2]	Percent of All Children/ Adolescents Served	Change in # Children/ Adolescents 2010 to 2011
BHRS (MT, TSS, BSC)	2010	$36,891,658	34.0%		4,207	30.8%	
	2011	$42,223,140	37.8%	14.5%	4,475	31.2%	6.4%
BHRS *Other/ Exception Services*	2010	$11,546,844	10.6%		5,575	40.8%	
	2011	$11,190,037	10.0%	-3.1%	5,759	40.2%	3.3%
Crisis Intervention	2010	$166,966	0.2%		875	6.4%	
	2011	$215,828	0.2%	29.3%	814	5.7%	-7.0%
D&A Other Svcs	2010	$43,843	0.0%		65	0.5%	
	2011	$61,718	0.1%	40.8%	137	1.0%	110.8%
D&A Outpatient *includes school-based*	2010	$139,899	0.1%		345	2.5%	
	2011	$135,330	0.1%	-3.3%	364	2.5%	5.5%
D&A Residential	2010	$2,095,213	1.9%		143	1.0%	
	2011	$1,860,732	1.7%	-11.2%	160	1.1%	11.9%
FBMH	2010	$15,453,550	14.2%		1,269	9.3%	
	2011	$14,570,605	13.1%	-5.7%	1,254	8.7%	-1.2%
MH Inpatient	2010	$6,596,318	6.1%		599	4.4%	
	2011	$8,413,159	7.5%	27.5%	625	4.4%	4.3%
MH Outpatient	2010	$8,422,162	7.8%		10,570	77.4%	
	2011	$8,941,267	8.0%	6.2%	11,094	77.3%	5.0%
MH Partial	2010	$2,006,563	1.8%		697	5.1%	
	2011	$2,048,366	1.8%	2.1%	682	4.8%	-2.2%
RTF and CRR-HH	2010	$22,169,597	20.4%		502	3.7%	
	2011	$19,332,137	17.3%	-12.8%	441	3.1%	-12.2%
Targeted Case Mgmt (MH)	2010	$3,078,734	2.8%		1,504	11.0%	
	2011	$2,622,483	2.3%	-14.8%	1,337	9.3%	-11.1%
TOTALS	2010	$108,611,346			13,652		
	2011	$111,614,803		2.8%	14,343		5.1%

[1]Services within categories:

- D&A Residential: Hospital-based and Non-hospital based detox and rehabilitation, and halfway house.
- D&A Other: D&A Targeted Case Management Services, Partial Hospitalization, D&A Intensive Outpatient Services
- BHRS Other: Evaluations, EIBS, Summer Therapeutic Activities Program, After School Program, and Multi-Systemic Therapy.

[2]Service category totals in this column are duplicated numbers as Members could receive more than one service. The final total is unduplicated.

During 2011, data related to adult services showed that four areas with the highest percent of services paid were: MH Inpatient and EAC (30.2%), D&A Residential (20.0%), MH Outpatient (18.0%), and Targeted Case Management (10.0%). Overall, services paid for adults increased 5.7% during 2011, which is less than the 11.4% increase for CY 2010.

Examining the data changes in adults served from 2010 to 2011, shows that four services reflected increases in utilization: MH Other Services, 12.8%, D&A Residential, 9.0%, D&A Other Services, 3.4% and MH Outpatient, 1.9%. Although five services declined in the number of adults served, all were less than 5.0%. They were: Targeted Case Management, 4.3%, MH Inpatient/EAC, and MH Partial, both at 2.2%, Crisis Intervention, 1.8%, and D&A Outpatient, 0.1%. Overall, the percent of adult Members served increased 4.1% for the year.

Table 14: Utilization Data for Adult Services

Services[1]		Adult Services Amount Paid	Percent of All Adult Services Paid	Change in Adult Services Paid 2010 to 2011	Adults Served[2]	Percent of All Adults Served	Change in # Adults Served 2010 to 2011
Crisis Intervention	2010	$487,290	0.9%	19.2%	2,288	12.6%	-1.8%
	2011	$580,703	1.1%		2,246	11.8%	
D&A Other Svcs	2010	$3,268,268	6.4%	6.7%	1,662	9.1%	3.4%
	2011	$3,486,728	6.4%		1,719	9.1%	
D&A Outpatient	2010	$1,391,549	2.7%	8.6%	3,024	16.6%	-0.1%
	2011	$1,511,756	2.8%		3,020	15.9%	
D&A Residential	2010	$9,596,089	18.7%	13.3%	1,495	8.2%	9.0%
	2011	$10,867,726	20.0%		1,630	8.6%	
MH Inpatient, EAC	2010	$16,201,892	31.5%	1.3%	1,929	10.6%	-2.2%
	2011	$16,413,263	30.2%		1,887	9.9%	
MH Outpatient	2010	$9,308,408	18.1%	4.9%	13,804	75.7%	1.9%
	2011	$9,764,341	18.0%		14,065	74.2%	
MH Other Svcs	2010	$3,878,968	7.5%	15.1%	555	3.0%	12.8%
	2011	$4,466,114	8.2%		626	3.3%	
MH Partial	2010	$1,825,846	3.6%	-0.9%	503	2.8%	-2.2%
	2011	$1,808,909	3.3%		492	2.6%	
Targeted Case Management	2010	$5,425,322	10.6%	-0.2%	3,056	16.8%	-4.3%
	2011	$5,412,648	10.0%		2,925	15.4%	

Services[1]		Adult Services Amount Paid	Percent of All Adult Services Paid	Change in Adult Services Paid 2010 to 2011	Adults Served[2]	Percent of All Adults Served	Change in # Adults Served 2010 to 2011
TOTALS	2010	$51,383,632		5.7%	18,224		4.1%
	2011	$54,312,188			18,965		

[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.

[2]Service category totals in this column are duplicated numbers as Members could receive more than one service. The final total is unduplicated.

ENROLLMENT

Enrollment refers to the number of eligible Members enrolled in the HealthChoices Program. Enrollment at the end of Calendar Year (CY) 2011, for the Counties totaled 181,755 eligible Members, an increase of 4.8% from CY 2010. This is the smallest percent of increase since CY 2008.

Table 15: Eligible Members and Change from Previous CY[1]

Year	CY 2008		CY 2009		CY 2010		CY 2011	
Members	150,171	2.31%	160,941	6.69%	172,960	6.95%	181,755	4.8%

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

Table 16 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 2008.

Table 16: Number of Eligible Members by County

County	CY 2008	CY 2009	CY 2010	CY 2011
Cumberland	18,967	20,806	23,111	24,003
Dauphin	44,787	47,390	50,230	52,120
Lancaster	63,588	68,762	74,382	79,608
Lebanon	18,667	19,874	21,151	22,716
Perry	5,830	6, 019	6,258	6,458
County totals are duplicated numbers.	151,839	162,581	175,132	184,905

The age breakdown, as shown in Table 17, shows that five of the age groups experienced increased percentages and two had the same percent as last year. 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.

Table 17: Number and Percent of Eligible Members by Age

Age Category	CY 2008		CY 2009		CY 2010		CY 2011	
	Num	Pct	Num	Pct	Num	Pct	Num	Pct
Ages 0 - 5	36,623	23%	39,046	23%.	46,620	22 %	42,930	23%
Ages 6 - 12	29,769	18%	32,025	18%	34,652	19%	36,629	22%
Ages 13 - 17	19,588	12%	20,622	12%	22,143	12%	23,293	13%
Ages 18 - 20	11,500	7%	13,338	8%	14,894	8%	15,254	8%
Ages 21 - 44	39,535	25%	42,408	24%	45,486	24%	48,088	26%
Ages 45 - 64	17,538	11%	18,944	11%	20.743	11%	22,743	12%
Age 65+	6,716	4%	6,734	4%	6,970	4%	7,254	4%

Note: Please note 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.

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 18 breaks down enrollment by category of aid. All of the categories increased in enrollment during CY 2011. 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 18: Enrollment Changes by Category of Aid

Category	CY 2008	CY 2009	CY 2010	CY 2011
Temporary Assistance to Needy Families (TANF) (0-21)[1]	76,738	56,825	59,073	60,866
Temporary Assistance to Needy Families (TANF (22+)[1]	n/a	23,655	24,651	25,880
Healthy Beginnings	41,509	46,378	51,848	54,449
Supplemental Security Income and Healthy Horizons with Medicare	16,437	17,199	18,143	19,172
Supplemental Security and Healthy Horizons without Medicare (0-21)[1]	28,234	15,025	16,276	17,281
Supplemental Security and Healthy Horizons without Medicare (22+)[1]	n/a	15,698	17,146	18,493
Categorically Needy, State Only General Assistance	5,312	6,060	6,782	7,242
Medically Needy, State Only General Assistance	2,335	2,557	2,842	3,034
Federal General Assistance	2,406	2,733	3,219	3,640

[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 19 documents penetration rates for each County and the Counties. Although enrollment throughout the Counties continued to increase, penetration declined in several counties.

Penetration rates for four of the five Counties experienced slight decreases. Lancaster was the exception, showing a slight increase.

Table 19: Penetration Rates

Fiscal Year	CY 2008	CY 2009	CY 2010	CY 2011
Counties	16.94%	17.70%	18.20%	18.08%
Cumberland	16.49%	17.11%	17.09%	16.78%
Dauphin	16.42%	16.92%	17.29%	17.24%
Lancaster	16.85%	17.66%	18.29%	18.37%
Lebanon	18.99%	20.41%	21.02%	20.53%
Perry	14.94%	15.38%	16.51%	15.83%

Table 20 shows that penetration rates within specific age groups reversed last year's data of increases in the majority of age groups, to all groups showing a decline this year. The 45-64 age group reflected the largest decline from last year, declining 1.15% from 26.67% to 25.17%.

Table 20: Penetration by Age

Age Category	CY 2008	CY 2009	CY 2010	CY 2011
Ages 0 - 5	4.13%	4.32%	4.32%	4.20%
Ages 6 - 12	19.72%	20.38%	20.85%	20.65%
Ages 13 - 17	24.36%	24.99%	25.68%	24.85%
Ages 18 - 20	13.72%	15.23%	14.89%	14.42%
Ages 21 - 44	21.26%	22.53%	23.16%	22.38%
Ages 45 - 64	25.50%	25.97%	26.67%	25.17%
Ages 65+	5.18%	5.02%	5.77%	5.80%

Table 21 highlights the penetration rates for Members by category of aid over the past four years. The penetration rate for all categories declined this year. The category with the greatest decline is Medically Needy, State Only, and General Assistance which declined 1.47%, from 9.15% to 7.68%.

Table 21: Penetration by Category of Aid

Category	CY 2008	CY 2009	CY 2010	CY 2011
Temporary Assistance to Needy Families 0-21 (TANF)	11.38%	10.93%	11.12%	11.03%
Temporary Assistance to Needy Families 22+	12.89%	14.42%	14.72%	14.10%
Healthy Beginnings	6.69%	7.19%	7.50%	7.22%
Supplemental Security Income and Healthy Horizon with Medicare	21.10%	21.41%	23.26%	22.24%
Supplemental Security Income and Healthy Horizon without Medicare 0-21	41.63%	43.76%	44.21%	42.89%
Supplemental Security Income and Healthy Horizon without Medicare 21+	33.61%	35.53%	31.58%	30.49%
Categorically Needy, State Only General Assistance	38.42%	38.38%	38.47%	35.53%
Medically Needy, State Only General Assistance	7.79%	9.62%	9.15%	7.68%
Federal General Assistance	42.44%	43.32%	41.13%	40.58%

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

Consumers by Race & Gender

CABHC strives to ensure quality of care and timely access to services for all Members, regardless of gender. This year, three groups account for almost 95% of all Consumers served: White (61.3%), Hispanic (18.2%), and Black (15.3%).

Tables 22 through 27 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 22, data for Cumberland County reflects increases in eligible Members and Consumers served in most categories. Penetration rates for Hispanics showed a decrease of 2.4%, going from 14.5% to 12.1%.

Table 22: Cumberland County Consumers by Race

Cumberland County	CY 2009			CY 2010			CY 2011		
	Eligible	Served	Penetration	Eligible	Served	Penetration	Eligible	Served	Penetration
American Indian	50	13	26.0%	63	9	14.3%	68	9	13.2%
Asian	540	28	5.2%	301	32	5.3%	598	33	5.7%
Black	1,829	190	10.4%	2,052	229	11.2%	,296	246	10.5%
Hispanic	1,019	149	14.6%	1,214	176	14.5%	1,352	165	12.1%
Other	1,713	226	13.2%	1,836	249,	13.5%	1,824	268	14.5%
White	15,656	2,938	18.8%	17,346	3,217	18.5%	17,856	3,382	18.9%

Table 23 indicates that Dauphin County generally experienced increases in all but the American Indian category in both eligible Members and Consumers served. Penetration rates were very similar to last year.

Table 23: Dauphin County Consumers by Race

Dauphin County	CY 2009			CY 2010			CY 2011		
	Eligible	Served	Penetration	Eligible	Served	Penetration	Eligible	Served	Penetration
American Indian	104	30	28.8%	119	25	21.0%	118	22	18.65%
Asian	1,316	42	3.2%	1,561	42	2.7%	1,839	53	2.9%
Black	18,200	3,000	16.5%	18,981	3,262	17.2%	19,572	3,416	17.5%
Hispanic	7,156	1,056	14.8%	7,573	1,110	14.7%	7,997	1,184	14.8%
Other	3,032	371	12.2%	3,186	399	12.5%	3,262	414	12.7%
White	17,586	3,460	19.7%	18,812	3,770	20.0%	19,297	4,024	20.8%

Table 24 for Lancaster shows increases in eligible Members and Consumers served in five of the six categories. The data for the American Indian category show slight declines. Penetration rates declined in American Indian and Black, while increasing in the other areas.

Table 24: Lancaster County Consumers by Race

Lancaster County	CY 2009			CY 2010			CY 2011		
	Eligible	Served	Penetration	Eligible	Served	Penetration	Eligible	Served	Penetration
American Indian	132	20	15.2%	115	19	16.5%	115	18	15.7%
Asian	1,757,	70	4.0%	2,121	78	3.7%	2,506	113	4.5%
Black	6,531	1,131	17.3%	6,853	1,231	18.0%	7,229	1,295	17.7%
Hispanic	19,781	2,941	14.9%	20,353	3,263	16.0%	21,743	3,591	16.5%
Other	3,440	513	14.9%	3,919	584	14.9%	4,252	662	15.6%
White	37,121	7,400	19.9	40,721	8,322	20.4%	43,138	9,018	20.9%

Table 25 documents that Lebanon County experienced increase for Eligible Members and Consumers served in all categories except American Indian. Penetrations rates increased in four categories.

Table 25: Lebanon County Consumers by Race

Lebanon County	CY 2009			CY 2010			CY 2011		
	Eligible	Served	Penetration	Eligible	Served	Penetration	Eligible	Served	Penetration
American Indian	25	8	32.0%	23	6	26.1%	14	5	35.7%
Asian	196	18	9.2%	208	15	7.2%	223	25	11.2%
Black	750	135	18.0%	805	148	18.4%	892	166	16.6%
Hispanic	5,945	932	15.7%	6,350	1,053	16.6%	6,923	1,139	16.5%
Other	407	66	16.2%	421	66	15.9%	484	87	18.0%
White	12,551	2,879	22.9%	13,344	3,141	23.5%	13,674	3,186	23.3%

Table 26 documents that Perry County experienced mixed results this year. Eligible Members increased in four of six categories, showing a decline in the American Indian and no change in the Asian category. Consumers served increased in all categories except American Indian which was the same as last year. Penetration rates varied; however, the smaller number of Members served to those eligible could cause greater variations in the penetration rate.

Table 26: Perry County Consumers by Race

Perry County	CY 2009			CY 2010			CY 2011		
	Eligible	Served	Penetration	Eligible	Served	Penetration	Eligible	Served	Penetration
American Indian	9	2	22.2%	6	2	33.3%	3	2	66.7%
Asian	19	2	10.5%	24	1	4.2%	24	2	7.3%
Black	56	9	16.1%	65	9	13.9%	98	10	10.7%
Hispanic	81	15	18.5%	104	14	13.5%	110	16	14.6%
Other	86	16	18.6%	98	22	22.5%	109	24	22.0%
White	5,769	879	15.2%	5,961	974	16.3%	6,111	990	16.2%

Table 27 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 27: Percent of Consumers Served by Gender

Gender	CY 2008		CY 2009		CY 2010		CY 2011	
	Consumers	Percent	Consumers	Percent	Consumers	Percent	Consumers	Percent
Female	12,485	49.1%	13,933	48.9%	15.473	49.2%	16,391	49.2%
Male	12956	50.9%	14,575	51.1%	15,984	50.8%	16,900	50.8%

CRITICAL INCIDENT REPORTING

CABHC's oversight responsibilities include ongoing monitoring of CBHNP's incident management system, which has been designed to monitor the health, safety, and rights of every individual who receives services. It is CBHNP and CABHC's goal to reduce critical incidents. The total number of all incidents was slightly lower than last year.

In terms of Member safety, it is noted that for the report year the use of restraints increased 8.0% this year, which is the third year for an increase. The increase could be attributed to providers being more compliant with reporting incidents and CCM more effectively reviewing reports submitted by providers. Regarding levels of care, RTF is reporting more incidents than any other level of care, followed by BHRS and Mental Health Inpatient services. CBHNP also reported that some providers appear to not be reporting CIR's as required. They pointed out that not reporting or underreporting could be a system problem as providers using Provider Connect are not being counted in the report. CBHNP is exploring this issue and will resolve the matter early in 2012. Additionally, CBHNP will develop a checklist for providers to use when

reporting critical incidents, which should be available by the second quarter of 2012. The check list seeks to act as a reminder to report incidents while improving the accuracy of the reporting process.

CBHNP continues to review critical incidents through their Quality Improvement (QI) department. This includes ongoing monitoring of CIR's that, due to the nature of the incident, may need additional review. During 2011, 31 CIR's were sent through the Quality of Care Committee (QOCC) by the QI department and the Clinical Department to their Corporate Compliance Committee (CCC) for review. The incidents reviewed by the CCC were Alleged Abuse by Staff (25), Member Safety (5), and Alleged Abuse by Family Member (1).

CABHC continues to distribute Critical Incident Report logs to designated County representatives. Table 28 summarizes critical incident data from CY 2008 through CY 2011.

Table 28: Critical Incidents by Category

Category	CY 2008	CY 2009	CY 2010	CY 2011	CY 2011 % less Seclusion and Restraint
Death of a Member while in Treatment	30	35	18	32	1.3%
Attempted Suicide	19	20	27	32	1.3%
Medication Error	47	62	64	41	1.7%
Any event requiring the services of the fire department, or law enforcement activity	310	310	360	423	17.5%
Abuse or Alleged Abuse of a Member	175	179	258	294	12.2%
Any injury or illness (non-psychiatric) of a Member requiring medical treatment more than first aid	232	249	233	323	13.4%
Unexplained Absence of a Member (AWOL)	137	189	270	194	8.0%
Any fire, disaster, flood, earthquake, tornado, explosion, or unusual occurrence that necessitates the temporary shelter or relocation of residents.	17	2	27	0	0.0%
Other incident identified by providers as Critical, Adverse, or Unusual	978	1,040	1,191	1,073	44.4%
Blank/Not Provided	6	3	21	5	0.2%
Subtotal	1,951	2,089	2,469	2,417	62.0%[1]

Category	CY 2008	CY 2009	CY 2010	CY 2011	CY 2011 % less Seclusion and Restraint
Seclusion	130	154	94	72	4.9%[2]
Restraint	1,559	1,251	1,304	1,409	95.1%[2]
Total of Seclusion/Restraint	1,686	1,405	1,398	1,481	38.0%[1]
Total of All Incidents	3,637	3,494	3,867	3,898	

[1]Percent of all Incidents (3, 898) [2]Percent of total of Seclusion/Restraints (1,481)

The data in Table 29 shows that the total number of critical incidents for all age groups showed a slight increase in 2011. The data shows that 84.3% of all critical incidents fall into the children/adolescent age range (0-17), which is slightly lower than last year's 85.2%. Critical Incidents increased by 38 for the 18-64 age groups, and four in the 65+ age group.

Table 29: Critical Incidents by Age

Age Category	CY 2007	CY 2008	CY 2009	CY 2010	CY 2011	% of CY 2011
Children (0-12)	1,038	1,284	1,050	1,281	1,515	38.9%
Adolescents (13-17)	1,226	1,852	1,883	2,014	1,770	45.4%
Adults (18-64)	346	496	553	505	543	13.9%
Adults (65+)	5	5	8	6	10	0.3%
Totals	2,615	3,637	3,494	3,867[1]	3,898[2]	

[1]Total includes 61(1.57%) that were submitted with no age identified. [2]Total includes 60(1.5%) that were submitted with no age identified.

The CABHC Clinical Committee reviews Critical Incidents each quarter and if there are irregularities in reporting practices or an increase in the number of any specific reporting category occurs, the findings are reviewed 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 also 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 36,497 requests for services; 13,836 for children and 22,661 for adults. The number of requests overall (+435) and for adults (+1,666) was higher than last year while the number of requests for children's (-1,231) declined.

The number of Members denied, who had a service, declined to 748 this year, compared to 1,023 last year. The decline demonstrates CBHNP's continued efforts 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 30 summarizes the reasons for treatment denials for the past four years. The main reason for denials continues to be Service Not Medically Necessary, which is almost at 100% for the second year, with 99.1 % in 2011.

Table 30: Reasons for Denials

Denial Reason	CY 2008			CY 2009		
	Denials	% of Total Denials	Unduplicated Members	Denials	% of Total Denials	Unduplicated Members
Service not medically necessary	2025	96.2%	1367	2778	97.2%	2,109
Service not covered under the plan	0	0.00%	0	2	0.1%	2
Facility failed to provide sufficient information	74	3.5%	59	76	2.7%	68
Recipient not covered for the service	2	0.10%	2	0	0.0%	0
Total	2106	100.00%	1,428	2856	100%	2,179

Denial Reason	CY 2010			CY 2011		
	Denials	% of Total Denials	Unduplicated Members	Denials	% of Total Denials	Unduplicated Members
Service not medically necessary	1313	99.2%	1,013	789	99.1%	673
Service not covered under the plan	0	0.0%	0	2	0.3%	2
Facility failed to provide sufficient information	11	0.8%	10	4	0.5%	3
Recipient not covered for the service	0	0.0%	0	0	0.0%	0
Total	1324	100%	1,023	795	100%	678

A denial does not necessarily indicate that a Member is not authorized to receive treatment. During the year, 65.3% of service requests that were denied were approved for some level of treatment. This is slightly higher than the 63.3% in CY 2010. The percent of Totally Denied decreased for the first time since 2008. Table 31summarizes the number of treatment denials across various dispositions with respect to alternative services.

Table 31: Disposition of Requested Service

Denial Reason	CY 2008			CY 2009		
	Denials	% of Total Denials	Unduplicated Members	Denials	% of Total Denials	Unduplicated Members
Totally denied	655	31.1%	539	941	32.9%	839
Service approved at different amount	575	27.3%	501	710	24.8%	647
Service approved at different duration	72	3.4%	65	139	4.9%	136
Service approved at different amount and duration	321	15.2%	217	395	13.8%	374
Different service approved	483	22.9%	460	676	23.6%	656
Grand Total	2106	100.00%	1420	2,861	100.00%	2,163

Denial Reason	CY 2010			CY 2011		
	Denials	% of Total Denials	Unduplicated Members	Denials	% of Total Denials	Unduplicated Members
Totally denied	486	36.7%	448	276	34.7%	255
Service approved at different amount	343	25.9%	313	209	26.3%	197
Service approved at different duration	46	3.5%	45	36	4.5%	36
Service approved at different amount and duration	95	7.2%	91	31	3.9%	30
Different service approved	354	26.7%	343	244	30.7%	240
Grand Total	1324	100.0%	1240	796	100%	757

Table 32 summarizes the breakdown of treatment denials by age group. Children's services (0-17) accounted for 80% of all denials, a decline from the 90.4% of a year ago. Adults, 18-64 increased to 18.1%, up from 9.10% last year. Denials for the specific age range of 13-17 have remained around 22% for the past four years.

Table 32: Denials by Age

Denial Reason	CY 2008			CY 2009 (Age categories changed)		
	Denials	% of Total Denials	Unduplicated Members	Denials	% of Total Denials	Unduplicated Members
Ages 0 - 5	318	15.28%	182	2,041	71.3%	1,464
Ages 06 - 12	1,182	56.82%	650			
Ages 13 - 17	474	22.77%	327	615	21.5%	505
Ages 18 - 20	31	1.49%	26	204	7.1%	193
Ages 21 - 44	55	2.64%	19			
Ages 45 - 64	20	1.00%	19			
Ages 65+	0	0.00%	0	1	0.0%	1
Denial Reason	**CY 2010**			**CY 2011**		
	Denials	**% of Total Denials**	**Unduplicated Members**	**Denials**	**% of Total Denials**	**Unduplicated Members**
Ages 0 - 12	910	67.7%	658	457	57.4%	349
Ages 13 - 17	305	22.7%	258	180	22.6%	167
Ages 18 -64	122	9.10%	114	144	18.1%	136
Ages 65+	4	0.30%	3	2	0.3%	2

Corrective Action Plan: Denial Letters

OMHSAS, Division of Quality Management conducted a review of denial notices in May 2011. In the report, dated October 2011, they noted two areas that required corrective action. The first area was that denial letters frequently did not include the credentials of the Provider or the Peer Reviewer. The second finding focused on the inclusion of an explanation of the reasons the services was not approved as requested along with the reasons for the denial were not clearly stated. Therefore, a Corrective Action Plan (CAP) was put in place to provide education and training of their staff to ensure that credentials were included in denial letters, and that the reasons for the denial are clearly provided in the letter. As a result of the CAP, CABHC developed a Denial Monitoring action plan that included:

1. Review quarterly the CBHNP QI department tracking records of denial letters.
2. Review quarterly CBHNP QI report to their clinical department.

3. Review Denial Worksheets to insure the inclusion of recommended credential omissions elements are included in the worksheet. The revisions were due to be completed by 11/30/2011.
4. Review 10% of each county's denial letters per month. (Denial letters are posted monthly to the CBHNP FTP site.)
5. Report of findings will be submitted quarterly and sent to OMHSAS and CBHNP.

CABHC conducted a review of CBHNP's Denial Worksheet and found that they were revised to include directives to include both the credentials and clearer statement of the rationale for the denial and rationale for approving a service other than the one requested were included in the revised worksheet. CABHC confirmed this and reviewed the sign-in sheets from the training sessions. CABHC will begin monitoring the denial letters effective in the first quarter of 2012.

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 2011, 90 Level I complaints were filed compared to 64 last year, a 40% increase. CBHNP resolved 100% of the Level I complaints within the required timeframe. Data analysis showed there were 0.53 Level I complaints per 1000 Members for the year. There was one Level II Complaint filed during the fiscal year.

CABHC monitors the type of complaints that are filed with CBHNP. During CY 2011, of the 90 Level I complaints filed, 83 were filed against providers and 7 against CBHNP. The three levels of service with the greatest percent of complaints were: BHRS, 37%, Psychiatric Outpatient, 30%, and Psychiatric Inpatient, 11%. 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 90% of the time, slightly lower than the 95% 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.

Tables 33-36 summarize the outcomes for grievances filed during CY 2011. Level I grievances fell from 180 to 111, a 38% decrease. Level II declined 40% falling to 18 from 30 in the previous year. The data for Level I shows an increase in grievances toward the end of the CY. A possible reason for the increase is related to the number of denials issued. The higher number of denials could lead to the higher number of grievances. Although the trend for grievances is up for the year, the chart shows that the increase in grievances during the last three months would have caused a sharp upturn. Even with the increase occurring, the overall data shows that the number of Level I grievances per 10,000 members is .66, well below the target from the previous corrective action plan of 3.5 per 10,000. The number of Level I grievances that moved to Level II continued to decline, to only 18. The percent of Level I moving to Level II, 16.2%, was slightly lower than the 16.7% of last year.

County data shown in the tables below reflect declines in both Level I and Level II grievances in most Counties. Dauphin County had the greatest decline in the number of Level I grievances for the year, from 61 to 26. Cumberland County is the only county that increased the number of Level II grievances this year, increasing by two, and Perry had no Level II grievances.

Shown in Table 34, outcomes for Level I grievance reviews this year revealed that 65.4% were Upheld for the MCO an increase from the 52.7% last year. The percent Overturned for the Member declined to 34.6%, from 47.3% a year ago.

Table 35 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 or did not resolve the complaint or grievance within 30 days when it was filed.

During CY 2011, there were only three External Reviews, compared to four in CY 2010. 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. Two of the three were withdrawn and one was upheld for the MCO. The one Fair Hearing filed last year was withdrawn.

Table 33: Level I & Level II Grievances by County

County	Level I Grievances			Level II Grievances		
	CY 2009	CY 2010	Cy 2011	CY 2009	CY 2010	CY 2011
Cumberland	52	22	15	17	1	3
Dauphin	134	61	26	27	11	5
Lancaster	138	66	46	36	10	5
Lebanon	52	22	21	19	6	5
Perry	16	9	3	4	2	0
Counties	392	180	111	103	30	18

Table 34: Grievance Escalation: Level I to Level II

County	CY 2009			CY 2010			CY 2011		
	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	52	17	32.7%	22	1	4.5%	15	3	15.0%
Dauphin	134	27	18.7%	61	11	18.03	26	5	27.7%
Lancaster	138	36	22.5%	66	11	16.7%	46	5	15.6%
Lebanon	52	19	36.5%	22	5	22.7%	21	5	27.7%
Perry	16	4	25.0%	9	2	22.2%	3	0	0.0%
Counties (Less withdrawn)	392	103	26.3%	180	30	16.7%	111	18	22.2%

Table 35: Grievance Outcomes: Level I/Level II

Outcome	Level I						Level II					
	CY 2009		CY 2010		CY 2011		CY 2009		CY 2010		CY 2011	
Denial Upheld	283	89.8%	59	52.7%	53	65.4%	72	84.7%	24	85.7%	12	80.0%
Overturned	32	10.2%	53	47.3%	28	34.6%	13	15.3%	4	14.3%	3	20.0%
Withdrawn	77	n/a	68	n/a	30	n/a	18	n/a%	2	n/a	3	n/a
Total (less Withdrawn)	315		112		81		85		28		15	

Note: Format concerns did not allow for the inclusion of data prior to CY 2009.

Table 36: Grievance: External Reviews/Fair Hearings

Outcome	External Review						Fair Hearings					
	CY 2009		CY 2010		CY 2011		CY 2009		CY 2010		CY 2011	
Denial Upheld	19	70.4%	3	75.0%	1	100%	1	50.0%	0	0.0%	0	0%
Overturned	8	29.6%	1	25.0%	0	0.0%	1	50.0%	1	100%	0	0%
Withdrawn	3	n/a	1	n/a	2	n/a	7	n/a	1	n/a	1	n/a
Total (less Withdrawn)	27		4		1		2		1		0	

Note: Format concerns did not allow for the inclusion of data prior to CY 2009.

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

CABHC also reviews Member satisfaction surveys conducted by CBHNP. 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 Counties. 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. 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 Consumer Satisfaction Services, Inc. (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.

As noted in the Service Support Contract section of this report, p. 29, CSS instituted several changes during the year to strengthen their team, maintain the validity and consistency of their data, and gain rapport with area service providers and the recovering community. The changes resulted in performance improvement with the survey process.

This year there was greater emphasis on conducting interviews face to face compared to those conducted by telephone or by mail. During this annual reporting period, July 2010 to June 2011, CSS conducted 935 interviews with consumers at various locations: drug and alcohol facilities, consumer homes and the CSS office. While the total number of surveys decreased from last year, the number of face to face interviews significantly increased to 93.2% compared to only 36% during last year. There were only 6.6%, of the interviews conducted by phone, and 0.2% conducted by mail. The significance of face to face interviews vs. telephone or mail allows consumers and surveyors to gather and report information with greater reliability and validity.

Data was collected by 9 interviewers from 45 treatment facilities. The 611 adult consumers received services from 39 service providers. The 324 child consumers received services from 13 service providers. Of the 45 service providers, 30 provided services only to adult consumers, 4 provided services only to child consumers, and the remaining 11 service providers provided services to both adult and child consumers.

The data from the survey is shown in tables 37 through 42. During FY 2010-2011, the percent of the gender break down revealed slightly more males (51.3%) than females (48.7%) were interviewed. Table 38 shows the number of interviews by County, again this year Lancaster had the largest number of respondents.

Table 37: 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%
2010-2011	935	611	63.3%	324	34.7%

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

Table 38: CSS Interviews by County

	FY 2007-2008		FY 2008-2009		FY 2009-2010		FY 2010-2011	
	Number Interviewed	% of Total	Number Interviewed	% of Total	Number Interviewed	% of Total	Number Interviewed	% of Total
Cumberland	210	17.28%	84	18.6%	134	10.8%	135	14.4%
Dauphin	341	27.9%	128	28.4%	348	27.9%	283	30.3%
Lancaster	410	33.5%	164	36.4%	477	38.3%	415	44.4%
Lebanon	117	9.6%	46	10.2%	236	18.9%	74	7.9%
Perry	76	6.2%	20	4.45%	36	2.9%	28	3.0%
Other	63	5.2%	7	1.6%	15	1.2%	0	0.0%
Missing	6	0.5%	2	0.4%	0	0.0%	0	0.0%
Total	1,223		451		1,246		935	

CSS follows a set rotation schedule for the inclusion of different types of services during the FY. A total of 13 different levels of care reported in the survey data. Table 39 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, five services made up the majority of surveys: Mental Health Adult OP (17.3%), Targeted Case Management (16.7%), Summer Therapeutic Activities Program (STAP) (11.1%) and Non-Hospital Residential Rehabilitation (11.0%).

Table 39: FY 2010-2011 CSS Survey - Level of Service

Level of Care	Adults		Children Adolescents		All Interviews	
MH –Psychiatric- Partial Hospitalization	30	4.9%	47	14.5%	77	8.2%
Targeted Case Management	108	17.7%	48	14.8%	156	16.7%
Non-Hospital Residential Rehabilitation	84	13.7%	19	5.9%	103	11.0%
Crisis Intervention	74	12.1%	22	6.8%	96	10.3%
MH –-Outpatient Clinic	162	26.5%			162	17.3%
D&A Detox	16	2.6%			16	1.7%
D&A Residential Halfway House	31	5.1%			31	3.3%
D&A Outpatient Clinic	63	10.3%			63	6.7%
Mobile Psychiatric nursing	13	2.1%			13	1.4%
Peer Support Services	30	4.9%			30	3.2%
Summer Therapeutic Activities Program			104	32.1%	104	11.1%
After School Program			68	21.0%	68	7.3%
Community Residential Rehabilitation – Host Home			16	4.9%	16	1.7%
Total	611		324		935	

Note; Shaded areas indicate that no children/adolescents or adults fell into the sample for that category.

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 the 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 Counties.

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

As seen in Table 39, scores in the Implementation section were all lower than a year ago. Overall, the majority of consumers are satisfied with their services. Although the overall satisfaction and Child/Adolescent scores have declined each year since 2008-2009, the scores have not had large changes and have been consistently in the 80% range. When looking at the

overall satisfaction ratings between Adults and Child/Adolescent, the scores are similar with adult respondents indicating that they "Agree" or "Strongly Agree" at 85.6% and those who received Child/Adolescent services reporting 83.0%.

Following three years of improvement, the area of Members being informed about their rights slightly declined from 93.2 to 92.0%. Two areas showed large declines this year. The overall response for having choice in selecting the service provider was 69.0%, compared to 79.0% last year. Adult satisfaction with selecting the provider declined from 74.2% to 63.5%, while the Child/Adolescent decline was smaller, 83.0% last year to 79.3%. Members were less satisfied about having the option of changing their service provider. The score was 9.7% lower this year than last, 86.1% to 76.4%. Child/Adolescent was less satisfied, decreasing from a high of 89.5% last year to only 72.7% in this survey.

Table 40: CSS Comparison Implementation Data

IMPLEMENTATION		2007-2008[1]	2008-2009	2009-2010	2010-2011
Mean satisfaction		76.8%	82.6%	80.6%	81.7%
Overall I am satisfied with the services I am receiving.	All	77.6%	86.7%	86.4%	84.7%
	Child		85.6%	83.9%	83.0%
	Adult		87.5%	89.5%	85.6%
I had a choice in selecting my service provider.	All	72.8%	72.9%	79.0%	69.0%
	Child		77.0%	83.0%	79.3%
	Adult		70.1%	74.2%	63.5%
I have the option to change my service provider should I choose to.	All	74.8%	76.1%	86.1%	76.4%
	Child		84.5%	89.5%	72.7%
	Adult		70.1%	82.1%	79.3%
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%	91.4%
	Child		91.4%	92.6%	93.2%
	Adult		86.4%	91.9%	90.5%
I was informed about my rights and responsibilities regarding the treatment I have received.	All	86.2%	88.9%	93.2%	92.0%
	Child		92.0%	93.9%	96.6%
	Adult		86.7%	92.3%	89.5%
Program staff respects the role of my ethnic, cultural and religious background in my recovery/treatment.	All	90.0%	90.5%	92.0%	89.7%
	Child		91.4%	91.0%	91.7%
	Adult		89.8%	93.2%	88.7%
I am an equal partner in the treatment process.	All	83.5%	86.9%	89.9%	89.6%
	Child		89.8%	90.1%	92.9%
	Adult		84.8%	89.6%	87.9%

[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".

As with the Implementation, Outcome scores declined for this survey year. Although the scores were lower than last year, the one area that showed improvement was that Members were hopeful about the future, which improved from 66.9% to 69.5%. The Child/Adolescent score slightly improved from 61.5% to 63.0%. The Adult score dipped slightly from 73.3% to 73.1%. The area with the greatest overall decline was in the area of strengthening their social support network. The ratings for dealing with people in social situations were much lower this year. There was a decline of 8.9%, from 68.0% to 59.1%, while Child/Adolescent scores were currently 55.2% compared to 65.7%. Adults rated better/much better at 61.2% of the time compared to 70.7% a year ago.

Of the seven Outcome questions, the overall scores for five have declined for three years. They are: Enjoying my free time, Managing daily problems, Strengthen my social support network, Feeling in control of my life, Feeling good (hopeful) about the future. CSS will be conducting a longitudinal study of the past five years of survey results. The results will be reviewed by the System Improvement Committee, and will be reported on the next annual report.

Table 41: CSS Comparison Outcome Data

OUTCOME		2007-2008[1]	2008-2009	2009-2010	2010-2011
		Better/Much Better			
Enjoying my free time.	All	60.0%	72.5%	73.0%	69.7%
	Child		75.4%	72.5%	72.8%
	Adult		70.5%	73.7%	68.1%
Managing daily problems.	All	65.7%	73.6%	72.9%	70.2%
	Child		67.4%	68.5%	64.5%
	Adult		78.0%	78.1%	73.2%
Dealing with problems or issue that led to seek services.	All	62.7%	70.5%	72.2%	68.6%
	Child		60.4%	68.3%	63.6%
	Adult		77.7%	76.8%	71.2%
Strengthen my social support network.	All	55.8%	69.8%	69.1%	61.5%
	Child		65.8%	66.9%	59.3%
	Adult		72.7%	71.8%	62.6%
Feeling in Control of my life.	All	57.1%	67.8%	66.9%	63.8%
	Child		56.7%	60.9%	56.2%
	Adult		75.8%	73.9%	67.9%
Feeling good (hopeful) about the future.	All	57.4%	71.4%	66.9%	69.5%
	Child		64.2%	61.5%	63.0%
	Adult		76.5%	73.3%	73.1%
Dealing with people in social situations	All	55.3%	65.9%	68.0%	59.1%
	Child		56.1%	65.7%	55.2%
	Adult		72.7%	70.7%	61.2%

[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 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" or "No" while excluding those who responded "Does Not Apply".

The survey found in table 42 shows 93.4% of all respondents responded "Yes" that overall, they were satisfied with the interactions they had with CBHNP, which is slightly higher than last year. Although the overall rating for CBHNP improved, the overall ratings for the other three questions showed decreases. Overall, Members having choice of at least two providers declined 14.4% from the highest score achieved last year (80.3%), to the lowest score this year of 65.9%. Adult scores in this area declined to below 60% for the first time at 59.5%. Adult Members being aware of their right to file a complaint or grievance decreased from 96.7% last year to 84.7%, the lowest rating in three years. The overall score for awareness of filing rights decreased from 93.1% last year to 88.5%.

Table 42: Questions Related to CBHNP

QUESTIONS RELATED TO CBHNP		2007-2008	2008-2009	2009-2010	2010-2011
Overall, I am satisfied with the interactions I have had with CBHNP.*	All	89.5%	93.5%	91.4%	93.4%
	Child		96.4%	90.6%	94.3%
	Adult		90.0%	91.9%	92.8%
I was able to obtain information on treatment and/or services from BHP without unnecessary delays.*	All	74.4%	78.3%	86.3%	79.7%
	Child		71.4%	85.3%	73.7%
	Adult		81.8%	87.4%	85.1%
I am aware of my right to file a complaint or grievance.*	All	85.4%	89.0%	93.1%	88.5%
	Child		88.3%	95.0%	95.6%
	Adult		89.5%	96.7%	84.7%
I was given, choice of at least (2) Providers from CBHNP regarding the type of service I am seeking. *	All	76.5%	76.2%	80.3%	65.9%
	Child		68.2%	85.4%	76.9%
	Adult		80.0%	73.3%	59.5%

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 81.2% of the time, slightly higher than the 79.4% rating last year. Those choosing Fair/Poor increased from 10.0% last year to 14.1% this year. Cleanliness was rated slightly higher than year's 81.2% with an

Excellent/Good rating of 83.8% this year, while 11.0% rated it as Fair/Poor, up from 7.9% last year. The rating for the friendliness of staff as Excellent/Good was slightly lower this year, scoring 85.4% compared to 87.8% rating a year ago, while Attentiveness slipped to 83.1% this year compared to 86.7% last year.

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 15,609 adult and child/adolescent Members who received services during 2010. Polk-Lepson conducted a random sampling to conduct the survey. The response rate for adults was 7.3% compared to 24.0% last year. The children/adolescent survey response rate of 7.88% was lower than the previous year's rate of 13.8%.

Adult Survey

The adult survey found that slightly more Members attended counseling or treatment for personal problems, family problems, emotional or mental illness this year, 95.2% to 96.1%. However, those seeking counseling or treatment for alcohol or drug abuse increased from 11.7% to 31.3%.

Adult Members responded positively this year than last year. Members rated their general health better as it showed an increase of those rating it very good or excellent from up 10.7% compared to last year. Similarly, Members rated their overall mental health very good or excellent higher this year, increasing by 9.5% from 17.2% to 26.7%. More responding Members indicated that they were provided information about self-help or support groups with 67.2% responding favorably, increasing from 60.9% last year. This is the highest rating for this area since 2008. In the area of getting counseling or treatment right away or as soon as they wanted improved from 66.1% last year to 72.2% this year. 58.5% of Members reported that delays in getting treatment or counseling while waiting for authorization was not a problem, increasing from 44.7% last year. Only 19.5% said it was a big problem.

Several areas showed a decline in satisfaction this year. 83.8% of Members reported that they were not as involved in their treatment or counseling as much as they wanted compared to 93.6% last year. Members also rated lower the amount of time people they went to counseling or treatment spent with them, from 90.2% last year to 83.6%. Members rated being respected slightly lower at 89.6% compared to 92.7% last year. In the area of having things explained in a way they could understand declined to 82.1%, its lowest rating since the survey began.

Overall, the area of Receiving Help is trending slightly down. Evaluation of Interaction during counseling or treatment and Information Received are both showing upward trends. Members rated their overall treatment or counseling they received on a scale that ranged from 0, worst

possible, to 10, best possible. 69.2% of Members assigned a rating of 8 or higher, the percent of those assigning a rating between 3-7 was 29.2% while and only 1.5% assigned a rating of 0-2.

Child/Adolescent Survey

In the area of receiving treatment or counseling as soon as Members wanted it, this improved to 68.1% from 63.9% last year. Examining how long a Member had to wait for treatment found that slightly over half, 57.7% had to wait three days or longer; however, 42.3% received services within two days, both scores reflect a change from last year when only 38.9% had to wait three days or longer last year, and 61.1% received services within two days. Members reported greater satisfaction for being seen within 15 minutes of the appointment with 80.3% responding Usually/Always. Members rated being listened to carefully, 89.9%, which is higher than the 81.4% rating a year ago. Members also reported that they were involved as much as they wanted in their child's counseling or treatment with 92.1% responding Usually/Always, 8.4% higher than last year.

When asked if the goals of treatment or counseling were discussed completely, 88.2% responded yes; however, that is a decline from a high of 97.6% last year and is the lowest response since 2008. There was also a decrease in those reporting that they were given information about self-help or consumer-run groups, with only 30.6% reporting they received information, down from 37.8% last year and from a high of 64.3% in 2009. In the area of rights, 83.4% reported that they were given information about their rights, the lowest rating since a high of 92.8% in 2008. This area is trending down. When asked to rate their overall mental health, only 27.4% reported that it was Excellent/Very Good, slightly lower than last year's 31.9%, while 72.6% reported it to be Good/Fair/Poor.

Looking at accessing services, there was an increase in the percent of Members who said that delays waiting for approval for service were not a big problem, increasing from 54.9% to 65.8% in this survey. Likewise, 52.1%, Members reported that it was not a big problem getting the help they needed when calling member services, up from 40.0%.

Members rated their overall treatment or counseling they received on a scale that ranged from 0, worst possible, to 10, best possible. 65.5% of adult Members rated their treatment as 8 or higher, a marked improvement from 51.8% a year ago. The percent of those assigning a rating between 3-7 was 32.8%, while 1.7% rated it 0-2.

Based on the results of the studies, CBHNP identified three areas for action; the ability to be seen "as soon as wanted", "satisfaction with information received" and "information on self-help or support groups." CBHNP will evaluate the need to improve access to counseling by comparing their results to the same areas of the C/FST surveys. Additionally, they will explore the feasibility of funding or at least encouraging providers to participate in the "Access Redesign" Quality Improvement Initiative sponsored by PCPA. This initiative focuses on streamlining documentation, encouraging walk-in models of operation which eliminate "no shows" and establishing "episodes of care" which are tied to functional scales to allow for efficient management.

A second initiative will address providing a resource directory for the region that will include all available self-help and support group resources. Additionally, a web based "Wellness Library" will be developed for inclusion on the CBHNP website. They will continue to encourage Providers to utilize the resources and make them available to Members in paper copy as they apply to their treatment needs.

PROVIDER SATISFACTION

CABHC Provider Satisfaction Survey

The Provider Satisfaction survey was sent to all Providers listed in the CBHNP Capital Area provider network to obtain feedback about CBHNP and the HealthChoices program. The survey was sent to 672 Providers via email and postcards which directed Providers to the CABHC website. Forty-eight surveys were returned as undeliverable. Of the 624 surveys that were delivered, 149 responses were received, which is a 23.9% response rate. This is an increase over the 19.5% response rate in 2010. 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.

The majority of responses, 69% came from providers of mental health services, while 18% were from substance abuse providers, and 15% provided Co-Occurring services. Percentages include Providers who indicated having both mental health and substance abuse services; and serving both children and adults. This accounts for percentages totaling more than 100%.

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. Ten new questions were added to this year's survey, including a section regarding the use of and satisfaction with the CBHNP Provider Manual. 70% of respondents found the Provider Manual "very helpful" or "somewhat helpful", and most Providers (65%) reported referencing the Manual monthly or more. The survey results shown in Table 43 show the individual complaint and grievance scores as well as a combined score. Additionally, all areas related to communication were combined into the Written/Electronic section.

Four sections decreased in average score from 2009 to 2010, and four sections increased, with one section, *Member Services*, remaining the same at 4.0. *Provider Relations* and *Provider Training* scored the highest 4.13 and 4.10 respectively. The largest decrease was in *Complaints and Grievances* which decreased by 0.53 to 3.29 out of 5 points. The 3.29 score for *Complaints and Grievances* was also the lowest score and the greatest change by section. The *Member Services Staff* score has been the most consistent over the past three years with all scores at 4.00. Although the overall score has slightly declined over the past three years, the change is less than one-tenth of one point.

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. Table 43 shows the average rating for each area for the past three years:

Table 43: CABHC Provider Satisfaction Survey

2010 Provider Satisfaction Scores	2008	2009	2010
Provider Relations	4.20	4.11	4.13
Clinical Department & Care Management	3.71	3.78	3.52
Provider Meetings and Training	3.94	3.90	4.10
Member Services Staff	4.01	4.00	4.00
Complaints	4.01	3.79	3.08
Grievances	3.65	3.69	3.45
Combined Complaint and Grievance	3.80	3.82	3.29
Written/Electronic Communication	n/a	3.71	3.82
Provider Newsletters[1]	3.94	3.10	n/a
Claims Processing	3.99	3.89	3.83
Administrative Appeals	3.62	3.72	3.71
Communication[1]	n/a	3.91	n/a
Provider Orientation	n/a	3.93	4.00
Overall Survey Average	3.90	3.83	3.81

[1]Communication and Provider Newsletter were merged into Written/Electronic Communication.

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 data in Table 44 provides a comparison of the survey demographics between 2009, 2010, and 2011. The response rate is slightly lower than last year. Of the 124 surveys returned, 38.7% (48) were from the Capital region, 25% (31) from the North Central region, and 36.3% (45) were Out of Network.

Table 44: CBHNP 2010 Provider Survey Distribution/Response Rate

	2009	2010	2011	Variance
Surveys distributed	1,352	1,401	1,196	-205
Surveys completed	197	160	124	-36
Surveys returned undeliverable	83	167	132	-84
Response Rate	15.5%	13.0%	11.7%	-1.3%
Surveys completed online	91	20	0	-20

The 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 analysis of the Capital region data found improvement in the Timeliness of Authorizations, from 89.8% last year to 95.7% this year, marking the third year this area increased. The survey found that the Availability of ER services was 100% for the third year. Also, the Availability of Clinical Care Managers has improved each year since 2009, increasing to 94.1% from 80.0%.However, the Availability of Services for Mental Health/Substance Abuse, 84.8%, has declined each year since 2008. Also trending down was Coordination of Physical Health Plans declining from 97.0% to 90.5% and Availability of Children's Services at 75.9% compared to 82.9% last year. Clarity of Documentation (86.0%) has improved each year since 2009.

The results in the area of Provider Relations showed an overall decrease in scores this year. Only 2 of the 11 areas scored above 90% compared to 8 scoring above 90% last year. Two areas that are trending down are Helpfulness of Provider Relations Staff (87.2%), down since 2008 and the Credentialing Process (84.6%) trending down since 2009. The two areas scoring above 90% were Timeliness of Calls Answered and Courtesy of Provider Relations Staff, both 91.5%.

Member Services/Care Management scores were similar to last year with only three arras scoring below 90%. Consistency of Response by Staff declined from 83.0% to 81.6% this year. This area has declined every year since 2009. Access to Second Opinion fell from 92.0% to only 80.0% this year and has been below 90% since 2008. Clinical Care Manager Turnover Rate fell 10%, from 97.0% to 87.0%. Timeliness of Calls Answered is trending upward and improved to 92.7% this year, compared to 86.8% last. The area with the highest score is Application of Levels of Care Criteria by Clinical Care Managers, at 93.3%, increasing from 88.4%.

In the Administrative Providers section of the study, there are many areas that Polk-Lepson identified as showing decreasing trends. In the area of claims, although scoring 92.3% this year, scores for the period of 2009-2011 were somewhat lower than the period from 2006-2008. The same pattern occurred for Timeliness of Claims Resolution and Timeliness of Complaint Resolutions. On a positive note, Consistency of Payment Fee Schedule scored 100% satisfaction this year. Additionally, Clarity of Precertification Policies improved from 91.7% last year to 92.1% this year.

Data for the Capital areas revealed that all six areas of Provider Relations fell below 90%. Three areas were identified by Polk-Lepson as trending downward. The Credentialing Process declined to 84.6%, Clarity of Provider Performance Specifications fell to 84.6%, and Provider Forum for Feedback/Problem Solving fell to 81.8%. Only Clarity of CBHNP QM/QA Goals improved from 84.5% to 89.2%.

Overall satisfaction with CBHNP by the Capital region providers decreased this year, scoring 91.4%, compared to last year's 93.3%. Previous studies showed fluctuations in satisfaction levels: from 100% in 2006 and 2008, and low of 86.8% in 2007, with a six year average at 93%. Given the variations from year to year, no trend exists for this measure.

Summary of CBHNP Quality Initiatives.

The Polk-Lepson analysis of the data found that comparing the two regions, only one attribute had ratings that were different enough to be statistically significant. This was coordination of transportation. They found the Capital Region providers had ratings higher than North Central Region providers. Based on the result of the Provider Study, CBHNP identified the following areas for action.

- Availability of children's services: Review communications to providers explaining the out of network agreement process and service availability.
- Ease of Authorization: Complete the implementation of unmatched treatments process network wide which will eliminate administrative items spent in pursuing authorizations for services which do not require prior authorization.
- Lack of clarity of documentation requirements and quality management goals: Conduct a brief survey to gain a better understanding of what additional information providers think would bring more clarity to these areas and would allow for additional action as necessary.
- Timeliness of claims complaint resolution: CBHNP will conduct an analysis of the number of claims related complaints/inquiries received and their timeframe for resolution. Review provider calls related to claims, and administrative appeals related to claim.
- Providers should be given a forum to provide feedback and problem solving: Offer forums for provider staff to discuss challenges and recommend resolutions in a "judgment free" environment.
- Clarity of Provider Performance specifications: Implement a regular review of provider performance data entry to ensure accuracy in reporting. Implement a regular schedule of review and discussion of Provider Performance reports with providers in all levels.

CBHNP will monitor the following areas for improved results: Second opinion of review of authorizations, timeliness of payment receipt, and consistency of response by staff.

A summary of the *2011 CBHNP Network Provider Satisfaction Study* is available at CBHNP's Website: http://www.cbhnp.org/qisurveyprov.aspx

FINANCIAL OVERVIEW

Financial oversight of the 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 2011 were the corporate finances of CABHC and CBHNP, HealthChoices Program solvency, and state reporting requirements.

CABHC Financial Performance[1]

CABHC's financial performance remained strong during FY 2010-2011. Enrollment was higher than anticipated and only slight increases in administrative expenses were the main factors in the strong financial standing of the corporation.

During FY 2010 - 2011, CABHC did not see any significant increases in administrative expenses over FY 2009-2010 resulting in a positive cash flow. CABHC made the decision to use their surplus to provide a one -time provider incentive to core MH and SA Outpatient providers in 10-11.

CABHC's Fiscal Committee is responsible for monitoring and reporting on the financial position of CABHC. The financial statements are reviewed monthly by the Fiscal Committee and reviewed at the monthly Board of Directors' meeting. CABHC's contracted auditors, The Binkley-Kanavy Group, also conducted a corporate audit at the close of the FY 2010- 2011. The Binkley-Kanavy Group issued an opinion that found no reportable findings in the CABHC audit.

CABHC Monitoring of CBHNP Financial Performance

CABHC's Fiscal Committee is 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 2011, CBHNP Capital Region, Corporate, and AmeriHealth Mercy Family of Companies all showed a positive outcome for 2011. No problems or concerns were voiced by the committee or CABHC's Board about CBHNP's solvency.

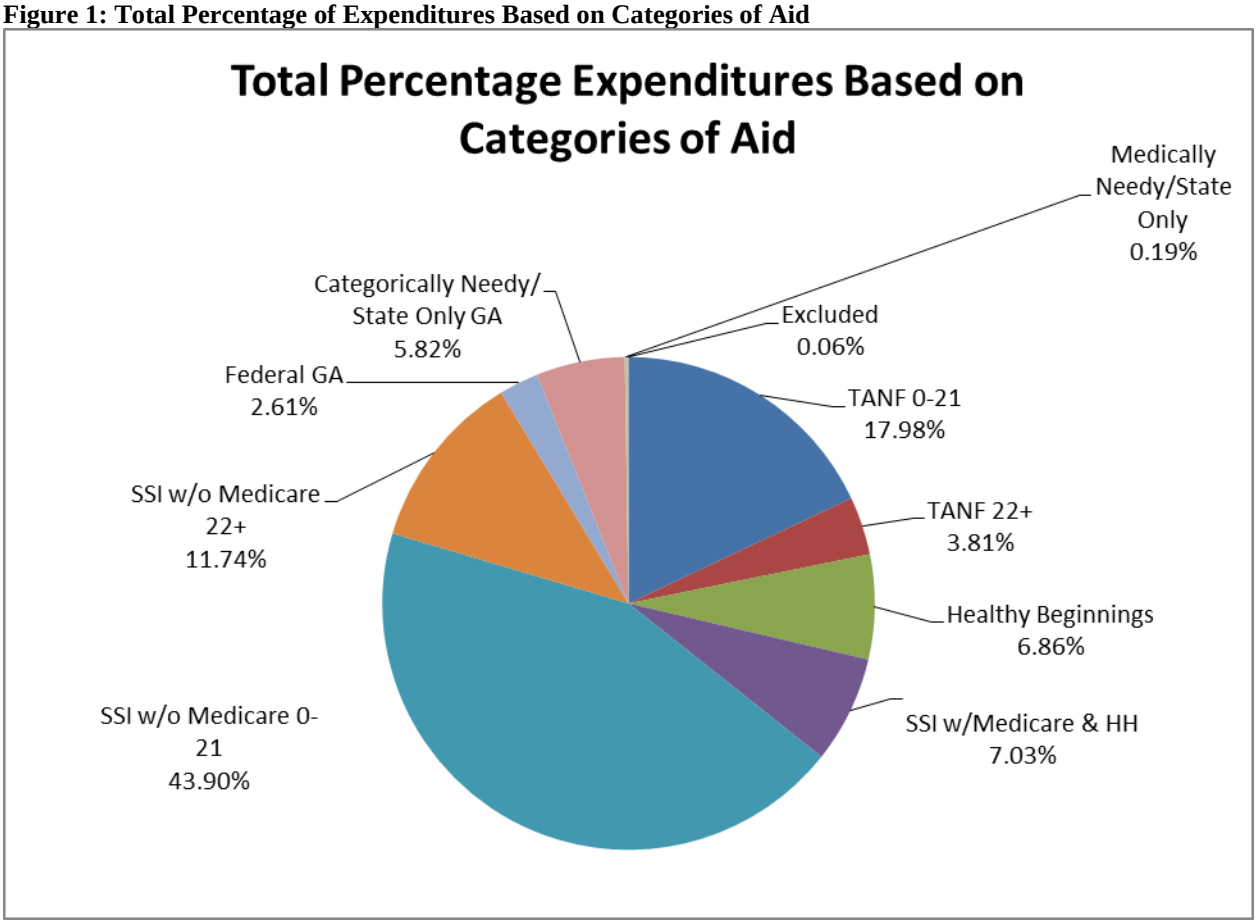
[1] The Audit conducted by Binkley Kanavy Group used for this report is based on FY 20010-2011.

HealthChoices Program – Financial Performance

The financial solvency of the HealthChoices Program is closely monitored through reviewing medical expenses 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.

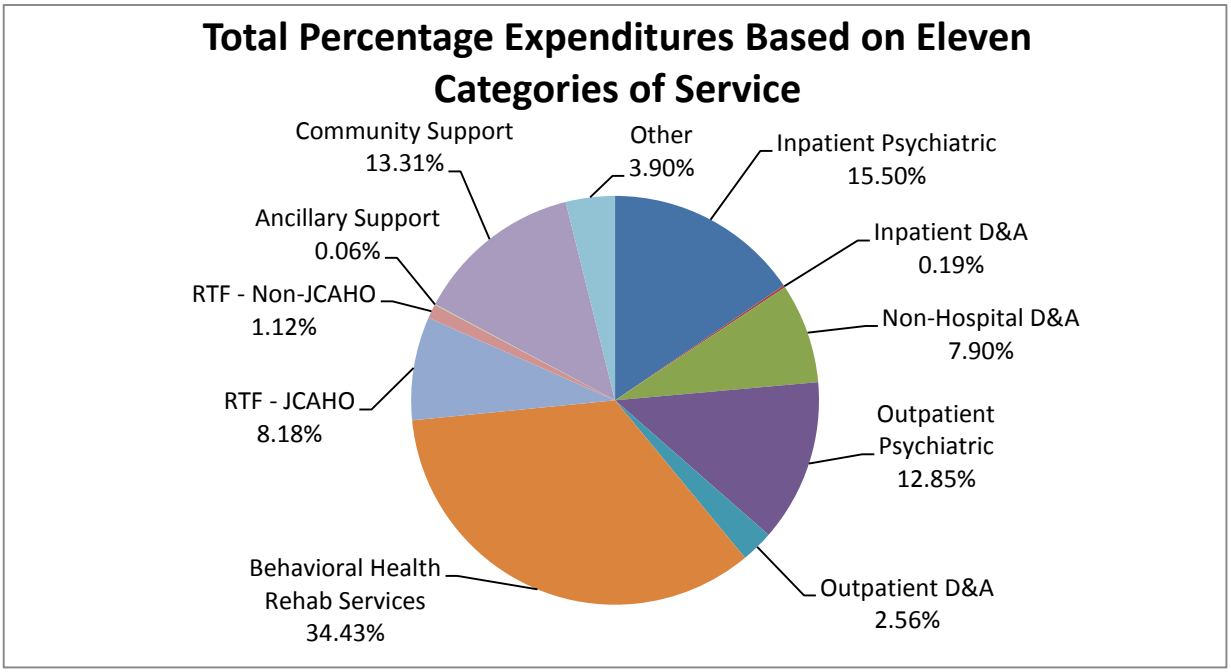
The division of medical expense percentages between the categories of aid is presented in Figure 1.

Figure 1: Total Percentage of Expenditures Based on Categories of Aid



Likewise, the percentage of medical expenses between the categories of services is presented in Figure 2**.**

Figure 2: Total Percentage Expenditures Based on Eleven Categories of Services



During FY 20010-2011, the medical capitation revenue exceeded medical expenses. This allowed the Counties to increase risk and contingency reserves, continue reinvestment services, as well as begin the process to develop new reinvestment plans.

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 2010-2011. The 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 found no reportable findings.

CONCLUSION

This Annual Report provides a detailed summary of the accomplishments achieved by the Program during CY 2011. The results were achieved due to excellent communication, coordination, and collaboration by stakeholders, Counties, and CBHNP. The successes highlighted and the areas identified that still need to improve, provide an opportunity for the continued development of a stronger provider network to serve our Members.

Many individuals throughout our HealthChoices Program have made exceptional contributions to the Program. The success that has been enjoyed is a direct result of the efforts of the staff at CABHC, the County Staff, the commitment of CBHNP, the stakeholders and the network of providers.

As we reflect on our successes, we also acknowledge we can improve on what has been accomplished and grow in the year ahead. Many challenges lie ahead, and if the success of the past is an indication of things to come, the future challenges will met head on with professionalism, quality and accessible services in order to improve the lives of 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 2011 an excellent year.

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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

CABHC BOARD OF DIRECTORS

Dan Eisenhauer	Chair	Dauphin County
Silvia Herman	Vice Chair	Cumberland County
Jim Laughman	Treasurer	Lancaster County
Jack Carroll	Acting Secretary	Perry County
Richard Kastner		Lancaster County
Evelyn Reese		Perry County
Carol Davies		Lebanon County
Kevin Schrum		Lebanon County
Linda McCulloch		Cumberland County
Peter Vriens		Dauphin County

CABHC COMMITTEES

Consumer/Family Focus Committee

Deborah Allen – CABHC	Frank Magel -Dauphin Co. MH/MR
Thanaaa Bey – PRO-A	Jamie Melnicove – RASE Carlisle
Jack Carroll - Cumberland/Perry Co.	David Measel – Recovery Connections
Paula Cole-Miller - Consumer	Becky Mohr - Lancaster Co. MH/MR
Robert Count - Lebanon Co. D&A	Debbie Murphy – Aurora Social Rehabilitation Services
Vanessa Cutler – Consumer	Kristen Noecker –RASE
Jeanette DeFrehn – Consumer	Lynn Novakoski - CABHC
Laurie Dohner – CSS	Kimberly Pry – Consumer
B.J. Genna –Nu-Way Recovery Services, Inc.	Steve Rexford – Person in Recovery
Chester Green, Jr. - Consumer	Abby Robinson - CSS
Lois Harding - Consumer	Doug Smith - Consumer

Silvia Herman –- Cumberland/Perry MH/MR	Vivian Spiese – Family Member
Denise Holden – RASE	Susan Steager – Consumer
Debra Jackson – Consumer	Denise Sturnes – Person in Recovery
Denyse Keaveney – Consumer	Scott Suhring – CABHC
Ralph Keeseman – Consumer	Jamil Sumerford - Consumer
Theresa Kern – Family Member	James Thomas – CSS
Holly Leahy – Lebanon MH/MR/EI	Terry Weller – Consumer
Velma Madden – Consumer	Denise Wright – Member

Peer Support Services Steering Committee

Deborah Allen – CABHC	Erin O'Connor-Pritchard – CBHNP
Lisa Basci – Community Services Group	Michele Porter – Keystone Service Systems
Chris Bilger– Certified Peer Specialist	Rebecca Rager – CABHC
Diana Fullem – Recovery-Insight Inc.	Amy Reeder –– CBHNP
Holly Leahy – Lebanon MH/ID/EI	Mary Schram –– CPS
Laura Jesic – STAR	Doug Smith – Certified Peer Specialist
Frank Magel –Dauphin Co. MH/MR	Greg Snyder – Lancaster Co. MH/MR/EI
Kim Maldonado – The Dauphin Clubhouse	Annie Strite – Cumberland/Perry MH/MR
Lynn Manganaro - CABHC	Scott Suhring – CABHC
Tom Newman – Dauphin Clubhouse	John Thomas – NHS Stevens Center

Clinical Committee

Deborah Allen – CABHC

Kim Briggs – Lebanon Co. MH/MR/EI

LeeAnn Edelman – CABHC

Dan Eisenhauer – Dauphin Co. MH/MR

Judy Erb – Lancaster Co. MH/MR

Silvia Herman – Cumberland/Perry MH/MR

Denise Holden – RASE

Megan Johnston – Cumberland/Perry MH/MR

Rick Kastner — Lancaster County D&A

Christine Kuhn – Lancaster Co. MH/MR

Holly Leahy – Lebanon Co. MH/MR/EI

Joe Mills – CABHC

Jenna O'Halloran-Lyter – CABHC

Matt Rys – Lebanon, Co. D&A

Rose Schultz – Dauphin Co. MH/MR

Helen Shuman — OMHSAS

Rhonda Slinghoff – Lancaster Co. MH/MR

Vivian Spiese – NAMI, Lancaster Co.

Robin Tolan – Cumberland/Perry MH/MR

Kelly Walters — OMHSAS

Denise Wright – Member

Provider Network Committee

Denise D'Addario – CABHC	Evelyn Reese – Cumberland/Perry D&A
Holly Leahy – Lebanon Co. MH/ID/EI	Scott Suhring – CABHC
Frank Magel – Dauphin Co. MH/MR/ID	Peter Vriens — Dauphin MH/ID
Becky Mohr – Lancaster County	Sheryl Swanson - CBHNP
Denise Wright – CFFC Representative	

Fiscal Committee

Carol Davies – Lebanon Co. MH/MR	Linda McCulloch – Cumberland/Perry Co. MH/MR
Paul Geffert – Dauphin Co. MH/MR	Melissa Raniero – CABHC
Jim Laughman – Lancaster Co. MH/MR	Evelyn Reese – Cumberland/Perry Co. MH/MR

D&A Reinvestment Workgroup Steering Committee

Deborah Allen – CABHC	Mavis Nimoh – Dauphin Co. D&A
Keven Cable – CBHNP	Evelyn Reese – Cumberland/Perry D&A
Jack Carroll – Cumberland/Perry MH/MR	Steve Rexford — Person in Recovery
Carol Davies— Lebanon Co. D&A	Abby Robinson – Consumer Satisfaction Services
LeeAnn Edelman – CABHC, Inc.	John Sponeybarger – Dauphin Co. D&A
Rick Kastner – Lancaster Co. D&A	Scott Suhring – CABHC