CAPITAL AREA BEHAVIORAL HEALTH COLLABORATIVE, INC.

CONTINUOUS QUALITY IMPROVEMENT PLAN 2012

Presented by: Scott W. Suhring

Prepared by: Deborah S. Allen

Contents

INTRODUCTION 3
CHILDREN'S SERVICES 3
PHYSICAL HEALTH/BEHAVIORAL HEALTH INTEGRATION (PH/BH) 6
PEER SUPPORT SERVICES (PSS) 7
CONSUMER SATISFACTION SERVICES 9
PERFORMANCE IMPROVEMENT PROJECTS (PIP)/COST DRIVER 10
PROGRAM EVALUATION PERFORMANCE SUMMARY (PEPS) 13
FISCAL STABILITY 17
CONCLUSION 18

CAPITAL AREA BEHAVIORAL HEALTH COLLABORATIVE, INC.
CONTINUOUS QUALITY IMPROVEMENT PLAN
2012

INTRODUCTION

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

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

The Continuous Quality Improvement Plan (CQIP) is a document that identifies key areas that will be monitored by CABHC. The CQIP also provides specific objectives that will be implemented as priorities for CY 2012 and provides a systematic, structured approach to the ongoing monitoring, analysis and expansion of the Program, including Member care and stakeholder satisfaction.

CHILDREN'S SERVICES

CABHC is committed to promoting the emotional wellbeing of children and ensuring that children with emotional and behavioral challenges have access to quality services. CABHC vies to form clear, integrated partnerships across child serving systems and increase responsiveness of services to families and their children. CABHC maintains to support a variety of initiatives to improve access of services to children.

Priorities for Children's Services for 2012

1. *Behavioral Health Rehabilitation Services (BHRS) Best Practice Workgroup/BHRS Redesign Workgroup*

During 2011, this workgroup has been diligently working on defining changes that will be implemented as part of BHRS. The purpose is to identify best practices that will reduce or substitute problem behaviors with positive, socially appropriate behaviors, as well as to support the family's movement toward the utilization of a less intensive treatment modality, and increase their use of family and community for ongoing support. All services, with the exception of the evaluation process, are provided in the home and community settings. The BHRS model

promotes ongoing collaboration between family, Providers, and systems across all settings for the duration of treatment.

In order to address the clinical challenges faced by BHRS Providers, *The BHRS Best Practice Workgroup* developed the Best Practice Guidelines which was completed in December 2010 and presented to OMHSAS in April 2011. This document was a qualitative set of standards expanding on existing regulations, and encompassing OMSHAS directives, CASSP best practice recommendations, published best practice guidelines utilized by other professional organizations, academic reviews of literature, and extensive HealthChoices Provider input. This document created a framework of recommendations for systematic clinical decision making.
The next step was for the BHRS Redesign Workgroup to create the *Facilitating Positive Change in BHRS* document. This revised workgroup is composed of CBHNP, CABHC, Providers, and Counties. The draft document was completed in October 2011. The workgroup is currently reviewing participant's additional comments and this document is targeted to be final in early 2012. With the completion of this document, the following outcomes will be implemented:

1. Improving Best Practice Evaluations, such as implementing the Child and Adolescent Needs and Strengths (CANS) tool.
2. Exploring Alternative Treatment Options, such as expedited BHRS (BHRS-E).
3. Reconsideration of Interagency Service Planning Team (ISPT) meetings. This may be conducting ISPT meetings prior to the Best Practice Evaluation.
4. Transitional/Independence Planning. Transitional/Independence planning will occur for all Members who have received BHRS treatment for 12 consecutive months unless that Member is impacted by an ASD.
5. Joining Treatment Plan and Functional Behavior Assessment (FBA) Submission. All submissions of FBA summaries will include a copy of the treatment plan that is based on the FBA.

Once these outcomes are implemented, CABHC will monitor their effectiveness/impact on BHRS.

2. The Residential Treatment Facility (RTF) Workgroup

The RTF Workgroup was developed out of CABHC's Clinical Committee. One major accomplishment in 2011 was the development of the Community Residential Rehabilitation Intensive Treatment Program (CRR-ITP) service description. The CRR-ITP program is a type of licensed CRR Host Home, but is a distinct 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 program places a strong emphasis on the strengths of the children, families, and communities they serve. The program goals and objectives are consistent with best practices guidelines outlined by the Department of Public Welfare and the CASSP principles.

The CRR-ITP Program was approved in May 2011. An RFP was distributed to Providers and the workgroup reviewed service plans from interested providers. In November 2011, the workgroup began to meet with each approved provider. It is expected in early 2012 selected

providers will be chosen and CABHC will monitor the implementation of this program and access their efficacy of achieving the stated objectives for 2012.

3. Therapeutic Staff Support (TSS) Schedule Implementation

For 2011, it was the objective of CABHC to work with CBHNP and the Counties to implement a new program model for the TSS Schedule, and to monitor the efficacy of its objectives. In July 2011, a revised policy which addressed provider suggestions was approved and sent to OMHSAS.

CABHC will analyze the new schedule and its effectiveness. In addition, CABHC and CBHNP will work together to develop outcomes for the TSS Schedule for 2012.

4. Multidimensional Treatment Foster Care (MTFC) Implementation Team

MTFC is a cost-effective alternative to placement in residential treatment facilities and incarceration for youth who have difficulty with chronic disruptive behavior. The evidence of positive outcomes from this unique multi-modal treatment approach is compelling.

The MTFC Implementation Team is comprised of CBHNP, CABHC, Children's Home of Reading (CHOR), Dauphin County Mental Health Staff, Dauphin County CYS and JPO, as well as Cumberland County Mental Health, JPO, and CYS.

CABHC has continued to attend the implementation team meetings and currently the CHOR Board is reviewing month to month progress of the program. Implementation of the program has moved slowly however, CHOR currently has four approved and trained MTFC Families, and three children receiving services. CABHC will continue to attend the MTFC meetings and will report on the implementation and expansion of the program in Cumberland and Dauphin Counties.

5. Family Based-Mental Health Services Best Practice Document

The Clinical Committee discussed the perceived lack of effectiveness of the family based model in current Family Based Mental Health Services (FBMHS). Some participants reported an inappropriate overuse of FBMHS for Members with Autism Spectrum Disorders. Others reported an overall ineffectiveness of FBMHS.

The Clinical Committee reviewed FBMHS data illustrating the utilization of family based services. Based on the data, the Clinical Committee expressed concerns that there appears to be a change to the family based model of services as evidenced by being over utilized by Members with an ASD diagnosis, which is further over utilized inappropriately by older Members when it is less effective. In addition, there were numerous out of home recommendations following a period of FBMHS services.

Based on the discussions regarding the data of FBHMS, CABHC directed CBHNP to set up meetings with FBMH providers in each of the Counties. The Clinical Committee agreed that the best way to address the needs of FBMHS is for CBHNP to develop a Best Practice document in

2012 which will be used with assisting providers in the delivery of FBMH services as evidenced by the model. CABHC will monitor the development of this document and monitor the revision of the Best Practice Document will be discussed. CABHC will also review FBMH Utilization data to ensure fidelity to the Best Practice document.

6. *Root Cause Analysis Findings*

In the summer of 2011, CABHC contracted with consultant Susan Signore-Smith to conduct a Root Cause Analysis around BHRS access. The preliminary findings are that the challenge of accessing BHRS Services is partially due to lack of clear discharge planning. Her final report is due to CABHC in January 2012. Once the report is received, CABHC will monitor the action steps of the document and implementation of her recommendations.

PHYSICAL HEALTH/BEHAVIORAL HEALTH INTEGRATION (PH/BH)

The PH-BH Workgroup was developed out of CABHC's Clinical Committee that began in October of 2010. Participants included staff from CABHC, CBHNP, Counties, and individuals in recovery. The purpose of the PH-BH Workgroup was to review available national, state, and local data and recommend integration projects focusing on specific interventions, services, and/or care coordination processes that would improve the physical well being and overall recovery of HealthChoices Members. What developed out of the workgroup in 2011 were four leading PH-BH projects. These projects will be implemented in 2012 and include:

1. *Federally Qualified Health Clinics (FQHC) Project*

To foster development of a more formalized program of FQHC's, SouthEast Lancaster Health Services, Sadler Health Center Corporation in Carlisle, and Hamilton Health Center in Dauphin County have committed to developing an integrated mental health service within their clinics. They are all developing different ideas and models. CABHC's goal is to see these integrated mental health services become fully operational in 2012 and provide assistance of development and monitor their use.

2. *Certified Peer Specialist (CPS)trainings*

A Targeted Case Management training conducted by Lilly on diabetes fundamentals for individuals with Serious Mental Illness (SMI) was completed this past summer. For 2012, CABHC and CBHNP will be scheduling this training for Certified Peer Specialists as well. In addition, CABHC will be assisting in the development with CBHNP a cardiovascular training for TCM's, CPSs, and possibly extending this to ACT teams and MPNs to distribute and share with consumers.

3. Mobile Psych Nursing (MPN) Expansion

Mobile Psych Nursing (MPN) in Dauphin and Cumberland/Perry Counties is a goal for expansion for 2012. CABHC will oversee and assist in the development of these expansion programs.

4. Member Wellness Initiatives

A Member Wellness Tool Kit project has been started and will continue to be developed in 2012. This is based on the 8 areas of the wellness wheel. With CABHC's guidance, CBHNP has added articles to their website library and initiated the Lilly Wellness site as well. A Doctor Appointment Tool will also be developed for 2012 which will be used to foster more effective communication between the individual, their PCP and/or their psychiatrist. Goals include being more responsive in the community and gearing towards trainings and other information for the website library.

PEER SUPPORT SERVICES (PSS)

Peer support for individuals with similar life experiences has proven to be exceptionally important toward assisting Members in their recovery. Certified Peer Specialists (CPS) are individuals who have self-identified as having received or is receiving mental health or co-occurring disorder services in his or her personal recovery process. CPS's have the ability to assist others in regaining control over their lives based on the principles of recovery. By inspiring the hope that recovery is an achievable goal, Certified Peer Specialists can assist others to achieve their personal recovery goals by promoting self-determination, personal responsibility, and the empowerment inherent in self-directed recovery.

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

Priorities for PSSSC for 2012

1. CPS Training

In 2011, CABHC sponsored a CPS training from August 15th-26th, facilitated by Recovery Opportunity Center out of Arizona. This increased the number of Certified Peer Specialists available for employment to Providers, which expanded the system capacity to serve more Members. Our goal for 2012 is to further explore the need to offer a geriatric and forensic peer specialist training. Lastly, CABHC plans to offer a CPS Supervisor training in June 2012.

2. Retention of Certified Peer Specialists

There has been an ongoing interest by the PSSSC in reviewing turnover rates. During 2011, the PSSSC examined different PSS models that may lead to improved retention rates. The committee will continue to center tasks related to CPS retention in 2012. CABHC will continue to provide

support and assistance to the PSSSC as they develop new, innovative ways to increase the retention of CPS.

3. *Peer Support Services Website Page*

Areas that are monitored each month on the CABHC Peer Support webpage include Peer Support Provider Job Posting Requests, as well as Peer Specialist Registration approvals. This past year, CABHC monitored matches that were made between Providers and Peer Support Specialists. This was beneficial and we will continue to do so in 2012 and report these findings to PSSSC.

IMPORTANCE of CONSUMER, FAMILY and ADVOCATE INVOLVEMENT

CABHC values the engagement of Members in the HealthChoices oversight, and encourages their participation on all CABHC Committees, Board Meetings, and Workgroups. The Consumer Family Focus Committee (CFFC) is the hub to this belief and functions as the core venue to enhance and ensure participation.

During 2011, the CFFC accomplished many goals toward the recruitment of members to serve on committees and to provide educational opportunities for its members. Among their accomplishments for the recruitment of members was the continued commitment of a smaller workgroup called the CFFC Recruitment Committee which conducted presentations to local Clubhouses, drop-in centers, and psychiatric rehabilitation programs. In addition, CABHC reached out to individuals who attended the 3 day WRAP training which was sponsored in October 2011, as well at the CPS training which was sponsored by CABHC in August 2011. Through these efforts, four individuals were recruited to participate on various committees and workgroups. A highlight of this process was that a member of CFFC also showed interest in the Fiscal Committee and is now a participant of that group, which has always been a Committee that lacked consumer participation.

CFFC Priority Goals for 2012

1. *Recruitment of Committee Members*

Provide ongoing support of recruiting additional members serving on committees. CFFC will also actively participate in member and family recruitment and retention and participate in committee and workgroups to provide stakeholder input.

2. *Develop Training Programs*

CFFC will develop two new training programs to further enhance recovery and resiliency 2012.

3. *Explore Educational Presentations*

This group also plans on securing more educational presentations for 2012 with topics related to LGBQTI, multicultural, and an update on the latest legal drugs of abuse. CABHC will support and assist in the securing these presentations.

CONSUMER SATISFACTION SERVICES

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

The System Improvement Committee (SIC), is composed of CABHC, CBHNP, CSS, the Counties, consumers, family members, surveyors, and persons in recovery. The SIC is focused on system and global issues that are identified by Members as part of their responses to satisfaction surveys. The committee analyzes the data, identifies appropriate issues and develops action plans to improve these issues.

CSS Priority Goals for 2012

1. *Technical Assistance*

CABHC will monitor CSS's efforts to increase the number of surveys for the coming fiscal year, by 200 while maintaining the 90% rate of face to face interviews. CABHC will monitor CSS's performance and provide guidance and support as requested. CABHC will assist in facilitating and monitoring of the implemented action plans as developed by SIC.

PROVIDER NETWORK

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

The Provider Network Committee focuses on monitoring CBHNP's Provider network to assure HealthChoices access standards are met and specialty needs are offered to Members; and monitor annual Provider satisfaction surveys; monitor CBHNP Provider profiling reporting; and monitor CBHNP Credentialing Committee activity.

Provider Relations Priority Goals for 2012

1. Provider Profiling & Performance

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

As a part of the profiling process, the Provider Network Committee, in conjunction with CBHNP, is evaluating updates to CBHNP's Provider performance tracking and reporting system. Upgrades in the Provider profiling system will include performance indicators for the assessment of co-occurring disorder competency, appropriate aftercare planning, coordination of care, and timeliness of submission of treatment information. The CABHC Provider Network Committee will utilize the CBHNP report data to evaluate the upgraded profiling measures used by CBHNP. The upgraded profiling system will be used as a tool by CBHNP to hold Providers accountable for their performance.

2. Network Development

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

Telepsychiatry began as a new service in January 2011 in Dauphin, Cumberland, and Perry Counties. It is a service delivery option offering individuals the opportunity to communicate with a psychiatrist via secure video conferencing. The service includes quality psychiatric evaluation and medication management. Effectiveness of Telepsychiatry services will continue to be monitored by CABHC in 2012 through analysis of the Providers' Member satisfaction surveys, access standards, and utilization data. CABHC will determine if expansion of this service will be a viable option in 2012.

3. Service Utilization

In 2012, the Provider Network Committee will analyze the utilization of services currently provided within the CBHNP network This will include analysis of utilization of services with access exceptions specific to each County, analysis of utilization by age groups, and by location such as in home, community, schools, and clinics.

PERFORMANCE IMPROVEMENT PROJECTS (PIP)/COST DRIVER

PIP

CABHC oversees CBHNP's submission of OMHSAS required Performance Improvement Projects (PIP). CABHC ensures that the reports follow the approved OMHSAS format, the data

is accurate, the analysis is consistent with the data, and that they are submitted to OMHSAS in a timely manner.

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

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

The second PIP report is to Increase the Rate of Follow-Up after Hospitalization for Mental Illness. Overall, the data during CY 2011 has shown a slight decline in the Territory rates, from the CY 2010 data. CBHNP conducted a Root Cause Analysis of this PIP and has established short and long term goals for the four indicators. Due to a continued decline in scores, CABHC has added this PIP to the CBHNP Performance Incentives Standards which will be monitored by the Clinical Committee quarterly. The standard for the Performance Objectives is the IPRO validated BH-MCO average score for measurement year 2010 with the objective that CBHNP will score above this average. CABHC will compare CBHNP scores to the BH-MCO average each quarter.

PIP Priority Goals for 2012:

1. Objective for Youth Receiving Substance Abuse Services

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

2. Increase Rate of Follow-up after Hospitalization

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

The goals as defined in the CBHNP Incentive Performance Standards, for this PIP are that the scores for the four quality indicators (QI) meet or exceed the 2010 OMHSAS BH-MCO averages which are: QI 1 (HEDIS) 7-day follow-up after discharge 45.4%, QI 2 30-day, 66.2% and the PS Specific Indicators QI A 7-day follow-up, 57.5% and QI B, 30 day follow-up, 74.1%. These scores will be reported to the CABHC Clinical Committee and the Board of Directors each quarter. CABHC will also meet regularly with CBHNP's QI Department to review and

analyze CBHNP's implementation of the Root Cause Analysis for Follow-Up after Hospitalization for Mental Illness, and its impact on the follow-up rates.

COST DRIVER

During 2011, three Cost Drivers emerged from a Root Cause Analysis. OMHSAS/Mercer evaluated the total cost of services utilizing HealthChoices rate setting data from state fiscal year 2009 and 2010 to calculate the cost and utilization of services. They identified services that were 30% above or 30% below the statewide average and considered them to be extreme outliners. They requested that each BH-MCO conduct a root cause analysis on each of the areas. CABHC/CBHNP identified three cost drivers for analysis which include: Family Based Mental Health Services, Reduction of Adult Mental Health Inpatient Utilization, and Reduction in Behavioral Specialist Consultant and Mobile Therapy High Penetration Rate. Based on this, CABHC created a Cost Driver Workgroup.

1. *Family Based Mental Health Services (FBMHS)*

The FBMHS is a cost driver impacted by three primary factors: penetration rate, units per user, and cost per consumer. The workgroup focused on high penetration rates as an opportunity for maximum impact given that penetration was an extreme outliner in all Counties and exceeds zone and statewide averages to a statistically significant degree. During the fall of 2011 the workgroup identified several areas for action during 2012. They include: Expand QI record audits and reporting for FBMH providers, initiate FBMHS quarterly meetings with providers to review the root causes associated with FBMHS, increased participation of CBHNP CCM in treatment planning, and develop Best Practice Guidelines. During 2012 CABHC will continue to participate on the workgroup and monitor the action steps taken by the workgroup.

2. *Reduction in Behavioral Specialist Consultant (BSC) and Mobile Therapy (MT) High Penetration Rate.*

BSC and MT penetration in the region is significantly higher than both state and regional rates. This is true for Members impacted by an Autism Spectrum Disorder (ASD) as well as those with other diagnoses. The workgroup prioritized the following factors: extended length of stay in treatment, lack of clear role and criteria definition between BSC and MT, and poor discharge planning system-wide. The workgroup identified the following actions with regard to this cost driver: implement discharge planning initiatives, implement initiatives that will provide education and assistance with discharge planning, develop a workgroup to explore the feasibility of an outpatient therapist in the role as supervisor for TSS, explore licensing of BSC, and ongoing collaboration with providers via BHRS quarterly meetings.

3. *Reduction of Adult Mental Health Inpatient Utilization*

The workgroup found that the Root Cause Analysis is one of primary factors with this cost driver is inadequate discharge planning leading to poor follow up and readmissions. The following actions were identified: repeat MH IP audit with improved questions specific to Recovery Principles, repeat Member Survey to capture Member's perspective of their discharge experience, remind providers of Reimbursement for recovery education, notifying all Case

Management units of newly admitted Members, increase Mobile Psych Nursing in Dauphin, Cumberland, and Perry Counties, establish the Bridge Appointment in the Capital area, and provide education on the role of Peer support onsite in MH IP units.

During 2012 CABHC will continue to participate on the workgroups and monitor the action steps and outcomes measures.

PROGRAM EVALUATION PERFORMANCE SUMMARY (PEPS)

As part of the Office of Mental Health and Substance Abuse Services (OMHSAS) monitoring of the HealthChoices Behavioral Health Program, OMHSAS conducts PEPS reviews on an annual basis, rotating key areas of the Program Standards and Requirement document on a three year cycle. CABHC monitored all activity of the CBHNP Corrective Action Plan. Highlights for 2011 included:

1. Care management resources have been increased and responsibilities have been realigned.
2. Significant education and training given to enhance care managers knowledge to direct care and opportunities.
3. Systematic tools to assess provider performance are being developed.
4. Emphasis has been made to educate Providers and Members on the importance of transferring skills to Members/Families.
5. Efforts have been made to integrate information across departments and utilizing QI to advise when CCM’s identify issues of concerns.
6. Peer to peer consultations with evaluators occur at the time of review for authorization, with the goal to eliminate the need for denials of service.
7. Best Practice guidelines have been developed and a proposal for re-design process associated with BHRS is targeted to be finalized by the end of the year.
8. A progressive discipline policy for providers is being finalized.

<u>PEPS Priority Goals for 2012</u>

1. PEPs CAP Monitoring Plan

Complete all monitoring activities as identified in the PEPS CAP Monitoring Plan. A number of initiatives in the CBHNP 2011 Action Plan are on-going or have completion dates in 2012. CABHC will conduct all identified monitoring activities per the monitoring plan and report the findings to CBHNP, OMHSAS, and CABHC’s Board of Directors at least quarterly. If CBHNP is not achieving the stated goals, CABHC will discuss with CBHNP any further action that may need to be taken to assure CBHNP completes all objectives in the CAP.

In 2012, CABHC will monitor CBHNP’s Corrective Action Plan related to denial letters. By monitoring this, the quality of the denial letters will improve and Members will have a clear understanding as to why their services were denied. By having a better understanding of the rationale of the denial the Member/Clinician would make more medically indicated treatment requests, therefore reducing the number of possible denials. Two specific areas will be monitored: 1. Lack of credentials; 2. Lack of clinical rationale to support the denial.

REINVESTMENT

Reinvestment Projects are developed from available HealthChoices County discretionary and treatment 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.

Priorities for Reinvestment Projects for 2012

1. Respite Management

During 2011, CABHC has directed and oversaw Youth Advocate Programs, Inc. (YAP) who is the contracted Respite Management Agency in the following areas that have been proven accomplishments. They include: 1. Recruitment of three new Providers (Staffing Plus, Delta-T Group, and Jewish Family Services). 2. CABHC has assisted YAP in developing a tri-fold brochure containing concise information on the program. 3. April marked the beginning of direct contract services with family members, friends, and neighbors who contract with YAP to provide respite care. Currently, YAP has three contractors to provide respite. To address sibling groups, a sibling group compensation rate was created for providers and direct contractors, by the Respite Workgroup which is composed of CABHC staff, CBHNP, Counties, and YAP. In addition with CABHC's support and direction, YAP has also been able to expand the number of adults being served, which now ranges from 15-20 adult clients at any given time.

For 2012, CABHC will monitor the number of Members utilizing respite services and for adult members. In addition to this, CABHC will monitor YAP's capacity with providers for out of home respite, and seek out another out of home respite provider. CABHC will assist YAP with further speaking presentations to the NAMI groups, parent support groups, Wernersville/Danville State Hospital groups, and an evening family presentation in Cumberland County. It was these groups in which the Respite Workgroup decided to focus on. This will also include re-presentations at case management units and provider meetings in order to establish contact and deliver updates regarding services. Another goal for 2012 is to increase friends/family/neighbors trained to provide respite. Lastly, the Respite Workgroup will also rework the current member survey in order to create a more concise and comprehensive way to measure outcomes, as well as discuss ways to obtain a greater percentage of surveys returned. The results will be discussed monthly with the Respite Workgroup, and be presented to the Clinical Committee on a quarterly basis.

2. Specialized Transitional Support for Adolescents

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

During 2012, CABHC will continue to monitor the programs' development of personal outcome measures for their participants, and the tracking of claims data that could illustrate that successful participants have a reduced need for more traditional in plan services.

CABHC will monitor the Jeremy Project's goals to expand employment opportunities for participants, increase individual sessions to focus on specific transition goals of each individual, and increase independent mobility, either via driver's license or learning how to ride the bus. CABHC will monitor NHS's 2012 Program goals in expanding program participation, increasing referrals in Perry County, and developing a parent group retreat for February 2012. In addition, CABHC will monitor both programs' goals related to Member outcomes.

3. The Recovery House Scholarship Program

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

To assure certain standards of quality, Recovery Houses interested in serving individuals receiving scholarships from this program must submit a written application and complete a site visit conducted by CABHC staff. During FY 2010-2011, 20 agencies from both within and outside of the five County area are participating in the Recovery House Scholarship Program. Many of these agencies operate numerous sites throughout the area, affording those in need ample opportunity for housing assistance. CABHC maintains a directory of Recovery House facilities on its website to keep substance abuse (SA) Providers up to date with available Recovery Houses. CABHC has awarded scholarships to 134 individuals during FY 2010-2011.

In 2012, CABHC will focus on collecting, analyzing data, and reporting grant expenditures, and present its findings quarterly to the CABHC Clinical Committee and the CABHC Board of Directors. CABHC will monitor the Member outcomes by reviewing and analyzing data collected on scholarship recipients from the participating Recovery Houses. The next Recovery House Annual Report will be completed in December 2012. CABHC looks forward to continuing to assist those in need of this support throughout 2012.

4. 2009-2010 Reinvestment Plan Implementation

The Reinvestment Plan Development Workgroup met in January 2011. The task of this group was to brainstorm ideas for the 2009-2010 reinvestment plan (Plan) that will determine how we expand services using funds retained from our 2009-2010 HealthChoices Behavioral Health Program contract year. This group made the final recommendation for Board action on how we can best invest the reinvestment funds. The plan was approved by The CABHC Board, and then OMHSAS in August 2011. The three programs that will be developed include:

1. Expansion of the *Specialized Transitional Support for Adolescents* program which will occur in Lancaster and Lebanon Counties. Development of a request for proposal (RFP) to manage these programs as well as formal selection process to award contracts will be implemented in 2012. CABHC will assume responsibility for the monitoring of the program in these additional Counties as well.

2. *Evidenced Based Practices* which include Cognitive Behavioral Therapy (CBT), Dialectical Behavioral Therapy (DBT), Parent-Child Interaction Therapy (CPIT), and Multidimensional Family Therapy (MDFT). This group met in early 2012 to finalize the selection process of the providers for these services. The next step will then be for CABHC to outline an action plan for development of the Evidenced Based Program expansion as part of our 2009-10 reinvestment plan. CABHC will monitor and report on each program developed.

3. *Drug & Alcohol Recovery Specialist Services* is currently being developed as part of the reinvestment plan. An RFP was issued in December 2011, with proposals due by February 2012. The RFP Selection Committee which is monitored by the D&A Reinvestment Workgroup, will then select a provider mid March 2012. Once a contract is established, CABHC will develop a monitoring process along with goals and outcomes to report on.

5. 2010-2011 Reinvestment Plan Development

The Reinvestment Plan Development Workgroup for the funds for 2010-2011 met in mid December 2011. This group brainstormed ideas for the 2010-2011 reinvestment plan (Plan) that will designate how we will utilize these funds to enhance our services and support for Members. This group will make final recommendations for Board action on how we can best invest the reinvestment funds in early 2012. CABHC will oversee any new programs that may arise out of the new reinvestment programs and will assist in developing goals and outcomes in which this will be reported on.

ADDITIONAL DRUG & ALCOHOL INITIATIVES

1. Recovery Oriented Methadone Services Best Practice Pilot

There have been recent discussions regarding recovery-oriented best practice strategies in the delivery of methadone treatment services within the HealthChoices program. CABHC, CBHNP and the SCA directors from the Counties have been researching a best practices initiatives being implemented in the Southwest HealthChoices region of the state that speaks to the Best Practice Standards for Providers of Recovery-Oriented Methadone Services. Together with the Chester County Drug & Alcohol Commission, CBHNP, and CCBH, a workgroup has been developed and has been meeting bimonthly since May 2011 to revise the best practices document so that it can be piloted in the Capital and Southeast areas with a shared methadone provider. This will be an opportunity to explore current practices, new strategies to enhance outcomes, and BH/PH service delivery in the provision of methadone services as part of a comprehensive recovery-orientated treatment program.

FISCAL STABILITY

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

Throughout 2011, financial solvency of HealthChoices and CBHNP was maintained through monitoring financial reports and reviewing them with the CABHC Finance Committee and CABHC Board of Directors. CABHC additionally reviews the Capital Region and Consolidated CBHNP Financial Statements.

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

Priorities for Fiscal Operations for 2012

1. *Financial Solvency*

CABHC will report on and monitor the financial solvency of the HealthChoices Program and CBHNP. This will be accomplished by reviewing medical claims surplus/deficit and CBHNP Financial Statements throughout 2012.

2. *Financial Reporting to OMHSAS*

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

3. *Monitoring of Behavioral Healthcare Expenses*

CABHC will monitor the Behavioral Healthcare expenses for the HealthChoices Program to determine actions that may need to be taken in a surplus or deficit situation. This will be ongoing throughout 2012. This will include the need to shift risk reserve funds to pay claims, assuring that the equity reserve meets minimum standards, that all reporting required by the bank for the Letter of Credit are maintained and designation of potential clams surplus is tracked for Board action.

4. *Monitoring of Reinvestment Programs*

A plan to pay and monitor the fiscal payments for Reinvestment Programs was developed, and policies and procedures are in effect for the payment process. Monitoring and yearly audit procedures are in the planning phase. This monitoring was recommended by the HealthChoices auditors. Further, the goal is to work collaboratively with other CABHC committees to develop

a plan that would determine if Providers are providing the contracted services and if they are achieving the stated fiscal outcomes.

5. CABHC and CBHNP Financial Position

Monitoring and reporting on the financial position of CABHC and CBHNP is vital. The Fiscal Committee will review monthly CABHC, CBHNP Consolidated, and CBHNP Capital Region's Financial Statements to determine solvency and compare administrative budget to actual expenses and revenues. All findings will be reviewed and presented at the Board's monthly meetings throughout 2012.

6. Monitor HealthChoices Program Membership

CABHC along with the Fiscal Committee will monitor the membership monthly. This will be accomplished by looking at three different membership spreadsheets; Membership with adjustment, membership without adjustment, and the net change in membership for the month. These reports will assist in determining if the administrative revenue received will continue to be adequate for the year.

CONCLUSION

Each year discovers diverse visions and challenges for the future. The Annual Plan will lead and guide us in the right direction for our priorities, goals and objectives for 2012. The *Annual Report* will follow and summarize and identify the success of the program.

CABHC will monitor, and collaborate with individual organizations, agencies and systems of care to meet the needs of its Members. Our priorities for the upcoming year emphasize innovation in service delivery based on ongoing monitoring to ensure the continued stability of the Program. The results of the goals stated in this Annual Plan will be revisited and reported as part of the 2012 Quality Improvement Annual Report. Our success depends upon our ability to collaborate within our own organization and with other individuals and agencies vested in the care of our Members. We have developed a competent, locally managed Medicaid Behavioral Health Program that supports recovery and resiliency while moving services to be more accountable and outcome focused.

We extend our appreciation to all those who have embarked upon making HealthChoices a success within the Capital Region. We look ahead to strive to improve and enhance our mission and objectives in the years to come.