CAPITAL AREA BEHAVIORAL HEALTH COLLABORATIVE, INC.

Established October 1999

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CONTINUOUS QUALITY IMPROVEMENT PLAN 2013

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INTRODUCTION

Capital Area Behavioral Health Collaborative, Inc. (CABHC) is a private, not for profit company formed out of the collaboration among Cumberland, Dauphin, Lancaster, Lebanon, and Perry Counties' Mental Health and Drug and Alcohol Counties. The result of the collaboration was the formation of CABHC, which was incorporated in October 1999. CABHC directs the behavioral healthcare contract with the Counties' managed care partner, Community Behavioral HealthCare Network of Pennsylvania (CBHNP).

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.*

The Continuous Quality Improvement Plan (CQIP) identifies significant areas that will be monitored by CABHC. The CQIP also provides an overview of prioritized objectives that will be implemented during Calendar Year (CY) 2013.

CHILDREN/ADOLESCENT SERVICES

CABHC is committed to promoting the emotional wellbeing of children and adolescents with emotional and behavioral challenges. In 2012, CABHC collaborated with CBHNP, the Counties, and BHRS providers on several initiatives to ensure access to quality services for CBHNP Members. Monitoring the outcomes of these initiatives as well as further assessment of system improvement contributed to the establishment of CABHC's priorities for children and adolescent services for the upcoming year.

Priorities for Children's Services for 2013

1. Behavioral Health Rehabilitation Services (BHRS) Best Practice Workgroup and the BHRS Redesign Workgroup

Throughout 2012 both the BHRS Best Practice Workgroup and BHRS Redesign Workgroup have been working on developing changes to the current BHRS system. The purpose of the Best Practice Workgroup was to identify best practices in delivering BHR services. The Best Practices are a tool to support providers in delivering appropriate and efficient services to our Members.

In addition to the BHRS Best Practice Workgroup, the BHRS Redesign proposed changes to the current BHR process that would improve timely access to BHR services, increase care management in treatment, and ease the administrative burden on providers.

The BHRS Redesign Workgroup which is composed of representatives from CBHNP, CABHC, Providers, and Counties developed "*Facilitating Positive Change"*, which was made final in late 2012. With the completion of this document, the following outcomes will be implemented:

1. Improving Best Practice Evaluations, through the implementation of the Child and Adolescent Needs and Strengths (CANS) tool. CBHNP is pursuing utilization of this assessment tool among network evaluators and is setting up meetings to discuss next steps. Evaluators are beginning to incorporate this tool as a decision support tool when making prescriptions. CABHC will monitor the implementation process in 2013 and will conduct chart reviews to identify evaluators who are using the tool in their evaluations.

2. Functional Enhancement of Interagency Service Planning Team (ISPT) meetings. The process redesign's focus is to obtain adequate information from the community before an evaluator makes a recommendation for out of home treatment. In the past some evaluators have made those decisions in isolation without any feedback from the Member's treatment team. This process should improve collaboration between the team and the evaluator, thus improving services to Members. CABHC will monitor ISPT re-design efforts in 2013.

2. The Residential Treatment Facility (RTF) Workgroup

The RTF Workgroup was developed out of CABHC's Clinical Committee. An initiative that arose out of this group was the Community Residential Rehabilitation Intensive Treatment Program (CRR-ITP) service description. The CRR-ITP is a licensed CRR Host Home, but is a distinct and separate service as a result of it being a comprehensive community based service design that incorporates elements of the CRR Host Home program with added elements and treatment standards. The program goals and objectives are uniform with best practices guidelines outlined by the Department of Public Welfare and the CASSP principles.

In 2012 the CRR-ITP Program was approved by OMHSAS and a Request for Proposal (RFP) was distributed to Providers. As a result of the RFP two providers were selected (The Bair Foundation and NHS). In order to ensure that all age ranges and Counties will benefit from this program, NHS decided to target Members up until the age of 12 years old. The Bair Foundation will work with Members 13 years of age and up. Both organizations will work with Members in each of the five Counties, and CABHC will monitor the implementation of this program and assess their efficacy of achieving the stated objectives for 2013. In addition, other 2013 goals include initializing recruiting efforts for staff and foster parents, receiving approved service descriptions and letters of support, initialize trainings for all new families, develop a process with OMHSAS on how to manage referrals and Medical Necessity Criteria, and educating evaluators on CRR-ITP. CABHC will continue to be involved and monitor the implementation of this program in 2013.

Also in 2012, the RTF Workgroup approved Philhaven's Short Term RTF program description. This program is a major shift in the RTF model. Unlike most RTFs, the expected length of stay (LOS) for this Short Term Residential Program is a maximum of 4 months. A key aspect to this model is the intensity and frequency of family involvement. Philhaven's short term RTF

conducts family therapy once a week in the Member's home. The goal is to strengthen the Member's natural environment thereby supporting a successful discharge. CABHC will monitor utilization of this program and length of stay in 2013.

3. STAP

In 2013, all STAP providers are expected to write new service descriptions for OMHSAS approval. CABHC will continue to support providers in the development of their service descriptions and will monitor their approved programs in 2013.

4. Family Based-Mental Health Services Best Practice Document

CABHC's Clinical Committee discussed the perceived lack of effectiveness of the family based model in Family Based Mental Health Services (FBMHS). Some participants reported an inappropriate overuse of FBMHS for Members with Autism Spectrum Disorders. Others reported an anecdotal opinion of the 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 nonconformity among providers to the family based model. In 2012, the committee focused on steps to restore the original intent of the service. Some action steps included provider audits and quarterly provider meetings to discuss opportunities for improvement. CABHC will attend a sample of provider audits throughout 2013 to ensure providers receive education in the areas where a need for improvement is identified.

In addition, the Clinical Committee supported a Best Practice document for Family Based services which will assist providers in maintaining fidelity to the Family Based model and in the delivery of effective and appropriate family based services. CABHC will monitor the development of this document in 2013 and will continue to monitor/attend the quarterly provider meetings in an effort to educate providers on best practices.

5. BHRS Access

CABHC contracted with consultant Susan Signore-Smith to conduct a Root Cause Analysis around BHRS access. Her final report was submitted to CABHC in January 2012. CABHC also collaborated with CBHNP to develop the action steps to the RCA. In 2012, CABHC began attending quarterly high volume BHRS provider meetings where monitoring of BHRS access is discussed.

In 2013, CABHC will begin to closely monitor the action steps identified by CBHNP to address BHRS access. One step identified by CBHNP which has been discussed at quarterly provider meetings, is active care management. If care managers attend the ISPT meeting they are aware of the current treatment needs and progress of the Member. If the Member is not receiving the full prescription that was authorized, perhaps they can intervene thereby improving BHRS access. If a Member is waiting but would benefit from outpatient services, a transfer could be made thereby eliminating the need for BHRS and improving BHRS access rates. Lastly, if a care manager attends ISPT meetings and the team feels the Member is meeting treatment goals,

BHRS services could be titrated thereby freeing up BHRS staff and improving BHRS access. Therefore, in 2013, CABHC will monitor whether CBHNP's care management participation at ISPT meetings improves 50 day access to treatment.

PHYSICAL HEALTH/BEHAVIORAL HEALTH INTEGRATION

CABHC's objective in moving forward with improved physical health and behavioral health is to advance efforts to improve the provider focused planning, policy development, communications, and practice enhancing collaboration and coordination of care between behavioral health providers and primary care providers serving HealthChoices Members of all ages. By improving integration and collaboration we would expect enhanced improvement of physical well-being and overall recovery of these Members. Four leading PH-BH projects were developed and will continue to be implemented in 2013. They include:

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

To develop an integrated PH/BH Model, CABHC and CBHNP are collaborating with our three FQHC's to integrate BH services into their program. These FQHC's include SouthEast Lancaster Health Services, Sadler Health Center Corporation in Carlisle, and Hamilton Health Center in Dauphin County.

Sadler Health Center hired an LCSW to provide Mental Health and Drug & Alcohol services when referrals are needed. SouthEast Lancaster Health Services has partnered with Catholic Charities to develop a similar model of the Primary Care Behavioral Health Model. Hamilton Health Center has partnered with Philhaven to develop an embedded clinic model with Primary Care Behavioral Health Model. CABHC's goals include: 1. Tracking utilization from encounter data by the place of service (POS) code, 2. Conduct longitudinal studies to access efficacy of integrated care on behavioral health service utilization, 3. CABHC will work with FQHC's to develop PH studies to assess the efficacy of the model, and 4. CABHC will oversee the FQHC's becoming fully operational in 2013.

2. *Trainings*

To assist Targeted Case Managers (TCM) have a better understanding of a specific health matter and Serious Mental Illness (SMI), a TCM training conducted by Lilly on diabetes fundamentals for individuals SMI was completed this past summer. This training included an in depth view at the SMI population and the high risk factors that contribute to Cardiovascular Disease (CVD) and provided tools the TCM's would be able to review with Members so they can assist the Member increase their understanding of CVD and encourage lifestyle changes if needed. For 2013, CABHC and CBHNP will be scheduling this training for Certified Peer Specialists as well. In addition, CABHC will be assisting CBHNP in the development of a cardiovascular training for TCM's, CPSs, and extending this to ACT teams.

3. Mobile Psych Nursing (MPN) Expansion

Another PH-BH project which was identified was expanding Mobile Psych Nursing (MPN) in Dauphin and Cumberland/Perry Counties. Due to implementation being delayed this year, Requests for Proposal (RFP) will be developed in 2013 and CABHC will oversee, support, and assist in the development of this expansion.

4. Member Wellness Initiatives

A Member Wellness Tool Kit project was completed in September this year. This is based on the eight (8) areas of the wellness wheel and can be used by Peer Specialists, Case Managers, therapists, and other human service professionals with Members (or by the Member themselves) as a way to assist in guiding them on their personal recovery. This Wellness Toolkit focuses on dimensions such as social, financial, environmental, intellectual, physical, spiritual, occupational, and emotional aspects. The Toolkit is set up so that a Member can pick and choose the dimensions they wish to focus on, or read it in its entirety. It is posted on CBHNP's website.

With CABHC's guidance, CBHNP has added articles to their website library. Topics include domestic violence, the dangers of smoking, shared decision making, and a recovery section.

A Doctor Appointment Tool will be developed for 2013 which will be used to foster more effective communication between the individual, their PCP and/or their psychiatrist. In addition, the Clinical Committee requested to continue to monitor the PH-BH projects and also create a Children's Toolkit for 2013 to focus on children since one for adults was created and successful.

PEER SUPPORT SERVICES (PSS)

Peer support services are those that are provided by someone who is on their own recovery journey and has completed the certification training in how to be supportive to others who participate in mental health services. This 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 currently receiving mental health or co-occurring disorder services in his or her personal recovery process. They assist Members with skill building, recovery/ life goal setting, problem solving, self-advocacy, and building and utilizing self-help recovery skills. By inspiring the hope that recovery is an attainable goal, CPS's assist individuals with a serious mental illness in achieving their personal recovery goals by promoting self-determination, personal responsibility, and the empowerment essential in self-directed recovery.

The Peer Support Services Steering Committee (PSSSC), which is supported by CABHC, provides a forum for CPS's, PSS Providers, the Counties, CABHC and CBHNP to assess the Program and develop ways to improve the delivery of PSS. Identified goals of the Steering Committee include the following:

Priorities for PSSSC for 2013

1. *CPS Training*

In 2012, CABHC sponsored a CPS Supervisor training on June 13th and 14th facilitated by the Mental Health Association of Southeastern Pennsylvania. There were a total of five (5) participants from our five counties. Feedback from the training participants was very positive overall. There have been several requests by PSSSC participants for Certified Peer Specialist training in 2013. It was noted by PSSSC participants that there was not an adequate pool of qualified CPS's available to the Providers and therefore, CABHC is currently looking into sponsoring a CPS training in 2013.

2. *Wellness Recovery Action Plan (WRAP) Trainings*

PSSSC has an interest in supporting WRAP trainings for the five counties throughout 2013. WRAP offers tools for empowerment that can assist an individual coping with mental health issues in order to improve their quality of life and achieve their own life goals. It also trains individuals in how to write and use their own WRAP Plan. CABHC will look at ways to sponsor these trainings for 2013.

3. *Creation of a Listserv for the Exchange of Peer-Related Information*

In 2012, PSSSC began work on creating a Listserv to assist in sharing information relevant to the peer service field. This Listserv would be used by peers, providers, County representatives, and other peer related groups and organizations. It will serve as a means to increase communication and sharing of information on topics such as peer support employment, training opportunities, and news relevant to peers and peer organizations. It is expected that the Listserv will be completed by March 2013. CABHC plans to develop and monitor the Listserv, ensuring information shared is appropriate to the Listserv's purpose. CABHC also plans to follow up with Listserv participants in order to obtain feedback on its use and discuss suggestions for its improved functionality, if required.

IMPORTANCE of CONSUMER, FAMILY and ADVOCATE INVOLVEMENT

CABHC values the participation of Members in the HealthChoices oversight, and supports their involvement in all CABHC Committees, Board Meetings, and Workgroups. The Consumer Family Focus Committee (CFFC) is the heart of this belief and operates as the central venue to increasing and ensuring Member participation.

CFFC Priority Goals for 2013

1. *Recruitment of Committee Members*

To achieve this goal, CABHC will actively participate in member and family recruitment efforts. CFFC plans to set up recruitment presentations in the five counties in 2013. CFFC consumer member of various counties have offered to assist in these recruitment sessions. These

presentations will target local Community Support Programs, Drop-In Centers, Clubhouses, and Psych Rehab Programs. This will begin in the Spring of 2013.

CABHC was present at CBHNP's Provider Fairs in October and November of 2012 and was able to make a number of potential contacts during this time. CABHC plans on following up with individual Members contacted through this venue into 2013 for recruitment of participation on CABHC Committees.

2. Develop Training Programs

CFFC will develop a new training program to further enhance recovery and resiliency in 2013. Training on "How to Talk to Your Pharmacist" has already been agreed upon by the committee. Jeffrey Kreitman, from AmeriHealth will be conducting the training in the five counties. Additionally, CFFC suggested developing a consumer run business training. CFFC is currently investigating this possible training and future training venues at this time.

3. Explore Educational Presentations

CFFC has hosted presentations in 2012 on LGBTQI, and The Pennsylvania Human Relations Commission. This group also plans on securing more educational presentations for 2013. Topics agreed upon by the Committee include Consumer Satisfaction Services yearly report, a presentation on the Science of Addiction, and Navigating the Managed Care System. CABHC will support and assist in scheduling these presentations.

CONSUMER SATISFACTION SERVICES

Consumer Satisfaction Services, Inc. (CSS) is a non-profit, consumer driven and consumer operated organization whose mission includes measuring Member satisfaction with mental health and substance abuse services for HealthChoices Members residing in Cumberland, Dauphin, Lancaster, Lebanon, and Perry Counties. CSS's goals include obtaining feedback on behavioral health services to determine if these services are meeting the standards set for quality, culturally sensitive and effective treatment. Additionally, CSS seeks to ensure consumers of these services have a strong voice in evaluating the services that are being provided.

CSS facilitates the System Improvement Committee (SIC), which is comprised of representatives from CABHC, CBHNP, CSS, the Counties, family members, surveyors, and individuals 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 2013

1. Increased Survey Goal

CSS's survey goal for the upcoming year is 1700, which is an increase of 200 surveys over this past year. CABHC will continue to provide support on how to increase survey numbers and work with target Members.

2. Consumer Focus Groups

CSS plans on facilitating consumer focus groups in order to review survey questions which have historically received negative responses. CSS also hopes to obtain ideas for targeted survey topics from these focus groups. CABHC will offer advice and assistance to CSS during this process.

PROVIDER RELATIONS

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

The Provider Network Committee concentrates on monitoring CBHNP's Provider network to assure HealthChoices access standards are being met and specialty needs are extended to Members. The committee also monitors the annual Provider satisfaction survey; monitors CBHNP Provider profiling reports; and monitors CBHNP Credentialing Committee developments and activities.

Provider Relations Priority Goals for 2013

1. Provider Performance

CABHC continues to monitor CBHNP's Provider Performance tracking system for efficacy, efficiency, and quality through the review of CBHNP reporting, concentrating on outliers, volume of and repetition of errors. Quality indicators such as the assessment of co-occurring disorder competency, appropriate aftercare planning, coordination of care, and timely submission of treatment information are considered. This is an ongoing and continuous process that results in identifying capacity and network needs, educating and providing feedback to Providers, and Quality Improvement Plans or Corrective Action Plans issued to Providers who may continually be below quality standards.

The CABHC Provider Network Committee will utilize the CBHNP Provider Performance report data, looking specifically at all Corrective Action Plans and Improvement Plans assignment by Provider, to evaluate the effectiveness of the profiling measures used by CBHNP.

2. Network Development

When the Counties and/or CBHNP establish a need for additional services, identify a gap in network composition and services, or know of another service that would be suitable, current services may be expanded or new services may be brought into the network.
CABHC monitors the utilization and effectiveness of new and expanded Medical Assistance (MA) services. Currently, CABHC is monitoring the utilization of Telepsychiatry. This service is offered 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 medication management and psychiatric evaluations. Effectiveness of Telepsychiatry services will continue to be monitored by CABHC through the Provider Network Committee, which reviews Member satisfaction surveys distributed by the Provider, as well as access standards, and utilization data. As current outcomes of Telepsychiatry continue to be favorable, the Committee will assess the viability of expansion in 2013.

3. Provider Corrective Action Plans

The Provider Network Committee will monitor Corrective Action Plans (CAPs) issued to Providers by the CBHNP Credentialing Committee. CAPs are issued based on referrals regarding Provider performance from various CBHNP processes. These include Quality of Care Committee, Provider Performance System monitoring, Clinical Care Managers, and Provider Relations Account Executives.

The Provider Network Committee monitors all aspects of the CAP process. This includes reviewing the requirements of the CAP, the Provider's response to the CAP, and CBHNP's ongoing monitoring of the Provider. CABHC ensures that appropriate steps are taken by CBHNP based on the provider's satisfaction of or failure to satisfy the CAP requirements.

PERFORMANCE IMPROVEMENT PROJECTS (PIP)

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

Increase the Rate of Follow-Up after Hospitalization for Mental Illness PIP, showed an overall decline for the data reported to OMHSAS for CY 2012. This is the first year that this standard was also reported in CABHCs CBHNP Performance Incentive Objectives with the goal that the scores will meet or exceed the HealthChoices BH-BHMO average. The Performance Objectives are reported for the FY. Data for FY 2011-2012 showed that CBHNP did not meet or exceed the HealthChoices average in any of the four indicators. CABHC will monitor this PIP quarterly.

Cost Drivers: FBMHS/BHRS/Adult MHIP

During 2012, three Cost Drivers have been monitored by CABHC. They are: Family Based Mental Health Services, Reduction of Adult Mental Health Inpatient Utilization, and Reduction in Behavioral Specialist Consultant and Mobile Therapy Penetration Rates (both ASD and Non ASD). CABHC will monitor the Major Action Steps identified in each of the Cost Driver Categories.

1. Family Based Mental Health Services (FBMHS)

The goal of the FBMHS cost driver is to reduce penetration rate through more appropriate referrals and reduced authorizations per family. Priority goals for 2013 are to monitor CBHNP's implementation of the practices that will address these issues, which include: Reviewing CBHNP practices addressing more appropriate referrals, reviewing CBHNP's process for

assessing and reducing multiple authorization periods per family, and to examine CBHNP's policies and procedures related to the appropriateness of ASD referrals.

2. BHRS

The root cause analysis identified three target areas: 1.) Extended length of stay in treatment, 2.) Lack of clear role and criteria definition between BSC and MT, and 3.) Poor discharge planning. The goal of BHRS is to reduce Behavioral Specialist Consultant (BSC) and Mobile Therapy (MT) penetration rates (both ASD and Non-ASD) to be more consistent with statewide and national averages. The key findings in this area addressed extended length of stay in treatment, lack of clear roles between MT and BSC, and poor discharge planning. Priority goals for 2013 are: Monitor CBHNP's BHRS redesign process to address discharge planning strategies; monitor CBHNP's enhanced efforts at exploring outpatient treatment as an integral part of discharge planning.

3. Reduction of Adult Mental Health Inpatient Utilization

The goal of the Adult IP Psychiatric cost driver is to improve discharge planning to increase follow-up services and reduce readmission rates, address low utilization of TCM involvement during hospitalization, and to increase utilization of Peer Supports. The priority goals for 2013 are: Monitoring CBHNP process for accessing Member involvement in the discharge planning process, monitoring CBHNP's development of Bridge Appointments to improve the discharge process and Member linkage to community resources, monitor CBHNP's development of education tools for MH IP units that will increase awareness and outline the benefits of Peer Supports.

PROGRAM EVALUATION PERFORMANCE SUMMARY (PEPS)

As part of the 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 throughout 2012.
CBHNP developed a CAP to address two areas regarding treatment denial letters: A lack of documenting credentials for the professional who requested the services or of the CBHNP reviewer, and a lack of clinical rationale to support the reason for the denial. At the close of 2012 OMHSAS reported that CBHNP successfully addressed the concern regarding the listing of professional credentials. Further, the report indicated that CBHNP had not effectively addressed in the denial letter the reason why the denial was issued. Therefore, the priority goal for 2013 will be to continue to monitor CBHNP's Denial letters for the effectiveness of stating the reasons why the denial was issued.

In response to the Triennial PEPS 2011 Review, CBHNP issued a CAP in July 2012 to address standards: 27, 28 and 86. Twelve areas were identified in the plan: 1) Evaluate care management staffing in relation to CBHNP established caseloads. 2) Evaluate the process for auditing care management documentation. 3) Consistent with national standards and practice of other HealthChoices BH-MCOs, ensure that care manager supervisors conduct regular oversight of

Care Managers (CM) through live call monitoring. 4) Consider enhancement of eCura client information system of Quality of Care (QOC) issues to increase efficiency for CM staff. 5) Consider automating inclusion criteria for Enhanced Care Management (ECM) program. 6) Revise the audit tool to assessing the degree of active care management, including the promotion of recovery principles, the promotion of Evidenced-Based Practices (EBP) and the identification of QOC issues. 7) Increase frequency of D&A level of care reviews. 8) Increase training, mentoring, and monitoring of CMs. 9) Increase training and monitoring of CMs and PAs to improve the identification of QOC concerns. 10) Amend documentation audit and other tools and protocols to assess CM. 11) Develop and implement clear protocols to guide ECM activities, including policies regarding frequency and nature of ECM contacts. 12) Improve oversight of the provider network and develop an effective process of identifying provider performance. During 2013, CABHC will review and monitor CBHNPs actions addressing the standards as listed in the CAP.

PERFORMANCE OBJECTIVES

The CABHC Performance Standards for CBHNP include: Access to Treatment after Discharge from Mental Health Inpatient, D&A Readmission rates and Access to BHR services.

D&A Readmission Rates. The target range, to earn points, for this incentive is to achieve a readmission rate between 11.2 % and an optimal score of less than 9.4%. Three areas are measured: Non-Hospital Detoxification, Non-Hospital Residential Rehabilitation, and Non-Hospital Halfway House. The individual scores are combined for an aggregate score. The aggregate D&A Readmission rate for the FY is 10.09%, which is an increase from the previous FY score of 9.98%.

Access to Treatment after Discharge for Mental Health Inpatient Services was included for the first time as a performance objective, and is measured using the FY. It has been an IPRO performance measure for the past several years. This goal uses the same logic/methodology established by IPRO to measure follow-up to treatment within 7 days and 30 days after discharge from inpatient hospitalization. The standard utilizes two different measurements. The first is a calculation based on industry standard codes (HEDIS) and the second is the PA Specific Measures that includes qualifying codes and/or those that are not mapable to industry standard. OMHSAS provides BH-MCO and County specific performance data in order to compare their performance to the HEDIS Medicaid Median scores and the scores in the PA Specific Measures. This standard is the same as the Performance Improvement Plan (PIP) that has been in place for a number of years and is reported to OMHSAS on a calendar year.

The performance standard is scored by comparing the YTD scores for all four indicators to the HC Behavioral Health-MCO average. The scores for the first year of this incentive showed improvement over the year. The analysis of the 7-day HEDIS and PA Specific scores fell just short of meeting the HC average. The 7-day HEDIS standard for FY was 43.21%, or 2.2% below the average of 45.4%. Similarly, the 7-day PA Specific standard was 55.94% or 1.6% below the HC average of 57.5%.

The HEDIS and PA Specific 30-day scores to the HC average were also close to meeting the goal. The final score for the HEDIS 7-day standard is 65.93%, which is just 0.3% lower than the

66.2% average. The PA Specific score for the FY is 74.04%, only 0.06% from meeting the goal of 74.1%.

The scores for **BHRS Access** all declined for the FY. The scores for the three areas: BSC, MT, and TSS are each rated separately, with the total score included in the aggregate scoring for the performance incentives. The overall rating for this area last year was, 6.7 points.

During 2013, CABHC will continue to monitor these scores quarterly, with reports shared with the CABHC Clinical Committee and the CABHC Board of Directors.

REINVESTMENT

Reinvestment Projects are developed from available HealthChoices treatment funds that are not expended during a given fiscal year, as well as any County or CABHC surplus administrative funds. If these funds are not designated to secure risk and contingency reserves, then they can be designated for reinvestment. Reinvestment funds can be used as start-up costs for In-Plan Services, development and purchase of Supplemental Services (in lieu of or in addition to in plan services) or non-medical services that support Members' behavioral health.

Priorities for Reinvestment Projects for 2013

1. Respite Management

During 2012, CABHC has closely monitored Youth Advocate Programs, Inc. (YAP) who is the contracted Respite Management Agency. Some areas which have been proven accomplishments for 2012 include: 1.) Recruitment of two new Providers (Chester County Respite Network and The Bair Foundation). 2.) April 2012 marked the beginning of direct contract services with family members, friends, and neighbors who contract with YAP to provide respite care. 3.) To address underutilization, an agreement was reached to expand the authorization time period for in-home and out-of-home services. 4.) YAP attended CBHNP's Provider Fairs in October and November to promote respite.
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 25-30 adult clients at any given time.

For 2013, CABHC will monitor the number of Members utilizing respite services by monitoring high users of respite and tracking Member's ability to access respite services. CABHC will assist YAP with further speaking presentations to the NAMI groups, parent support groups, and Wernersville/Danville State Hospital groups. YAP will also include re-presentations at case management units in order to establish contact and deliver updates regarding services. For 2013 CABHC will support YAP's efforts to increase friends/family/neighbors trained to provide respite. The Respite Workgroup is also hopeful to have an adult Peer to Peer respite program running in late 2013 in an effort to encourage more adult Members to take part in this service. 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. YAP will also enlist the assistance of the providers to

gather these surveys so that a greater quantity is 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 concentrates on areas such as employment, education, housing, and community life.

During 2013, CABHC will monitor the Jeremy Project's goals to expand employment opportunities for participants to increase individual sessions that focus on specific transition goals of each Member, and increase independent mobility, either via driver's license or learning how to use public transportation. In addition, they will increase Member involvement in person centered planning and implementation, prepare the Member for adulthood in the four domains (Employment, Education, Independent Living, and Community Involvement/Socialization), and establish a circle of unconditional support combining formal and informal resources.

CABHC will also monitor NHS Stevens Center's 2013 Program goals to expand program participation, to hire a Transition Coordinator Assistant, to increase referrals in Perry County, and increase their number of volunteers from two (2) to four (4). In addition, CABHC will be monitoring both of these Programs to assess the continued benefit of these services and will monitor the efficacy of the Programs to reduce the need for in-plan service by the tracking of claims data.

In 2012, CABHC had two expansion programs for Specialized Transitional Support for Adolescents. Lancaster County selected Community Service Group (CSG) as their provider. They plan to start services in April 2013. Lebanon County selected Pennsylvania Counseling Services as their provider and began receiving referrals in December 2012. Both programs will be submitting outcomes to CABHC. The Counties and CABHC will be monitoring these two expansion programs in 2013.

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 explicitly designed to assist in 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. CABHC can provide scholarships to fund the first sixty days of housing (not to exceed $300 per 30 day period) for persons who qualify for this program to move into a Recovery House that participates with this program.

To ensure particular 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 2011-2012, 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 several sites throughout the area, affording those in need

sufficient opportunities for housing assistance. CABHC maintains a directory of Recovery House facilities on its website to keep substance abuse (SA) Providers current with available Recovery Houses. Additionally, CABHC has an informational brochure that provides information on the scholarship Program as well as a list of participating Recovery House organizations. This brochure is updated annually and disseminated to the five County Drug and Alcohol Commissions, CBHNP, and any interested D&A IP provider. CABHC has awarded scholarships to 152 individuals during FY 2011-2012.

In 2013, CABHC will focus on collecting, analyzing data, 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. Additionally, CABHC will be moving toward a uniform repayment process for those individuals who leave the recovery house within the first 60 days of residency. The Recovery House Mid-Year Report was completed in December 2012, with the Annual Report to follow at the conclusion of the Fiscal Year. CABHC will provide ongoing assistance to those in need of this support throughout 2013.

4. Reinvestment Plan Implementation

The plan to fund services using Reinvestment monies retained from our 2009-2010 HealthChoices Behavioral Health Program Contract year was approved by the CABHC Board, and OMHSAS. The three programs that are under development include:

Evidenced Based Practices which include Cognitive Behavioral Therapy (CBT), Dialectical Behavioral Therapy (DBT), and Parent-Child Interaction Therapy (PCIT). Early in 2012, CABHC finalized the selection process of the providers for these services. CABHC also outlined an action plan for development of the Evidenced Based Program expansion as part of our 2009-10 reinvestment plan. For 2013, Dr. Pucci from the National Association of Cognitive-Behavioral Therapists will be conducting a CBT training for selected providers. Regarding certification of PCIT and DBT, contract development with providers will occur in early 2013 and CABHC will monitor and develop reporting on each program.

5. Drug & Alcohol Recovery Specialist Services

The RFP Selection Committee which was comprised of members of the Drug & Alcohol Reinvestment Workgroup, selected the RASE Project to oversee this new Reinvestment service in February 2012. Services began in June 2012 and monthly encounter data and Program updates have been submitted to CABHC. RASE will continue to attend scheduled Drug & Alcohol Reinvestment Steering Committee meetings to provide updates, as well as engage in open dialogue with committee members regarding the progress of the Program. In 2013, the Drug & Alcohol Reinvestment Workgroup will continue to monitor this Program as it continues to grow and will work with RASE to develop goals and outcomes for reporting purposes. As the program evolves, CABHC will also assess its efficacy to determine if this service could be brought over to Medical Assistance as a Supplemental Service.

2010-2011 REINVESTMENT PLAN DEVELOPMENT

The Reinvestment Plan Development Workgroup developed ideas for the 2010-2011 reinvestment plan (Plan) that designate how we utilize these funds to enhance our services and

support for Members. Seventeen initiatives/projects were identified on how we can best invest the reinvestment funds. In addition, the Workgroup decided that each county have the opportunity to develop its own initiatives relating to specific county interests.

Approved Mental Health Initiatives-MH IP Integrated Peer Specialist Service, Lebanon Co-Occurring OP services, and Cumberland/Perry's Forensic CPS were all approved by OMHSAS in 2012. CABHC will oversee these new programs and others which are still pending (Lebanon's mobile CIS expansion, Dauphin's teleconferencing for RTF Family Therapy, Dauphin's MH OP the Incredible Years, Dauphin Mobile MH-ID Behavioral Intervention, Dauphin IDDT MH PH Program, and Lancaster's crisis residential program) that are currently under review with OMHSAS. We will assist in developing goals and outcomes for these programs and they will be reported on in 2013 if approved by OMHSAS.

The initiatives/projects related to Drug and Alcohol services are as follows:

There are continued funds for substance abuse housing support and D&A Recovery Specialist Services. Start-up funding to establish the Peer Operated Recovery Centers, Recovery House Development, and the D&A Adolescent OP Clinic have been approved. CABHC is still waiting to hear back from OMHSAS on the Dauphin-Adult Substance Abuse OP Clinic, Cumberland/Perry D&A Treatment Court Recovery Specialist Service, Cumberland/Perry D&A OP Clinic Cognitive Behavioral Therapy, and Lancaster Adolescent D&A Rehabilitation Facility. The development of these D&A specific initiatives will occur throughout 2013 as a part of CABHC's D&A Reinvestment Steering Committee.

ADDITIONAL DRUG & ALCOHOL INITIATIVES

1. Recovery Oriented Methadone Services Best Practice Pilot

There have been ongoing discussions regarding recovery-oriented best practice strategies in the delivery of methadone treatment services within the HealthChoices program. Since February 2011, CABHC, CBHNP and the SCA directors from the Counties have been researching a best practice initiative 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 was developed to revise the best practices document so that it can be piloted in the Capital and Southeast areas with a shared methadone provider. Throughout 2012, the workgroup revised the best practices document to reflect the standards it wishes to see implemented by the selected shared methadone provider.

In 2013, this provider will be called upon to review the document, offer feedback, and participate in meetings with the workgroup so that the pilot may commence. Next year CABHC plans 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 monitored the financial performance of the HealthChoices Program and CBHNP, as well as CABHC's own financial operations to ensure there is sustained solvency and success of HealthChoices for the Counties.

CABHC verifies the financial data and reporting to OMHSAS by completing the monthly OMHSAS accuracy review check list.

Priorities for Fiscal Operations for 2013

All of CABHC's fiscal oversight is based on a FY 2012-2013, therefore reporting for the Calendar Year Q1 report reflects this FY period.

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 2013.

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 continue to 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 includes the need to shift risk reserve funds to pay claims, assuring that the equity reserve meets minimum standards, that all reporting necessary 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*

CABHC will manage all fiscal payments for Reinvestment Programs. Monitoring and yearly audit procedures will be conducted throughout 2013. CABHC will work collaboratively with 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 imperative to the overall solvency of the HealthChoices Program. 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 2013.

6. Monitor HealthChoices Program Membership

The Fiscal Committee and CABHC will monitor the membership on a monthly basis. This will be accomplished by examining three different membership spreadsheets: membership with adjustment, membership without adjustment, and the net change in membership for the month.

CONCLUSION

Each year presents an assortment of challenges yet offers visions for direction for the future. The Annual Plan will guide and direct us in the best route for our goals, priorities and objectives for 2013. The *Annual Report* will follow providing an in-depth look of the success of the program.

CABHC will collaborate with Providers and CBHNP to meet the needs of its Members, as well as monitor these priorities outlined in this plan. Our goal is to ensure the continued stability of the Program. The results of the priorities stated in this Annual Plan will be revisited and reported as part of the 2013 Quality Improvement Annual Report.