CAPITAL AREA BEHAVIORAL
HEALTH COLLABORATIVE, INC.
Established October 1999

CAPITAL AREA BEHAVIORAL HEALTH COLLABORATIVE, INC.

CONTINUOUS QUALITY IMPROVEMENT ANNUAL REPORT

Calendar Year 2013

Contents

EXECUTIVE SUMMARY

CABHC is the primary contractor for the HealthChoices Behavioral Health contract for Cumberland, Dauphin, Lancaster, Lebanon and Perry Counties. Through our partnership with PerformCare, the Counties and other stakeholder groups, we provided services to a total of 35,731 consumers out of a possible membership of 189,975. Adults comprise 57% of the consumers compared to 43% for children/adolescents, with Lancaster County maintaining the greatest number of consumers out of the five Counties.

In 2013, there were several efforts made to improve the delivery of children/adolescent Behavioral Health Rehabilitation Services (BHRS). PerformCare has initiated routine meetings with high volume BHRS providers to review performance metrics associated with access and length of stay. The meetings have proven productive with reducing length of stay; however access continues to remain a challenge, primarily related to staffing capacity. The Child and Adolescent Needs Summary (CANS) assessment tool was implemented with three high volume providers on a pilot basis as a means to provide immediate decision support information regarding treatment recommendations. Evaluators were trained on how to use the tool and approximately 104 assessments were completed by the end of the year. Data will be collected to measure the efficacy of the tool. The Counties, PerformCare and CABHC met in a BHRS Summit to review all BHRS improvement projects and brainstorm new ideas. As a result of the workgroup a new initiative was developed called the "Initial BHRS (TSS, BSC, MT and FBA) Request Process Change". Final action steps will be completed in early 2014.

The number of child/adolescents accessing behavioral health services has steadily increased over the last several years. Consumers with an autism spectrum diagnosis increased almost 3% from 2012 to 2013 while consumers without an autism spectrum diagnosis increased the same amount. The three main services utilized by children/adolescents continue to be Therapeutic Staff Support, Mobile Therapy and Behavioral Specialist Consultant representing 37% out of the $113,812,122 that was spent on children/adolescent services.

From 2012 to 2013 there was a 1.9% increase in the number of adult consumers who utilized services out of a network of 400 adult behavioral health providers. Adult services were utilized by 20,695 consumers of which 77% accessed an outpatient service resulting in an increase of 1.8% from the previous year. Telehealth, which is a relatively new service, experienced a 21% increase in the number of consumers who utilized the service.

In an effort to increase the utilization of Mobile Psych Nursing (MPN), CABHC issued a Request for Proposal in 2013 to expand MPN throughout the five Counties. MPN is provided by one organization and has limited capacity beyond Lancaster County. Northwestern Human Services submitted a successful proposal and services are expected to begin in 2014.
The number of consumers who utilized Peer Support Services increased 5.6% and were affiliated with six different providers. Peer Support Services are conducted by self-identified current or former consumers of behavioral health services who are trained and certified to assist Members 18 years of age or older and can be instrumental in a consumer's recovery process. Units of service and costs increased in 2013 which is largely the result of consumers staying engaged in the service for longer periods of time.

Inpatient services were utilized by 2,068 consumers which is 10% of the total number of adult consumers who utilized behavioral health services at 48 different providers. There was a 3% reduction in the number of individuals who sought treatment although the cost of services increased 7%. This was primarily driven by an increase in the length of service and specialized rates for several consumers who experienced exceptional needs during the year.

Drug and Alcohol (D&A) services are accessed by individuals experiencing substance abuse as well as those with a co-occurring behavioral health diagnosis. Out of the approximately 5,700 consumers who utilized D&A services, 58% accessed a corresponding behavioral health service in 2013. Outpatient and Non-Hospital Detox, Rehabilitation and Halfway Houses were the most utilized services. The number of Child/Adolescents who utilized D&A services decreased 4% while the number of adults increased 5%.

PerformCare in 2013 had 654 providers in the network who were credentialed while 62 providers voluntarily left the network due to retirements or the facility no longer participated in the network. There is an equal distribution of providers throughout four of the five counties with Perry County being the exception due to the rural nature of the county and low number of eligible members. A small number of waivers were necessary for service access standards in all five counties. Mental health outpatient providers make up the largest segment of providers followed by all BHRS and Substance Abuse Outpatient services. In order to assure that providers meet a high standard of quality, PerformCare routinely conducts Provider Profiling on eleven different levels of care. Provider profiling is used to identify areas for improvement, allows for meaningful comparisons across similar levels of care, and highlights capacity and network needs. An additional process that PerformCare uses to evaluate providers is through the Treatment Record Review (TRR) audits that align with the credentialing cycle. In 2013 PerformCare conducted 49 TRRs.

CABHC relies on the involvement of community members for Committee, Board and workgroup participation in order to assure that consumers and stakeholders have input into the availability and quality of behavioral health service throughout the five Counties. The Consumer and Family Focus Committee (CFFC) serves as the center of all consumer involvement and is tasked at ensuring there is Member participation on all standing committees and workgroups. The CFFC members identified various projects to work on throughout the year that included trainings that were offered for members or employees of providers, support of resources supported through the CABHC website that created a link with potential employers and persons seeking employment in Peer Support and the implementation of a PSS Listserv that offers a forum to share information and support.

There were several Physical Health/Behavioral Health initiatives throughout 2013 that included adding additional resources to the PerformCare website and providing trainings to Targeted Case Management staff such as Cardiovascular Disease in the Seriously Mentally Ill. The Perinatal program continued to support women who are pregnant or just delivered and experiencing behavioral health symptoms or postpartum depression. The collaboration with Federally Qualified Health Centers (FQHC) to co-locate behavioral health services in the clinics were successful in serving 359 consumers.

Reinvestment activity continued at a brisk pace with several initiatives moving forward including the development of D&A Recovery Houses and Peer Operated Recovery Centers, a residential crisis diversion program and a mobile Mental Health/Intellectual Disability behavioral support team, to name a few. In addition, CABHC supports four reinvestment programs that have been operational for multiple years that continue to demonstrate positive results.

Although CABHC experienced a decrease in the FY2012/2013 administrative portion of the capitated rate, the financial performance of the agency was able to end the year in a positive position as a result of closely monitoring expenses and expanded membership. Any revenues in excess of expenses were applied toward risk and contingency reserves or to fund reinvestment projects.

CABHC Overview

The Capital Area Behavioral Health Collaborative (CABHC) is a private, not-for-profit company established in 1999 through the collaboration of Cumberland, Dauphin, Lancaster, Lebanon, and Perry Counties' Mental Health and Substance Abuse programs in order to provide monitoring and oversight of the Office of Mental Health and Substance Abuse Services' (OMHSAS) HealthChoices Behavioral Health contract. CABHC contracts with a Behavioral Health Managed Care Organization (BH-MCO) called PerformCare that carries out the management of the HealthChoices contract. The goals of the OMHSAS HealthChoices Behavioral Health Program are to enhance Members' access to health care services, to improve the quality of care accessible to Members, and to stabilize Pennsylvania's Medical Assistance spending. In accordance with these goals, CABHC's mission is:

To ensure access to and delivery of a coordinated, effectively managed, comprehensive array of quality mental health and substance abuse services that reflect the holistic needs of eligible residents throughout the five county area.

This report is intended to summarize CABHC's efforts during the 2013 calendar year to continue execution of its mission, and the goals of the HealthChoices program.

CABHC Organizational Structure

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

The County Commissioners of each of CABHC's member Counties appoint two representatives to the Board of Directors, one representing Mental Health and one representing Substance Abuse. In addition, two non-voting representatives from the Consumer and Family Focus Committee serve as liaisons to the Board. In their role, they keep the Board updated regarding information and concerns expressed by the Consumer Family Focus Committee (CFFC)

concerning Mental Health (MH) and Drug and Alcohol (D&A) matters, and keep the CFFC briefed regarding the Board's actions related to the Program.

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

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

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

Clinical Committee
The Clinical Committee is responsible for providing clinical analysis and to review continuity of care issues across all levels of care and oversight of treatment related activities of the HealthChoices program. This committee analyzes best practice guidelines and developments, monitors activity of Reinvestment Services, and as needed conducts additional studies of matters related to providing and delivering services to Members.

Consumer and Family Focus Committee
Consumers and family members comprise the majority of the Consumer and Family Focus Committee which is responsible for recruitment and training of Consumers' participation in the CABHC committee structure, providing feedback and recommendations of how the Program is managed, and education and outreach efforts to consumers and Members in the community regarding HealthChoices and recovery.

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

Provider Network Committee
The Provider Network Committee is responsible for the oversight of the provider network developed by PerformCare. Areas of focus includes monitoring the BH-MCO's provider network to assure access standards are met, choice is provided, specialty needs are available to Members, develop and monitor the need for additional existing service locations and for new services, develop and monitor provider satisfaction surveys, monitor provider profiling reports, and monitor CBHNP credentialing committee activity.

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

MEMBERSHIP

CABHC receives on a weekly basis a file from the Department of Public Welfare of individuals who are determined to be Medicaid eligible. The file is audited by our management information partner Allan Collautt Associates Inc. (ACA) to verify that the eligibility information is accurate, and once verified the list of eligible Medicaid participants becomes the member count. The data in Table 1 reflects the number of members for calendar years 2011-2013 by gender, age and County. In order for a member to be counted, they must be Medicaid eligible for one day in the calendar year. Since 2011, there has been a 4.5% increase in the number of eligible members. In CY 2013 56% of the members were females and 44% were males.

Table 1: Membership

		CY 2011			CY 2012			CY 2013		
County	**Gender**	**C/A[1]**	**Adult**	**Total**	**C/A**	**Adult**	**Total**	**C/A**	**Adult**	**Total**
Cumberland	Female	6,095	7,439	13,357	6,485	7,727	14,047	6,741	7,967	14,517
	Male	6,737	4,104	10,637	6,976	4,249	11,063	7,130	4,434	11,376
Total		**12,832**	**11,543**	**23,994**	**13,461**	**11,976**	**25,110**	**13,871**	**12,401**	**25,893**
Dauphin	Female	13,178	16,251	28,997	13,438	16,466	29,480	13,827	16,746	30,196
	Male	14,202	9,308	23,083	14,426	9,627	23,656	14,937	9,973	24,506
Total		**27,380**	**25,559**	**52,080**	**27,864**	**26,093**	**53,136**	**28,764**	**26,719**	**54,702**
Lancaster	Female	19,553	25,043	44,008	20,061	25,670	45,067	20,298	25,853	45,500
	Male	21,446	14,214	35,043	22,064	14,699	36,074	22,270	14,647	36,275
Total		**40,999**	**39,257**	**79,051**	**42,125**	**40,369**	**81,141**	**42,568**	**40,500**	**81,775**
Lebanon	Female	5,620	6,979	12,408	5,839	7,100	12,747	5,897	7,217	12,930
	Male	6,257	3,743	9,801	6,370	3,844	10,062	6,628	3,902	10,323
Total		**11,877**	**10,722**	**22,209**	**12,209**	**10,944**	**22,809**	**12,525**	**11,119**	**23,253**
Perry	Female	1,641	1,980	3,569	1,663	2,023	3,635	1,723	1,997	3,677
	Male	1,777	1,164	2,886	1,778	1,115	2,848	1,818	1,177	2,939
Total		**3,418**	**3,144**	**6,455**	**3,441**	**3,138**	**6,483**	**3,541**	**3,174**	**6,616**
Grand Total	Female	**45,552**	**57,022**	**101,135**	**46,864**	**58,353**	**103,720**	**47,854**	**59,100**	**105,507**
	Male	**49,826**	**32,272**	**80,593**	**50,975**	**33,258**	**82,785**	**52,103**	**33,818**	**84,421**
Total		**95,378**	**89,294**	**181,728**	**97,839**	**91,611**	**186,505**	**99,957**	**92,918**	**189,928**

1) C/A = Child/Adolescent

In 2013 the number of consumers who accessed services increased 2.5% from 2012 (See Table 2). Lebanon County experienced a 0.7% decrease in consumers receiving service from 2012 to 2013 that included a 4.7% decrease with adult males. Lancaster County had a 3.9% increase from 2012 to 2013. Males had an increase of 4.4% compared to 3.3% for females. Perry County

had the largest change from 2012 to 2013 with adult males increasing 12.7% followed by Lancaster County adult males increasing 6.8%.

Table 2: Consumers

		CY 2011			CY 2012			CY 2013		
County	**Gender**	**C/A[1]**	**Adult**	**Total**	**C/A**	**Adult**	**Total**	**C/A**	**Adult**	**Total**
Cumberland	Female	647	1,423	2,046	735	1,547	2,256	769	1,596	2,341
	Male	1,170	924	2,058	1,227	1,019	2,221	1,273	1,022	2,266
Total		**1,817**	**2,349**	**4,106**	**1,962**	**2,566**	**4,477**	**2,042**	**2,618**	**4,607**
Dauphin	Female	1,343	3,142	4,435	1,332	3,236	4,526	1,391	3,193	4,546
	Male	2,387	2,372	4,681	2,468	2,405	4,822	2,520	2,514	4,981
Total		**3,730**	**5,514**	**9,116**	**3,800**	**5,641**	**9,348**	**3,911**	**5,707**	**9,527**
Lancaster	Female	2,383	4,872	7,182	2,660	5,182	7,743	2,729	5,379	7,999
	Male	4,127	3,491	7,519	4,315	3,644	7,850	4,428	3,891	8,196
Total		**6,510**	**8,363**	**14,701**	**6,975**	**8,826**	**15,593**	**7,157**	**9,270**	**16,195**
Lebanon	Female	719	1,648	2,338	746	1,677	2,395	762	1,677	2,411
	Male	1,281	1,029	2,271	1,337	1,078	2,389	1,359	1,027	2,338
Total		**2,000**	**2,677**	**4,609**	**2,083**	**2,755**	**4,784**	**2,121**	**2,704**	**4,749**
Perry	Female	228	320	543	237	363	590	246	364	606
	Male	310	195	501	349	189	531	327	213	534
Total		**538**	**515**	**1,044**	**586**	**552**	**1,121**	**573**	**577**	**1,140**
Grand Total	Female	**5,291**	**11,282**	**16,392**	**5,672**	**11,899**	**17,366**	**5,858**	**12,091**	**17,745**
	Male	**9,219**	**7,946**	**16,909**	**9,625**	**8,277**	**17,684**	**9,834**	**8,604**	**18,179**
Total		**14,510**	**19,230**	**33,303**	**15,297**	**20,176**	**35,050**	**15,692**	**20,695**	**35,924**

1) C/A = Child/Adolescent

The data in Table 3 reflects the diversity and the distribution of consumers throughout the five Counties. American Indian consumers had the largest increase from 2011 to 2013 at 29% with increases primarily occurring in Dauphin and Lancaster Counties.

Table 3: Race

Year	Race	Cumb.	Dauphin	Lanc.	Leb.	Perry	Total
CY 2011	American Indian	9	21	19	6	1	56
	Asian	33	55	110	25	2	221
	Black	253	3,424	1,322	167	10	5,141
	Hispanic	169	1,189	3,604	1,149	16	6,102
	Other	257	401	623	85	22	1,376
	White	3,385	4,026	9,023	3,177	993	20,407
Total		**4,106**	**9,116**	**14,701**	**4,609**	**1,044**	**33,303**
CY 2012	American Indian	9	24	20	2		55
	Asian	41	69	112	23	1	245
	Black	286	3,459	1,367	172	18	5,272
	Hispanic	195	1,260	3,958	1,214	19	6,615
	Other	295	428	701	101	22	1,537
	White	3,651	4,108	9,435	3,272	1,061	21,326
Total		**4,477**	**9,348**	**15,593**	**4,784**	**1,121**	**35,050**
CY 2013	American Indian	8	34	24	4	2	72
	Asian	37	81	113	23	3	256
	Black	267	3,387	1,414	167	17	5,221
	Hispanic	206	1,352	4,175	1,272	17	6,982
	Other	291	469	755	101	27	1,633
	White	3,778	4,103	9,660	3,171	1,066	21,567
Total		**4,587**	**9,426**	**16,141**	**4,738**	**1,132**	**35,731**

CHILDREN/ADOLESCENT SERVICES

CABHC is committed to promoting the emotional wellbeing of children and adolescents and ensuring that children/adolescents with emotional and behavioral challenges have access to quality services. Making services available at an early age affords the best chance for success as they enter adolescence and adulthood. All services are based on the Child and Adolescent Service System Program (CASSP) that ascribes to the principles that services should be child centered, family focused, community based, multi-system, culturally competent and the least intrusive.

Equally important is the need that services are accessible both in assuring that the service is available when needed and that they are located geographically as close as possible to a child/family home. For this reason, CABHC through PerformCare maintains a network of 328 child/adolescent providers, with 55 providers who have multiple service locations and have the ability to provide services directly in the home and school. Services available to children include Behavioral Health Rehabilitation Services (BHRS) that are typically provided in the home,

school or community. Outpatient services are predominately office/clinic based. In addition, there are residential options that include Community Residential Rehabilitation Host Homes (CRR-HH), Inpatient Psychiatric Hospitalization and Residential Treatment Facilities (RTF).

BHRS

Over the past year there have been several efforts centered on improving BHRS services. These include:

1) Improving Access Times

   An emphasis was placed on conducting individual meetings with high volume providers to review their performance and discuss strategies they are taking to improve performance. The data reviewed during these meetings is insightful in drawing attention to strengths as well as areas that need improved such as completion and implementation of Functional Behavioral Assessments (FBA), access time for services, recruitment and retention of qualified staff and Length of Stay (LOS) in service. Providers are compared to a baseline that is composed of all the providers in the network. Efforts to improve access time will continue in 2014.

2) Implement the Child and Adolescent Needs Summary

   In 2013 CABHC along with PerformCare initiated the use of the Child and Adolescent Needs Summary (CANS) that is an evidenced based evaluation tool. Community Data Roundtable was engaged to develop a CABHC specific CANS that is to be used by all evaluators as a means to provide immediate decision support information regarding treatment recommendations. The use of the CANS tool was started as a Pilot program in order to assess its implementation and identify any technical issues since it is completed in electronic format, as well as analyze the quality of the tool in making accurate assessments and recommendations for service. At the end of 2013 there were 104 evaluations completed using the CANS. CABHC will monitor the implementation of CANS throughout 2014 to evaluate the changes that occur in the assessment process and authorized services.

3) BHRS Summit

   In 2013 there was a BHRS Summit meeting that included representation of all five Counties, PerformCare and CABHC to brainstorm issues related to BHRS and consolidate existing improvement proposals. The result of this summit was the development of a task list that will be used as the roadmap for all children/adolescent projects, including their objectives, who is responsible and continuous monitoring of the projects through the use of the Base Camp management tool. One of the key initiatives is the development of the "PerformCare's Proposed BHRS Process Changes", which has been renamed to "Initial BHRS (TSS, BSC, MT and FBA) Request Process Change". The final objectives and action steps will be discussed and refined in 2014.

Over the past three years there has been a steady increase in the number of child/adolescent consumers, with consumers with an Autism Spectrum Diagnosis (ASD) increasing 2.8% since 2012. Children/adolescents without an ASD also increased 2.8% during the same time period (see Table 4). Perry County experienced the greatest increase in consumers with an ASD.

Although there has been an increase in consumers, the cost/consumer has decreased in each successive year since 2011.

Table 4: Autism Spectrum Diagnosis

		CY 2011		CY 2012		CY 2013		% change CY 12-13	
County	**ASDx**	**Cons**	**Cost/Cons**	**Cons**	**Cost/Cons**	**Cons**	**Cost/Cons**	**Cons**	**Cost/Cons**
Cumberland	No	1,487	$ 6,643	1,599	$ 5,835	1,711	$ 4,961	7.0%	-15.0%
	Yes	516	$ 10,569	552	$ 9,920	554	$ 9,023	0.4%	-9.0%
Total		**1,817**	**$ 8,438**	**1,962**	**$ 7,546**	**2,042**	**$ 6,605**	**4.1%**	**-12.5%**
Dauphin	No	3,310	$ 6,948	3,399	$ 6,340	3,499	$ 5,551	2.9%	-12.4%
	Yes	695	$ 11,169	754	$ 10,373	766	$ 10,006	1.6%	-3.5%
Total		**3,730**	**$ 8,246**	**3,800**	**$ 7,730**	**3,911**	**$ 6,926**	**2.9%**	**-10.4%**
Lancaster	No	5,894	$ 5,436	6,332	$ 5,077	6,512	$ 4,710	2.8%	-7.2%
	Yes	1,056	$ 12,942	1,207	$ 12,317	1,246	$ 11,564	3.2%	-6.1%
Total		**6,510**	**$ 7,021**	**6,975**	**$ 6,740**	**7,157**	**$ 6,299**	**2.6%**	**-6.6%**
Lebanon	No	1,820	$ 6,350	1,898	$ 6,030	1,915	$ 5,646	0.9%	-6.4%
	Yes	351	$ 12,530	383	$ 13,053	396	$ 12,346	3.4%	-5.4%
Total		**2,000**	**$ 7,977**	**2,083**	**$ 7,895**	**2,121**	**$ 7,402**	**1.8%**	**-6.2%**
Perry	No	496	$ 5,904	537	$ 5,964	512	$ 5,782	-4.7%	-3.1%
	Yes	80	$ 10,153	96	$ 9,021	120	$ 5,725	25.0%	-36.5%
Total		**538**	**$ 6,953**	**586**	**$ 6,944**	**573**	**$ 6,365**	**-2.2%**	**-8.3%**
Grand Total	No	**12,936**	**$ 6,138**	**13,667**	**$ 5,683**	**14,056**	**$ 5,148**	**2.8%**	**-9.4%**
	Yes	**2,681**	**$ 11,970**	**2,976**	**$ 11,435**	**3,059**	**$ 10,673**	**2.8%**	**-6.7%**

Within the BHRS array of services, the three services that are basically considered to represent BHRS are Behavioral Specialist Consultant (BSC), Mobile Therapy (MT) and Therapeutic Staff Support (TSS). Behavioral Specialist Consultant is a master's level consultant who conducts assessments and observations in order to develop a behavior/treatment plan that addresses the behavioral health needs of the consumer. In 2013, the DPW required all BSCs to complete and pass required trainings and submit required documentation to the Department of State to receive their Behavioral Specialist license in order to continue to provide BSC services to children/adolescents with an ASD. PerformCare monitored the application process throughout 2013 to assure there was adequate capacity of BSs to meet the needs of ASD consumers.

In 2013 the total number of consumers who received TSS, MT and BSC decreased 1.7% from 2012, and costs decreased 10.7%. Table 5 highlights the number of consumers who received service and the corresponding cost for calendar years 2011-2013. Over the past year there have been increased efforts focused on evaluator education, active care management and improved appropriate prescriptions.

Table 5: TSS, MT, BSC Utilization by County

		CY 2011		CY 2012		CY 2013	
County	**Service**	**Consumers**	**Dollars**	**Consumers**	**Dollars**	**Consumers**	**Dollars**
Cumberland	TSS	325	$3,923,323	342	$4,227,507	320	$3,530,002
	MT	300	$540,419	359	$591,907	364	$725,208
	BSC	373	$1,147,225	415	$1,307,540	393	$1,101,291
	Total	574*	$5,610,967	640*	$6,126,953	635*	$5,356,502
Dauphin	TSS	627	$6,109,190	646	$6,413,144	628	$6,028,649
	MT	873	$2,348,264	904	$2,375,019	970	$2,447,421
	BSC	617	$2,012,967	678	$2,236,109	674	$1,995,720
	Total	1,267*	$10,470,420	1,338*	$11,024,273	1,385*	$10,471,790
Lancaster	TSS	925	$12,027,902	986	$13,572,532	943	$11,633,013
	MT	1,212	$2,606,539	1,170	$2,454,427	995	$2,164,335
	BSC	1,029	$3,326,352	1,205	$3,751,289	1,198	$3,596,494
	Total	1,792*	$17,960,792	1,933*	$19,778,248	1,839*	$17,393,842
Lebanon	TSS	366	$4,008,414	377	$4,605,554	337	$3,785,376
	MT	402	$1,114,973	438	$1,048,254	359	$788,631
	BSC	296	$970,970	335	$989,758	350	$1,091,495
	Total	604*	$6,094,356	637*	$6,643,566	603*	$5,665,502
Perry	TSS	54	$466,461	42	$400,165	46	$301,491
	MT	97	$176,210	110	$238,221	126	$275,004
	BSC	69	$196,256	72	$200,756	72	$191,814
	Total	139*	$838,927	154*	$839,143	163*	$768,309
Grand Total		**4,355***	**$40,975,463**	**4,673***	**$44,412,182**	**4,594***	**$39,655,944**

*Unduplicated count of consumers

CRR Host Homes (CRR-HH)

CRR-HHs are caregivers that are under contract with Providers to offer a therapeutic and stable home life for consumers who are unable to live in their natural home. PerformCare has closely managed the utilization of CRR-HHs to assure consumers who meet criteria receive their prescribed treatment and Length of Stay (LOS) is monitored to reduce extended stays. The number of consumers who received service decreased from 135 in 2012 to 91 in 2013. The LOS decreased from 301 days to 279 days and costs decreased from $3,749,402 to $2,403,079.

An initiative continued in 2013 to develop CRR-HH Intensive Treatment Program (CRR-HH-ITP) services. CRR-HH-ITP is a comprehensive program licensed as a CRR-HH that utilizes caregivers who go through an extensive training program in order to be able to serve as mentors to the biological or adoptive parents by working to transfer a set of skills and family system structure that has been effective with the child in the host home to the natural home environment. The program also must provide active treatment and therapy while the child/adolescent is in the home. Two providers were selected to develop the service, BAIR Foundation and Northwestern Human Services. At the conclusion of calendar year 2013, there were five consumers admitted into a CRR-HH-ITP.

Summer Therapeutic Activity Program (STAP)
STAP is a six week summer program that provides a range of age appropriate specialized therapies designed to aid in the development of interpersonal relationship, daily living, decision making, problem-solving and coping skills which requires appropriately qualified staff. These services are provided for the purpose of furthering individualized therapeutic goals as described in the individualized treatment plan. In 2013 OMHSAS issued a bulletin to clarify programmatic expectations for STAPs, provide direction to providers for developing and operating STAPs, reiterate the services that are allowable for payment by the Medical Assistance Program, update the format for STAP service descriptions and clarify roles and staffing requirements. CABHC, along with the Counties and PerformCare, developed a workgroup to assist the Providers interested in running a STAP, and in creating new service descriptions that met the new OMHSAS criteria for operating a STAP.

In 2013, as a result of the changes enacted by OMHSAS, the number of active STAP providers decreased from ten to six and the number of consumers decreased from 594 to 322. In addition, the cost of STAP decreased 50% from $1,624,696 to $813,864.

Family Based Mental Health Services (FBHMS)
FBMHS is an intensive community based service that is authorized for an initial 180 days and utilizes a two person therapist team to address the behavioral health needs of the consumer and provide parenting skills to the family. The team is on-call 24 hours a day in order to meet the needs of the consumer.

The utilization of FBMHS has been closely monitored by PerformCare after it was identified as an outlier in comparison to the rest of PA. During 2013, PerformCare implemented several Performance Improvement Plans (PIPs) in an effort to address the utilization and LOS that is effected by the number of extension requests. One of the objectives was the development of FBMHS Best Practice Guidelines that was submitted to OMHSAS in May 2013. Approval was not granted for moving forward with these however an alternative document with a new name will be proposed for CABHC to consider which will incorporate feedback from OMHSAS. Efforts were also made to evaluate the frequency of multiple authorizations for the same family unit and treatment planning issues. Quarterly meetings were initiated with providers to discuss primary and secondary causes that contribute to service delivery issues, along with the implementation of expanded Quality Improvement audits to evaluate the performance of Providers in meeting defined benchmarks.

The data in Table 6 reveals an overall reduction from 2012 to 2013 in the number of consumers utilizing FBMHS, the LOS as well as the cost of the service. Cumberland County experienced the greatest reduction in the number of consumers served and total cost.

Table 6: Family Based Mental Health Services

	CY 2012			CY 2013			% Change		
County	**Cons**	**LOS**	**Dollars**	**Cons**	**LOS**	**Dollars**	**Cons**	**LOS**	**Dollars**
Cumberland	149	182.9	$1,906,466	109	180.8	$1,456,380	-26.8%	-1.1%	-23.6%
Dauphin	238	174.5	$2,882,641	198	163.4	$2,304,830	-16.8%	-6.4%	-20.0%
Lancaster	469	179.9	$5,310,062	379	176.9	$4,608,564	-19.2%	-1.7%	-13.2%
Lebanon	183	179.4	$1,961,757	158	174.6	$1,891,207	-13.7%	-2.6%	-3.6%
Perry	67	177.3	$984,814	56	190.0	$934,541	-16.4%	7.1%	-5.1%
Total	**1,097**	**178.8**	**$13,045,739**	**894**	**174.7**	**$11,195,521**	**-18.5%**	**-2.3%**	**-14.2%**

Outpatient Services

During 2013 there was an increase in the utilization of outpatient services that included clinics, rural clinics and telepsychiatry or "telehealth". Telehealth is provided by NHS Human Services and includes a psychiatrist using real-time, two-way interactive audio-video transmission for the purpose of consultation, outpatient visits, individual psychotherapy, psychiatric diagnostic interview examinations or pharmacologic management. The service improves access for consumers who have difficulty traveling to outpatient clinics. Table 7 highlights the utilization of outpatient services from 2011 to 2013. The number of consumers who accessed an outpatient rural clinic increased 108% and the number of consumers who accessed Telehealth increased 43%. Collectively, there was a 3% increase in the number of consumers who utilized outpatient services.

Table 7: Outpatient Service

	CY 2011		CY 2012		CY 2013	
Service	**Consumers**	**Dollars**	**Consumers**	**Dollars**	**Consumers**	**Dollars**
Telehealth	3	$496	88	$56,597	126	$55,333
OP Physician	1,663	$1,310,669	1,594	$1,448,106	1,296	$1,201,601
OP Rural Clinic	15	$7,008	25	$8,149	52	$17,937
OP Clinic	10,095	$7,358,594	11,147	$7,971,885	11,578	$8,278,810
Grand Total	**10,968***	**$8,676,767**	**11,938***	**$9,484,738**	**12,290***	**$9,553,681**

*Unduplicated count of consumers

Inpatient Psych Hospital Services

Inpatient hospitalization provides a locked setting for the delivery of acute care and combines security and restrictiveness with intensive treatment, for the purpose of establishing within the child the self-control and/or capacity for constructive expression and more adaptive interpersonal skills necessary to continue treatment in a more natural and less restrictive setting.

In 2013, CABHC utilized a network of 25 providers to meet the acute psychiatric needs of 787 consumers throughout the territory. Table 8 provides information on the number of consumers, LOS and cost of services for calendar years 2011 through 2013. Although the number of consumers who utilized Inpatient Psych Hospitalization services increased from 2012 to 2013, the LOS decreased by almost one day. The cost per consumer decreased 2% from $11,028 in 2012 to $10,826 in 2013.

Table 8: Inpatient Psych Hospital

	CY 2011			CY 2012			CY 2013		
County	**Cons**	**LOS**	**Dollars**	**Cons**	**LOS**	**Dollars**	**Cons**	**LOS**	**Dollars**
Cumberland	71	13.6	$ 768,436	74	12.6	$ 830,044	100	11.7	$ 1,004,534
Dauphin	180	14.8	$ 2,460,821	175	13.5	$ 1,990,312	188	12.8	$ 2,447,893
Lancaster	249	15.9	$ 4,062,387	306	12.9	$ 3,083,826	346	12.5	$ 3,355,142
Lebanon	112	11.3	$ 1,043,291	124	12.6	$ 1,424,249	122	11.6	$ 1,320,996
Perry	17	12.4	$ 212,015	29	17.1	$ 479,595	32	11.7	$ 391,471
Grand Total	**625**	**14.4**	**$ 8,546,951**	**708**	**13.2**	**$ 7,808,026**	**787**	**12.3**	**$ 8,520,036**

Residential Treatment Facility (RTF)

Residential Treatment Facilities provide services for children/adolescents with serious mental, emotional and/or behavioral problems who require the coordinated, intensive and comprehensive treatment available from a multi-disciplinary team within a structured, residential setting. The service is provided in an unlocked, safe environment within a restrictive setting for the delivery of psychiatric treatment and care as an alternative to inpatient hospitalization.

The number of consumers who utilized the 20 RTFs in the CABHC network decreased 11% and costs decreased 5% in 2013 compared to 2012; however the average LOS increased by 36 days, leading to an 8% increase in the cost/consumer (see Table 9). Lancaster and Perry Counties each experienced significant increases in the cost/consumer from 2012 to 2013 at 15% and 29% respectively, even though the number of consumers and LOS decreased. The increase in the cost/consumer can be attributed to the exceptional costs of a few children/adolescents and an overall increase in facility costs for consumers from Perry County.

Table 9: Residential Treatment Facilities

	CY 2012				CY 2013			
County	**Cons**	**LOS**	**Cost/Cons**	**Dollars**	**Cons**	**LOS**	**Cost/Cons**	**Dollars**
Cumberland	44	210	$54,830	$2,412,534	36	328	$59,682	$2,148,551
Dauphin	65	258	$57,708	$3,750,998	48	325	$52,461	$2,518,149
Lancaster	130	265	$55,217	$7,178,206	127	295	$63,317	$8,041,253
Lebanon	44	337	$46,218	$2,033,573	40	292	$45,971	$1,838,833
Perry	14	258	$40,010	$560,139	13	232	$51,556	$670,225
Total	**294**	**265**	**$54,202**	**$15,935,450**	**261**	**301**	**$58,303**	**$15,217,011**

ADULT SERVICES

CABHC is committed to developing and maintaining the highest quality services to support adults with mental health and/or substance abuse with their recovery. This requires working collaboratively with all our partners that include the Counties, PerformCare, consumers and families, OMHSAS and other stakeholders. Services for adults follow the Community Support Program and Recovery principles that guide providers and consumers in developing treatment plans and strategies that address each person's mental illness and substance abuse.

In 2013, 20,695 adult consumers accessed one or more HealthChoices behavioral health service. The majority of consumers utilized a community based service such as an outpatient clinic with just 2,064 consumers requiring an inpatient service. Providing the appropriate service can be a challenge due to the multiple mental health diagnosis's that consumers present and developing treatment strategies that will have the most significant impact. Table 10 highlights the ten diagnoses' that afflict the most consumers. A consumer may have multiple diagnoses including co-occurring substance abuse. Services related to substance abuse will be addressed in the Drug and Alcohol section of this report.

Table 10: Diagnosis

Diagnosis	%	Consumers
Major Depression	27%	7,337
Bipolar Disorder	14%	3,851
Adjustment Reaction	12%	3,213
Opioid Dependency	10%	2,722
Schizophrenia	9%	2,458
Depressive Disorder	9%	2,431
Neurotic Disorders	8%	2,133
Other Substance Related Disorder	4%	1,061
Alcohol Dependency	4%	1,004
Childhood Hyperkinetic Syndrome	3%	839

Adult services were provided by a network of 400 providers, many who are individual practitioners. Services follow a continuum of least intrusive such as Targeted Case Management, Outpatient, Mobile Psych Nursing and Peer Support Services. Individuals with more acute needs have access to Assertive Community Treatment services and when necessary Inpatient services.

Targeted Case Management

Targeted Case Management (TCM) is a service that is comprised of Intensive Case Management (ICM), Blended Case Management and Resource Coordination (RC) and is located in the County Case Management Units and/or delivered by private providers in Dauphin and Lancaster Counties. Table 11 displays the utilization of TCM throughout the territory for calendar years 2012 and 2013. In 2013, 14% of all adult consumers accessed a form of TCM which is an increase of 1% over 2012. The LOS and cost of the service both decreased 2% however, the units of service provided decreased 35%.

Table 11: Targeted Case Management

		CY 2012				CY 2013			
County	**Service**	**Cons**	**Units**	**LOS**	**Dollars**	**Cons**	**Units**	**LOS**	**Dollars**
Cumberland	ICM	150	31,723	266	$466,404	141	18,260	332	$420,466
	BCM	2	21	51	$362	2	79	22	$2,078
	RC	164	17,701	94	$241,832	165	11,580	86	$233,113
Total		**305**	**49,445**	**137**	**$708,599**	**297**	**29,919**	**144**	**$655,656**
Dauphin	ICM	558	91,221	185	$1,560,278	532	58,213	217	$1,519,957
	BCM	260	38,802	130	$669,247	286	29,170	134	$735,762
	RC	908	73,066	78	$1,252,069	914	51,376	72	$1,206,483
Total		**1,602**	**203,089**	**107**	**$3,481,594**	**1,645**	**138,759**	**116**	**$3,462,203**
Lancaster	ICM	378	57,759	337	$1,059,293	247	25,216	268	$739,760
	BCM	159	14,944	36	$268,663	225	17,484	91	$553,811
	RC	305	25,669	70	$384,503	315	18,605	80	$424,272
Total		**686**	**98,372**	**155**	**$1,712,459**	**707**	**61,305**	**121**	**$1,717,843**
Lebanon	ICM	88	10,796	242	$180,724	72	5,152	411	$122,322
	BCM					1	38	63	$954
	RC	203	13,183	73	$183,419	188	9,843	65	$195,544
Total		**276**	**23,979**	**97**	**$364,143**	**253**	**15,033**	**94**	**$318,820**
Perry	ICM	23	3,894	133	$57,019	22	2,835	246	$63,262
	BCM	3	38	6	$645	1	12	30	$323
	RC	22	4,202	114	$56,727	29	2,236	85	$45,401
Total		**43**	**8,134**	**115**	**$114,390**	**51**	**5,083**	**125**	**$108,986**
Grand Total		**2,891**	**383,019**	**120**	**$6,381,184**	**2,923**	**250,099**	**117**	**$6,263,508**

Outpatient Services

Outpatient treatment is an organized, non-residential treatment service providing psychotherapy in which the client participates in regularly scheduled treatment sessions. Across the Collaborative adult Outpatient services are provided as individual or group therapy, and typically provided in an outpatient clinic.

Over the past year PerformCare has focused on increasing the utilization of Outpatient services in an effort to improve recovery and reduce readmission rates into inpatient facilities. There was a 1.8% increase in the number of consumers who accessed Outpatient services from 2012 to 2013 and a 214% increase in consumers who accessed a rural Outpatient Clinic. (See Table 12) Due to a coding change in 2013, the units in Outpatient Other increased when medication checks were transferred to this service category. Telehealth, which is a new service that started in 2012 and allows a consumer to access a physician remotely, experienced a 21% increase in the number of consumers utilizing the service.

Table 12: Outpatient Services

	CY 2012			CY 2013			% Change 2012-2013		
Service	**Cons**	**Units**	**Dollars**	**Cons**	**Units**	**Dollars**	**Cons**	**Units**	**Dollars**
OP Clinic	13,260	167,569	$9,278,963	13,350	174,641	$9,644,542	0.7%	4.2%	3.9%
OP Partial	487	75,908	$1,690,537	526	81,835	$1,912,682	8.0%	7.8%	13.1%
Rural Clinic	65	427	$20,296	204	677	$21,154	213.8%	58.5%	4.2%
OP Physician	2,967	27,030	$1,042,111	3,516	42,310	$1,577,285	18.5%	56.5%	51.4%
OP Other	1,452	4,848	$381,551	1,453	6,833	$502,142	0.1%	40.9%	31.6%
Telehealth	238	1,002	$168,511	288	1,115	$117,734	21.0%	11.3%	-30.1%
Total	**15,576**	**276,784**	**$12,581,968**	**15,856**	**307,411**	**$13,775,540**	**1.8%**	**11.1%**	**9.5%**

Mobile Psych Nursing

Mobile Psychiatric Nursing Services (MPN) provides ongoing psychiatric assessment, medication management, and clinical support by qualified registered nurses with psychiatric training in home or community settings. It is expected that the use of MPN services will offset the use of more restrictive and costly services such as IP Psychiatric services by diverting persons who might have been admitted/readmitted or stepped down sooner from an inpatient psychiatric placement.

Behavioral Healthcare Corporation provides MPN services throughout the Capital Area; however their service footprint is primarily located in Lancaster County. See Table 13 for information on MPN utilization in 2013. Cumberland County experienced a 100% increase in the number of consumers utilizing MPN from 2012 to 2013 and Dauphin County had a 47% increase for the same time period. There was a 15% overall increase in the number of consumers from 2012 to 2013 and 7% increase in both units and cost.

Table 13: Mobile Psychiatric Nursing

	CY 2012			CY 2013		
County	**Cons**	**Units**	**Dollars**	**Cons**	**Units**	**Dollars**
Cumberland	8	892	$28,589	16	1,031	$33,044
Dauphin	19	2,167	$69,452	28	2,411	$77,273
Lancaster	126	14,675	$471,215	137	15,383	$493,094
Lebanon	9	768	$24,614	7	1,013	$32,467
Perry	3	286	$9,166	4	199	$6,378
Total	**164**	**18,788**	**$603,037**	**189**	**20,037**	**$642,255**

In 2013, CABHC issued a Request for Proposal to expand MPN in the five counties with a special emphasis on Cumberland, Dauphin and Perry Counties. The proposal submitted by Northwestern Human Services was accepted, and after contract negotiations were completed, the service is expected to begin in 2014.

Peer Support Services:
Peer Support Services (PSS) are specialized therapeutic interactions for individuals 18 years of age or older that are conducted by self-identified current or former recipients of behavioral health services who are trained and certified to offer support and assistance in helping others in their recovery and community-integration process. The service is designed to promote empowerment, self-determination, understanding, coping skills, and resilience through mentoring and service coordination supports that allow individuals with severe and persistent mental illness and co-occurring disorders to achieve personal wellness.

CABHC members have access to six different providers who manage Peer Support Services with Recovery Insight, Inc. the highest volume provider. (See Table 14) From 2012 to 2013 there was a 5.6% increase in the number of consumers accessing PSS. Units of service and cost increased 16% due to the slight increase in consumers and the average length of stay increased 21% from 114 days to 138 days.

Table 14: Peer Support Services

	CY 2012				CY 2013			
County	**Cons**	**LOS**	**Units**	**Dollars**	**Cons**	**LOS**	**Units**	**Dollars**
Cumberland	31	106	3,100	$53,475	36	186	4,320	$74,520
Dauphin	124	120	18,229	$314,450	99	119	17,813	$307,274
Lancaster	140	122	30,420	$524,744	169	155	35,315	$608,839
Lebanon	43	89	3,794	$65,447	51	117	7,032	$121,302
Perry	2	35	49	$845	5	36	159	$2,743
Total	**340**	**114**	**55,592**	**$958,961**	**359**	**138**	**64,639**	**$1,114,678**

Assertive Community Treatment (ACT)
ACT is a service delivery model for providing comprehensive community-based treatment to persons with serious mental illness. It is a self-contained mental health program made up of a multidisciplinary mental health staff who work as a team to provide the majority of treatment, rehabilitation, and support services consumers need to achieve their goals. ACT services are targeted to individuals with serious mental illnesses that cause symptoms and impairments in basic mental and behavioral processes.

CABHC has a relationship with two different providers who each support two ACT teams. Northwestern Human Services (NHS) has the largest team in Dauphin County called NHS Capital that supports 90 consumers. Their NHS Stevens ACT program supports 33 consumers in Cumberland County. Philhaven Lancaster supports 47 consumers and Philhaven Lebanon supports 50 consumers. Bi-annually the ACT teams report outcome data to CABHC for analysis and consolidation so that it can be shared with all the ACT teams. Slight modifications were made in 2013 to the data collection methodology in order to more accurately capture information related to employment, community involvement and readmissions. Table 15 is the final CY2013 ACT outcome data. The data indicates that the ACT teams are doing well with community involvement; however they are struggling to assist consumers in acquiring competitive employment and meeting readmission targets. There have been several discussions with the ACT

teams involving employment, and CABHC is researching supported employment training options in order to increase employment opportunities for consumers.

Table 15: ACT Outcomes

	70 % Cons. meeting employment goal	90% of cons. meet community activity goal	85% of cons. maintain stable housing	90% of discharges will have no readmissions	95% of readmissions will have LOS<12 days	90% will have no legal involvement
NHS Cap	7%	96%	99%	99%	14%	100%
NHS Stevens	6%	37%	91%	91%	0%	100%
Philhaven-Lanc.	8%	89%	77%	77%	50%	100%
Philhaven-Leb.	9%	87%	81%	81%	56%	96%
Average	8%	77%	87%	87%	30%	99%

Inpatient Services

In 2013, 2083 adults utilized Inpatient Psychiatric services. Based on the total number of adult consumers in the Capital area (20,695), 10% were admitted into an inpatient unit. Forty-eight providers were utilized in 2013 which is down from the 55 providers that were utilized in 2012. The five Inpatient Providers who provided the most service were; Pennsylvania Psychiatric Institute, Philhaven, Roxbury, Lancaster General Hospital and Lancaster Regional Medical Center.

Between 2012 and 2013 there was a 2.3% reduction in the number of consumers served in Inpatient settings, however the number of episodes increased 1% and the average LOS increased 5%. The cost/consumer increased 12% while total costs increased 9%. (See Table 16)

Table 16: Inpatient Services

	CY 2012					CY 2013				
County	**Cons**	**Epd.**	**LOS**	**C/C**	**Dollars**	**Cons**	**Epd.**	**LOS**	**C/C**	**Dollars**
Cumb.	257	364	14.2	$ 9,764	$ 2,509,395	255	354	14.7	$ 9,553	$ 2,436,019
Dauphin	709	1,124	14.7	$ 12,896	$ 9,143,093	654	1,046	16.5	$ 15,426	$ 10,088,521
Lanc.	861	1,188	10.8	$ 6,620	$ 5,700,072	876	1,278	11.0	$ 7,045	$ 6,171,380
Lebanon	249	361	15.2	$ 11,188	$ 2,785,854	236	358	15.2	$ 13,108	$ 3,093,573
Perry	64	80	10.8	$ 6,647	$ 425,413	78	111	11.3	$ 8,116	$ 633,083
Total	**2,131**	**3,117**	**13.1**	**$ 9,650**	**$ 20,563,827**	**2,083**	**3,147**	**13.7**	**$ 10,765**	**$ 22,422,576**

DRUG AND ALCOHOL SERVICES

Drug and Alcohol services are provided to children/adolescents and adults through an array of treatment options that include Targeted Case Management, Outpatient, Intensive Outpatient, Non-Hospital Detox, Rehabilitation, Halfway Houses and the administration of Methadone and Buprenorphine or Suboxone ® treatment for individuals who are dependent on an opiate substance. In many instances, consumers also have a co-occurring behavioral health diagnosis as evidenced by 333 children/adolescents who accessed both a behavioral health service and a D&A service and 2,950 adults who accessed both services.

Outpatient Services

Outpatient services are provided under the supervision of a physician and include Clinic, Intensive Outpatient (IOP) and Partial Hospitalization services. 71% of all children who utilized outpatient services were seen in a clinic setting compared to 60% for adults. The number of children/adolescents who accessed outpatient services in 2013 decreased 2% along with a corresponding 15% decrease in costs and adults who accessed outpatient services increased 11% with a 15% increase in cost. (See Table 17)

Table 17: D&A Service by Age/Level of Care

		2012		2013		% Change	
Age	**Level of Care**	**Cons**	**Dollars**	**Cons**	**Dollars**	**Cons**	**Dollars**
Child/Adolescent	**Outpatient**	427	$233,327	419	$198,488	-1.9%	-14.9%
	NH-D,R,HH[1]	156	$2,049,209	120	$1,555,393	-23.1%	-24.1%
	Total	500	$2,283,377	480	$1,753,881	-4.0%	-23.2%
Adult	**Outpatient**	3682	$2,987,626	4084	$3,438,536	10.9%	15.1%
	Inpatient-D,R	59	$391,906	52	$282,711	-11.9%	-27.9%
	NH-D,R,HH	1,697	$11,939,559	1788	$13,340,319	5.4%	11.7%
	Methadone	857	$2,750,470	955	$3,048,959	11.4%	10.9%
	Bup Program[2]	398	$387,774	441	$443,477	10.8%	14.4%
	Total	5,000	$18,021,280	5,255	$20,058,372	5.1%	11.3%
	Grand Total	5,467	$20,304,657	5,694	$21,812,253	4.2%	7.4%

[1]Non-Hospital Detox, Residential Rehab, Halfway House
[2] Buprenorphine Coordination Program

Detox, Rehab and Halfway House

Non-Hospital (NH) Detox, Residential Rehab and Halfway House D&A services are provided in an Inpatient or NH setting, with the majority of services occurring in the NH setting. Consumers who require physical health care are referred to inpatient settings for Detox and Rehab services. In 2013, of the 1,788 adult consumers who utilized NH services, 1,572 consumers accessed Residential Rehab, 848 accessed NH Detox, and 295 consumers utilized a Halfway House that indicates consumers may access multiple services throughout their recovery.

Methadone/Buprenorphine Coordination Program

Consumers that have an Opiod addiction have access to two different medication assisted treatment; Methadone delivered in a licensed clinic or Suboxone (aka Buprenorphine) that is prescribed by a certified physician. For those Members that are being treated with Suboxone, they can also receive additional support through the Buprenorphine Coordination Program, a CABHC developed Medicaid supplemental service. Methadone services were available through eight providers in 2013 and the BUP Program is administered by the RASE Project through participating physician groups. The data in Table 17 indicates an increase in the number of consumers accessing both Methadone treatment (11.4%) and the BUP Program (10.8%).

Recovery Oriented Methadone Services (ROMS) Pilot Work Group

The Methadone best practice standards were developed through a collaboration of six counties; Chester, Cumberland, Dauphin, Lancaster, Lebanon and Perry and the Behavioral Health managed care organizations serving those counties, Community Care Behavioral Health Organization and PerformCare. These standards were significantly informed by the work commissioned by Southwest Behavioral Health Management, Inc. (SBHM). This latter work included support from the Institute for Research, Education, and Training in Addictions (IRETA) to arrive at scientifically/clinically-based and recovery-oriented recommendations regarding clinical services in opioid treatment programs using methadone. The ROMS workgroup, along with the selected pilot provider (CRC Health) met throughout 2013 to review the proposed Best Practices document and come to an agreement on terms of the pilot project and implementation. It is anticipated that implementation will begin in the fall of 2014.

Additional D&A services will be reviewed under the Reinvestment Section.

PROVIDER NETWORK

The Provider Network Committee is responsible for monitoring PerformCare's Provider Network to assure HealthChoices access standards are being met and specialty needs are extended to Members. In addition to the overall monitoring of the Provider Network, the Committee performs the following functions:

- Participates in the development and selection with PerformCare's RFP/Invitation for Service Expansion process
- Reviews the Out-of-Network report on a quarterly basis which identifies providers who are currently being used outside of the network and monitors PerformCare's process of bringing Out of Network Providers into the network
- Reviews provider reimbursement structures developed by PerformCare
- Develops, distributes and analyzes a Provider satisfaction survey
- Reviews and monitors Provider Profiling reports prepared by PerformCare and Credentialing Committee activities, which includes the review of Providers who are currently on Corrective Action Plans and Quality Improvement Plans

Provider Capacity

At the end of 2013, there were a total of 654 In-Network Providers for the CABHC contract. Throughout the year, there were a total of 62 Providers terminated from the Network. All of these terminations were voluntary. Reasons for termination included retirement or the practitioner or facility was no longer serving CABHC Members. This represents a turnover rate of 9%.

The number of Providers and the variety of services offered are similar throughout each of the five Counties. The exception to this is Perry County, where due to population and a low number of Members, there is a smaller number of Providers offering services. It should be noted that Perry County Members are served by Providers from Cumberland County as well.

The three levels of care with the highest number of Providers are Mental Health Outpatient, followed by Behavioral Health Rehabilitation Services, and Substance Abuse Outpatient Services.

Service Access Standards

Pennsylvania HealthChoices standards require that the following access requirements are to be met or an access waiver must be requested:

- Ambulatory services – 2 providers within 30 minutes travel time (urban counties); 60 minutes travel time (rural counties)
- Inpatient and residential services – 2 providers, one of which must be within 30 minutes travel time (urban counties); 60 minutes travel time (rural counties)

On an annual basis PerformCare completes a GeoAccess analysis to determine if access requirements have been met for Ambulatory, Inpatient, Crisis, D&A and RTFs. CABHC requested and received five in-plan service access exceptions from OMHSAS for the 2013/2014 fiscal year that include:

- Inpatient Psychiatric Hospitalization (Child): Access standard of distance for the Southwest (SW) quadrant of Lancaster County.
- Hospital-based Drug and Alcohol Detoxification (Adult and Child/Adolescent): Access standard of distance for all five Counties.
- Hospital-based Drug and Alcohol Rehabilitation (Adult and Child/Adolescent): Access standard of distance for all five Counties.
- Methadone Maintenance (Adult): Access standard of distance for SW quadrant of Lancaster County; Northwest (NW) and Northeast (NE) quadrants of Dauphin County; NW quadrant of Cumberland County; and NW quadrant of Perry County.
- Residential Treatment Facility (Child/Adolescent): Access standard of distance for the NW quadrant of Dauphin County; and the SW quadrant of Lancaster County.

Provider Profiling

CABHC monitors PerformCare's Provider Profiling process which is an important provider-level quality improvement activity that tracks and trends data over a set period of time. The Provider Profiling process creates the ability to identify areas for improvement. It is used to make

meaningful comparisons based on a varied data set including claims data, authorization data, quality reports, complaints, Consumer/Family Satisfaction Team reports and demographic information. PerformCare completes Provider Profiles on eleven levels of care for treatment services offered in the network that include: Behavioral Health Rehabilitation Services (BHRS), Community Residential Rehabilitation Host Homes (CRR HH), Family Based Mental Health Services (FBMHS), Partial Hospitalization Services (PHP), Mental Health Inpatient Services (MH IP), Mental Health Outpatient Services (MH OP), Residential Treatment Facilities (RTF), D&A Services, Halfway House, Short Term Rehabilitation and Long Term Rehabilitation Services. The only service not currently profiled is Targeted Case Management.

Results of the Provider Profiling process are used to identify performance and network needs, and to focus on service areas where improvement can be made. Profiling also allows PerformCare the ability to customize trainings for Providers, based upon the services they offer and the opportunities for improvement identified in the Profiling process. All of the profiled Providers are fully credentialed and in good standing with PerformCare.

Provider Performance

Treatment Record Reviews (TRR's) are conducted by PerformCare and CABHC staff on Providers in-sync with the credentialing cycle, which is every three years. They can also occur more frequently if quality of care concerns are brought to the attention of CABHC or PerformCare. PerformCare utilizes the results of TRR's as part of the Provider Profiling process, as well as a tool to ensure compliance with all applicable HealthChoices and PerformCare policies and regulations. If a Provider scores below the benchmark, follow-up TRR's will be completed on a yearly basis until they score above the benchmark.

The benchmark for Providers in 2013 was to achieve a score of 90% out of 100% on the TRR for FBMH Providers and 75% for all other services, which was an increase from 72% in 2012. Providers scoring below 75% are required to submit a Quality Improvement Plan (QIP). In 2013, 49 TRR's were conducted and 17 resulted in the need for a QIP. If the Provider fails to submit a QIP, or the QIP they submitted was inadequate in addressing the concerns identified in the TRR, they can be required to submit a Corrective Action Plan (CAP).

CAP's can only be requested through the Credentialing Committee and are issued based on referrals regarding Provider performance from various PerformCare processes. These include the Quality of Care Committee, Provider Performance System monitoring, Clinical Care Managers, and Provider Relations Account Executives. In 2013, there were seven CAP's requested by the Credentialing Committee, two of which were for the same Provider. Three of the CAP's were closed due to the Provider meeting all requirements outlined in the CAP, and four were still open with the Credentialing Committee at the end of 2013.

STAKEHOLDER INVOLVEMENT

Consumer and Family Focus Committee

CABHC values and encourages 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 center of this principle and operates as the main venue to increasing and ensuring Member participation.

In 2013 CABHC organized three presentations for the CFFC. Abby Robinson from Consumer Satisfaction Services, Inc., reviewed findings from their 2012/2013 annual report, discussed their initiative to revise their survey tool with input from provider and consumer focus groups and informed the group of their plans to facilitate focus groups to assist in the development of targeted survey questions.

Kristen Noecker from RASE offered an abridged presentation of a full day training titled "The Science of Addiction". This training covered many of the biological aspects of addiction as a disease of the brain. Bonnie Clark from PerformCare offered updates on Physical Health-Behavioral Health projects being pursued by PerformCare. She noted that 167 unique individuals accessed the online Wellness Toolkit since January 2013, discussed the Diabetes and Cardiovascular Disease trainings offered to Targeted Case Management, ACT teams and Peer Specialists, as well as their efforts to educate providers on the potential side effects of psychotropic drugs.

County-wide Trainings

The CFFC concluded that based on the success of the "How to Talk to Your Psychiatrist" training, consumers would benefit from a training related to Pharmacists. A similar training was presented in Dauphin County and received positive feedback from those who attended. PerformCare was able to arrange for Jeffrey Krietman, Regional Pharmacy Director, AmeriHealth Caritas, to provide training to members from Cumberland/Perry, Lancaster, and Lebanon County. Attendance was very good in Lebanon County (approximately 20 attendees) however Cumberland/ Perry and Lancaster County suffered from rescheduling issues due to inclement weather and unforeseen scheduling conflicts. Cumberland/Perry and Lancaster Counties are considering the possibility of repeating the trainings in 2014.

Recruitment of Committee Members

In 2013, recruitment of committee members focused on identifying transitional aged members for inclusion on the CFFC. Recruitment presentations were made with the specialized transitional aged programs in Dauphin and Cumberland/Perry counties to program participants and family members. While some family members showed interest in participating on the CFFC, transitional aged consumers showed little interest. Recruitment then focused on a broad based recruitment of members from the Capital Area counties. Recruitment presentations were completed at the Dauphin County Community Support Program (CSP), Ship Dock Drop-In Center in Shippensburg, the Aurora Club in Mechanicsburg, Cumberland/Perry CSP, ICAN and the Arch Street programs in Lancaster County, as well as the Lebanon County CSP and Adult Autism Support meeting in Lebanon County. As a result of all the recruitment efforts, 16 members were added to the CFFC. One of the new committee members was also asked and agreed to participate on CABHC's Clinical Committee.

Other Committee Projects

The Committee reviewed and offered feedback on the How to Talk to Your Psychiatrist Toolkit, drafted by the Pennsylvania Mental Health Consumers Association and based on their previous training of the same name. The toolkit was completed and posted to the PerformCare website as a Health and Wellness resource.

A Reinvestment Listing was also drafted for CFFC Committee members as a reference and resource for ongoing and past reinvestment projects initiated by the Collaborative.

Peer Support Services Steering Committee

Trainings

A Survey was completed and sent to Peer Support Services Supervisors in the Capital Region to determine interest in a CPS training to be sponsored by CABHC. Feedback indicated that there was interest for additional CPS trainings, however trainings were held by other agencies that filled the need.

Recovery Insights Inc., in collaboration with Philhaven, presented two CPS trainings and one CPS Supervisor training. The Mental Health Association of Southeastern PA also partnered with Philhaven to offer a CPS training. CABHC awarded seven individuals partial or full scholarships toward their training to become a Certified Peer Specialist in 2013. All seven completed their training and received certification. Two of those individuals have been hired for peer specialist positions.

A Session One WRAP training was sponsored by CABHC and Facilitated by Kathyann Corl of Keystone Human Services. The training had twelve attendees and the overall feedback was positive based on the returned surveys.

Peer Information Listserv

A listserv that is hosted by CABHC on its web page was completed in 2013 and is designed to share peer related information such as available CPS trainings, WRAP trainings and governmental news related to peer services with peer service providers, peer specialists and interested consumers. The Member Relations Specialist manages the listserv and utilizes it to forward or send out peer related news and surveys.

Certified Peer Specialist (CPS) Website Activity

A total of six new CPSs registered on CABHC's website in 2013. This brings the total current number of registered to twenty six. Two new job postings for CPSs were added to the website in 2013. Registering on CABHC's website can assist an individual in obtaining employment as peer support service providers also visit the site to post job openings. The registration process is very simple and involves the Certified Peer Specialist listing their name and email contact information under the peer support tab of the website.

PHYSICAL HEALTH/BEHAVIORAL HEALTH (PH/BH) INTEGRATION

CABHC has been active with the objective to facilitate projects that will support the integration of physical health and behavioral health care that will improve the overall quality of Member's lives. By improving collaboration and integration, we would expect enhanced improvements of physical well-being and overall recovery of these Members. CABHC and PerformCare, along with the Counties have actively participated and supported the development of projects that achieve this objective. In collaboration with the Clinical Committee, a PH/BH Workgroup comprised of the Counties, CABHC, Consumers and PerformCare has functioned to develop projects which improved the integration of Physical and Behavioral Health systems of care. The following PH/BH integration projects were accomplished in 2013.

Mobile Psychiatric Nursing (MPN)

An effort was made in 2013 to expand the utilization and accessibility of MPN throughout the territory. The utilization increased from 164 consumers in 2012 to 186 consumers in 2013. In order to increase accessibility, a Request for Proposal was distributed to expand MPN equally throughout the CABHC territory. Northwest Human Services submitted a successful proposal and contract negotiations were completed at the end of 2013. Services are expected to begin in 2014.

Member Wellness Initiatives

PerformCare has maintained a website section of updated materials related to Domestic Violence, Childhood Obesity and Smoking Cessation. Additionally, online resources such as **Health Education Answers™** and **Self-Management Tools** are offered for a comprehensive approach to multiple health topics from sleep to stress. A Targeted Case Management training on Cardiovascular Disease in the seriously mentally ill population was completed in February 2013. A Consumer/Family/Provider PH/BH training was completed in June 2013 for the Cumberland and Dauphin County Recovery Conference.

Perinatal Program

Specialized case management is offered to any women who are currently pregnant or Members who have recently delivered and are experiencing postpartum depression. Members are able to self-identify or are referred through utilization review care management or by community providers. In 2013 there were 41 pregnant and 4 postpartum Members who received services. Thirteen perinatal women agreed to the program and 4 postpartum women were provided additional support through follow up calls by a nurse. Behavioral Health treatment resources were provided until the service was no longer necessary.

Federally Qualified Health Centers (FGHC)

FQHCs provide comprehensive health care for uninsured and underinsured persons in our Counties. To improve the holistic approach to care in the Centers, we have implemented both integrated and co-located behavioral health treatment in three of the Centers. South East

Lancaster Health Clinic has partnered with a MH OP provider that embedded a licensed psychologist into the Center who works with the providers (doctors) by providing warm handoffs for assessment and brief treatment. A second MH OP provider is also located in the Center's satellite office and offers a similar service utilizing a CRNP and a LCSW. The CRNP can also provide medication management services. In Harrisburg, Hamilton Health Center has hired a LSW to provide assessment and brief treatment after members have been screened by the provider and it is determined they might benefit from behavioral health treatment. Hamilton Health Center has also partnered with a licensed MH OP provider, Philhaven, who has created a satellite MH OP clinic at the Center. Assessment, brief intervention and psychiatric services are being offered to persons who are also receiving their healthcare at the Center. Finally, Sadler Health Center, located in Carlisle, has hired a LCSW who provides assessment and brief treatment that follows the Primary Care Behavioral Health model developed by Dr. Neftali Serrano, PSYD.

The total number of consumers who utilized a FQHC in 2013 was 421. The majority of consumers who utilized the service were adults age 18 and older with a total count of 370. There were 51 children/adolescent consumers who utilized the service.

CareConnections

Lancaster General Hospital (LGH) started their CareConnections program in 2013 to focus on management of Members with a mental health diagnosis as well as complex and unmanaged physical health issues. They are utilizing a Brief Treatment Model and PerformCare is working with LGH on establishing data transfers with Member authorization and connections to PerformCare Care Management.

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 or administrative costs, 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.

There are four reinvestment projects that were approved through OMHSAS and have been maintained with reinvestment funds for multiple years. CABHC receives and evaluates monthly performance information to determine if stated objectives are occurring for each project. The information is reviewed for frequency, quantity, location of services and alignment with the stated objectives to assure that the needs of the consumers enrolled in each service are being met. The financial status of each project is monitored to verify that reinvestment funds are expended appropriately and the projects stay within budget. The four projects include:

Respite

CABHC provides Reinvestment funding to support the provision of Respite services to children/adolescents and adults. Respite services have been provided to Capital Area

HealthChoices Members since 2004. The service is utilized primarily by children and adolescents and is typically provided in the member's home. Management of the service is provided by a respite management agency (RMA), Youth Advocate Program (YAP), who is under contract with CABHC. The Respite outcome data is maintained on a fiscal year. For FY 2012/2013 the respite program served a total of 307 members which is 25% less than in 2012 and provided 14,027 respites which is down 38% from 2012. (See Table 19) The decrease in respites was partly due to a loss of a provider during the year. Total expenditures for FY 2012/2013 amounted to $204,700. YAP will increase their efforts in 2014 to expand the number of providers who will offer respite in order to reach more members who are interested and will benefit from the service.

Table 19: Respite Services

County	# Members Served			In Home Hours			Out of Home Days		
	10/11	11/12	12/13	10/11	11/12	10/11	10/11	11/12	10/11
Cumberland	33	62	39	787	1,628	1,146	5	2	14
Dauphin	121	135	128	4,035	4,864	2,540	164	130	71
Lancaster	71	89	97	1,802	3,028	2,162	34	35	52
Lebanon	20	35	35	648	1,373	946	0	8	1
Perry	9	23	8	124	298	146	8	6	10
Totals	254	341	307	7,396	11,195	6,940	211	181	148

Specialized Transitional Support for Adolescent

This Reinvestment service targets adolescents up through the age of 22 who have a mental health diagnosis and need support in the areas of employment, education, independent living and community involvement and socialization. Transition Coordinators working with these youth conduct educational groups and/or individual sessions in order to work on the steps needed to reach individualized goals. The outcome of this program is to foster and encourage success in adulthood. The annual reports submitted by each program indicate successful outcomes for the majority of the program participants, especially the consumers who stay engaged in the program. Through June 30, 2013, 108 Members received services from the four programs that include:

Cumberland and Perry Counties- NHS Stevens Center
Dauphin County- The JEREMY Project, through CMU
Lancaster County- Community Services Group (began in April, 2013)
Lebanon County- The WARRIOR Project, Pennsylvania Counseling Services (began in February, 2013)

Substance Abuse Supportive Housing Program

CABHC's Substance Abuse (SA) Supportive Housing Program provides scholarships to individuals from Cumberland, Dauphin, Lancaster, Lebanon, and Perry Counties who require financial assistance to enter a Recovery House as part of their recovery from substance abuse. Recovery from substance abuse can be extraordinarily difficult, requiring dedication

and persistence to make changes in every aspect of one's life. Making these changes can be particularly difficult for those stepping down from inpatient rehabilitation or halfway house services. All too often, these individuals find themselves returning to homes and neighborhoods overflowing with old triggers and memories of substance abuse. CABHC can provide scholarships to fund up to two (2) months' rent (not to exceed $300/month) for qualified consumers to move into a Recovery House that participates with the 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.

At the conclusion of FY 2012-2013, there were a total of 25 participating Recovery House agencies, which offered a combined total of 65 site locations. This is an increase of five agencies and 11 sites from FY 2011/2012. A total of 128 unique scholarships were issued to individuals in need of this support compared to the 152 individuals who received scholarships in FY 2011/2012. All participating Recovery Houses are required to submit a follow-up individual questionnaire for each consumer upon their departure or at a minimum at the end of six months of residency. Recovery Houses submitted 106 questionnaires to CABHC that indicated 34% of consumers left the recovery house within 60 days, 51% left between 60 days and 6 months and 15% were still there after six months. Questions related to employment indicate that 53% of the 106 consumers were employed and 16% of those unemployed were looking for work. Ninety-four of the questionnaires that were returned addressed sobriety that revealed that 61% maintained sobriety and 70% were actively engaged in participating in external meetings while residing in a recovery house.

Recovery Specialist Program (RSP)

The D&A Recovery Specialist Program provided by the R.A.S.E Project is non-clinical in nature and focuses on life and recovery skill development that is vital to the success of an individual's sustained recovery from their addiction. Supports are identified and recovery plans are developed by the member with the assistance and support of a Recovery Specialist. These include but are not limited to recovery education, identification and engagement with community resources that encourage recovery, support systems to remain engaged in formal treatment, and identification and access to stable housing and employment as a cornerstone to assist in an individual's recovery. Services are primarily delivered face-to-face in the community.

The outcomes that have been established by RASE are: Engagement in and completion of Treatment; Acquisition of Safe and Stable Housing; Reduction of Involvement in the Criminal Justice System; and Acquisition of Employment. The results of the first full year of operation from June 2012 through June 2013 were very promising. 51% of the consumers completed their treatment program, 75% of the consumers remained in stable housing during their program involvement, 99% of the consumers had no incidents of criminal activity, and 57% of consumers acquired employment during their program involvement. The results from the first year indicate that a majority of the 126 consumers who received RSP services made significant improvement towards sustained recovery.

In addition to the four sustained reinvestment projects mentioned above, there are 17 approved projects that are in various stages of development or operation. Six of the projects benefit all the Counties and the remaining 13 are County specific. Please see Appendix A for a list of all reinvestment projects that includes a status update of the project.

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 both from an individual provider review as well as from a HealthChoices Behavioral Health system review.

The following are highlights from the FY 2012/2013 CSS Annual Report.

CSS surveyed 2,533 respondents from the five Counties representing 593 (23.4%) adults and 1,940 (76.6%) children. This is an 879 (53%) increase in interviews from FY 11/12. (See Table 20) Of the 593 adult consumers, 588 (99.2%) responded for themselves. Parents and guardians responded for the remaining 5 adult consumers. Parents and guardians responded for 1,767 (91.1%) of the child consumers and the remaining 173 (8.9%) child consumers responded for themselves. There were no significant differences in satisfaction with regard to who was interviewed.

Data was collected by seven interviewers from 62 treatment facilities. The 593 adult consumers received treatment at 43 facilities and the 1,940 child consumers received services from 26 treatment facilities. Overall, 2,500 of the 2,533 interviews (98.7%) were face-to-face interviews and 33 were conducted by phone. Of the 593 adult interviews 588 (99.2%) were face-to-face interviews and the remaining 5 were conducted by phone. Of the 1,940 child interviews 1,912 (98.6%) were face-to-face interviews and the remaining 28 were conducted by phone. Overall, the sample was 37.9% female (959) and 62.1% male (1,574). Of the 593 adult consumers, 355 were female and 238 were male. Of the 1,940 child consumers, 604 were female and 1,336 were male.

Table 20: Total Interviews and Face–Face

Fiscal Year	Adult	Face-Face	%	Child	Face-Face	%	Total	Face-Face	%
11/12	1,192	1,147	96.2%	462	417	90.3%	1,654	1,564	94.6%
12/13	593	588	99.2%	1,940	1,912	98.6%	2,533	2,500	98.7%
Change	**-599**	**-559**	**2.9%**	**1,478**	**1,495**	**8.3%**	**879**	**936**	**4.1%**

CSS utilized a survey that contained 27 questions with each question rated as 1 (strongly disagree) to 5 (strongly agree). A score of 109-135 indicates a high level of satisfaction. In all, 18 different types of treatment were assessed by the respondents. The consumers of adult services who responded to the survey received 10 different types of treatment and the consumers of child services received 12 different types of treatment. Of the 2,533 respondents, 2,233 (88.2%) received Mental Health services, 145 (5.7%) received Drug & Alcohol services, 143 (5.6%) received both Mental Health and Drug & Alcohol services, and 12 (0.5%) received Other services.

Overall, the majority of consumers were satisfied with their services that are reflected in the combined satisfaction score of 115.37, which is an increase from the FY11/12 score of 108.31. (See Table 22)

Table 22: Satisfaction Score

Fiscal Year	Adult	Child	Total
2011/2012	1,192	462	**1,654**
	107.26	111	**108.31**
2012/2013	593	1,940	**2,533**
	114.02	115.79	**115.37**

The full CSS Inc. report provides detailed information on the satisfaction scores by age, county, race, Implementation, Outcomes and analysis of each of the 27 questions. To review the complete report, please see the attached Consumer Satisfaction Services FY12/13 Annual Report.

FISCAL OVERVIEW

Financial oversight of the Corporation (CABHC), the HealthChoices Program and monitoring of PerformCare's financial statements remains an ongoing, shared endeavor between CABHC staff, CABHC's Fiscal Committee and the Counties. Areas of focus in 2013 include monitoring of corporate finances of CABHC and PerformCare, and monitoring the HealthChoices Program solvency.

CABHC 12-13 Financial Performance

CABHC's financial performance remained strong during FY 2012/2013. Even though there was a decrease in the FY 2012/2013 administrative portion of OMHSAS's capitated rates, CABHC was able to retain a strong financial position. Member enrollment continued to increase from FY 2011 to 2013 that provided for an increase in capitation payments, offsetting the loss from the administrative portion of the rates. CABHC did not experience increases in administrative expenses resulting in a positive cash flow situation. CABHC used management fees received from the Counties in excess of related expenses to pay for reinvestment services approved by OMHSAS and developed in collaboration with CABHC and the Counties.
CABHC's Fiscal Committee is responsible for monitoring and reporting on the financial position of CABHC, reviewing financial statements and presenting the information to the Board of

Directors on a monthly basis. CABHC's contracted auditors, The Binkley Kanavy Group, conducted a corporate audit at the close of the fiscal year resulting in no reportable findings and issued the opinion that the financial statements were presented fairly, in material respects, to the financial position of CABHC and the changes in its net position and cash flow for the year ended in accordance with generally accepted accounting principles.

CABHC Monitoring of PerformCare Financials

The Fiscal Committee of CABHC monitors PerformCare's financial solvency and reports its findings to the CABHC Board of Directors. The committee monitors PeformCare by reviewing the following: Capital Region Financial Statement, PerformCare Corporate Financial Statements and the AmeriHealth Caritas Corporate Audit including the PerformCare Supplemental Statement. During FY 2012/2013 when questions or concerns were raised, PerformCare was active in providing clarification so that the Committee could fully understand the financial position of PerformCare and its parent company.

HealthChoices Program Performance

The financial solvency of the HealthChoices Program is closely monitored through a review of the CABHC medical expenses via the Surplus/Deficit Report prepared by the CABHC contracted actuary. Along with the monitoring of this report, CABHC's contracted actuary provides quarterly risk reports and certifies incurred but not reported (IBNR) estimates that are reported to OMHSAS on the quarterly financial reports.

In Tables 23 and 24 are figures which reflect the division of medical expenditures for FY12-13 based on categories of aid and categories of service.

Table 23: Expenditures by Category of Aid

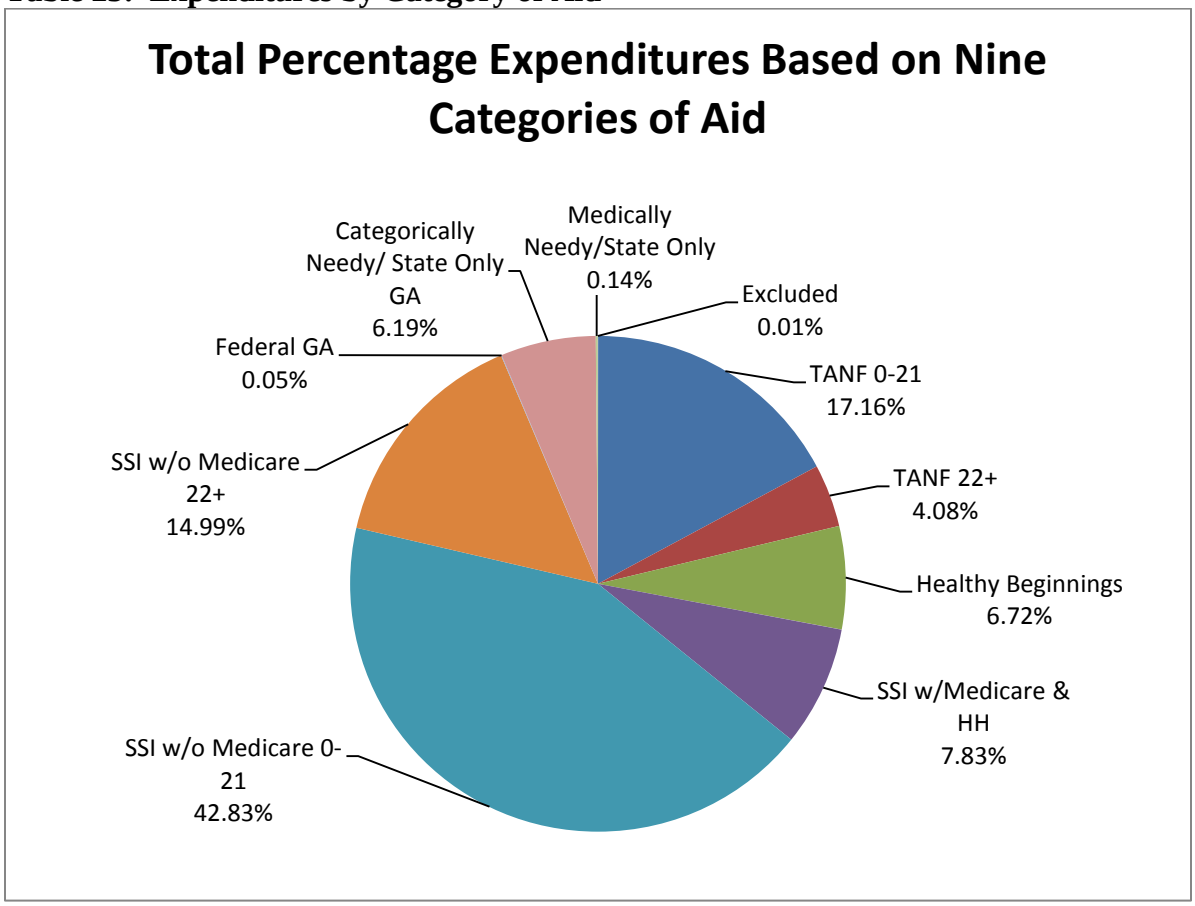
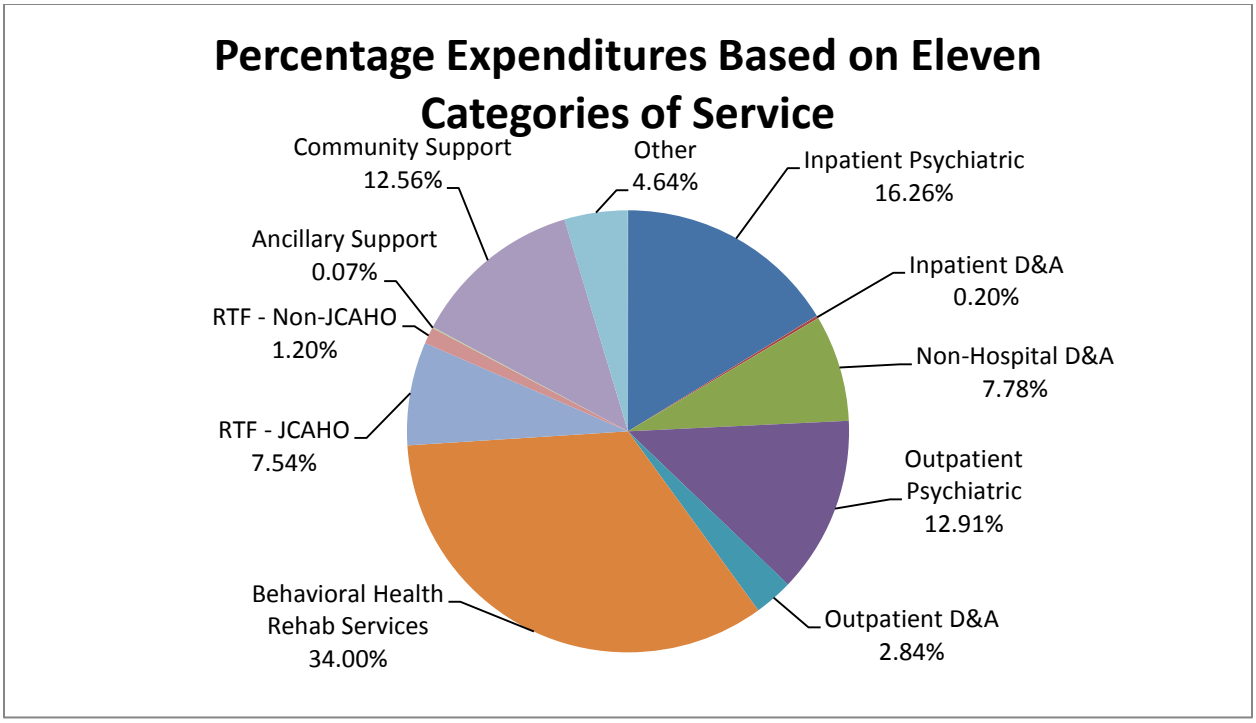


Table 24: Expenditures by Level of Care



During FY 2012/2013, the HealthChoices medical capitation revenue paid by DPW to the Counties' HealthChoices Program exceeded medical expenses. This allowed the Counties to increase risk and contingency reserves and prioritize and approve additional reinvestment projects.

In FY 2013, the Binkley-Kanavy Group also conducted an audit of various aspects of the HealthChoices program which included claims processing, MIS/Encounter data reporting, MCO subcontractor incentive arrangements, and financial management and reporting for the fiscal year. The yearlong audit included quarterly claims data testing, an annual trip to Counties and several visits to PerformCare. The Binkley Kanavy Group found no reportable findings and issued the opinion that the financial schedules were presented fairly, in material respects and in conformity with accounting principles prescribed by the Commonwealth of PA, Department of Public Welfare.

CONCLUSION

Each year discovers diverse challenges and opportunities for the future of the HealthChoices Program. There have been many occasions to celebrate over the past year as members have moved along their path of recovery. As noted throughout this Annual Report, the structure that supports people along their journey is the result of a strong partnership starting with the OMHSAS, County partners, PerformCare and the many providers who are the front line in developing and providing vital service.

Even though there has been considerable improvement over the past year to be more efficient and provide the highest quality service, there is still more that can be accomplished. CABHC will continually monitor and collaborate with PerformCare, OMHSAS and stakeholders to meet the needs of its Members. Our priorities for the upcoming year emphasize innovation in service

delivery based on utilizing best practice and evidenced based processes. The success of CABHC is dependent on Providers, PerformCare and stakeholders to be vested in providing efficient and high quality service to our Members.

We extend our appreciation to all those who have embarked upon making HealthChoices a success throughout the CABHC territory. We look forward to improve and enhance our mission and value in the years to come.

CABHC BOARD OF DIRECTORS

Dan Eisenhauer	Chair	Dauphin County
Silvia Herman	Vice-Chair	Cumberland County
Jim Laughman	Treasurer	Lancaster County
Jack Carroll	Secretary	Perry County
Richard Kastner		Lancaster County
Evelyn Reese		Perry County
James Donmoyer		Lebanon County
Kevin Schrum		Lebanon County
Linda McCulloch		Cumberland County
Mavis Nimoh		Dauphin County

CABHC Staff

Scott Suhring, CEO
Judy Goodman, Executive Assistant
Melissa Raniero, Chief Financial Officer
Deb Allen, Clinical Director
Jenna O'Halloran-Lyter, Children's Specialist
Mark Modugno, Member Relations Specialist
LeeAnn Edelman, D&A Specialist
Michael Powanda, Quality Assurance Specialist
Matthew Wagner, Provider Network Specialist
Akendo Kareithi, Accountant
Aja Orpin, Receptionist/Administrative Assistant

CABHC COMMITTEES

Consumer/Family Focus Committee

Sandy Zimmerman, Consumer
Holly Leahy, Lebanon County
Jack Carroll, Cumberland/Perry County
Rodney Hartzell, Consumer
David Hornberger, Consumer
Mark Modugno, CABHC
Robert Count, Lebanon County
Becky Mohr, Lancaster County
Lisa Klinger, Family
Kristen Noecker, RASE
Laurie Dohner, CSS
Jessica Eaken, CSS

Michele Printup, Consumer
Chester Green, Jr., Consumer
Bert Gutshall, Aurora Rehab Social Services
Silvia Herman, Cumberland/Perry County
Maggie Park, Family
Jeff Bowers, Consumer
Angela Pieruccini, Consumer
Denyse Keaveney, Consumer
Kimberly Pry, Consumer
Steve Rexford, Person in Recovery
Abby Robinson, CSS
Jonathan Park, Family
Scott Suhring, CABHC
Vanessa Traynham, Consumer
Patty Skiles, Consumer
Denise Wright, Consumer

Peer Support Services Steering Committee

Diana Fullem, Recovery-Insight, Inc.
Lisa Basci, Community Services Group
Chris Bilger, Certified Peer Specialist
Lynn Manganaro, Recovery-Insight, Inc.
Holly Leahy, Lebanon County
Kelly Lauer, PerformCare
Laura Jesic, STAR
Frank Magel, Dauphin County
Scott Suhring, CABHC
Michele Porter, Keystone Service Systems
Rebecca Rager, PerformCare
Mark Modugno, CABHC
Mary Schram, CPS
Kim Maldonado, The Dauphin Clubhouse
Greg Snyder, Lancaster County
Annie Strite, Cumberland/Perry County

Clinical Committee

Dan Eisenhauer, Dauphin County
Kim Briggs, Lebanon County
Matt Rys, Lebanon County
Kristin Noecker, RASE
Judy Erb, Lancaster County
Rick Kastner, Lancaster County
Christine Kuhn, Lancaster County
Megan Johnston, Cumberland/Perry County
Denise Wright, Consumer
Michael Powanda, CABHC
Jenna O'Halloran-Lyter, CABHC
LeeAnn Edelman, CABHC
Rose Schultz, Dauphin County
Kelly Walters, OMHSAS
Rhonda Slinghoff, Lancaster County
Vivian Spiese, NAMI, Lancaster County
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Scott Suhring, CABHC
Becky Mohr, Lancaster County
Denise Wright, CFFC Representative
Holly Leahy, Lebanon County
Frank Magel, Dauphin County
Kelly Lauer, PerformCare
Matthew Wagner, CABHC

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