



Commonwealth of Pennsylvania
Department of Public Welfare
Office of Mental Health and Substance
Abuse Services

2011 External Quality Review Report
Community Behavioral HealthCare
Network of Pennsylvania
FINAL REPORT

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GLOSSARY OF TERMS

Average (i.e., arithmetic mean or mean)	The sum of all items divided by the number of items in the list. All items have an equal contribution to the calculation therefore this is un-weighted.
Confidence Interval	Confidence intervals (CIs) are ranges of values that can be used to illustrate the variability associated with a given calculation. For any rate, a 95% CI indicates that there is a 95% probability that the calculated rate, if it were measured repeatedly, would be within the range of values presented for that rate. All other things being equal, if any given rate were calculated 100 times, the calculated rate would fall within the CI 95 times, or 95% of the time.
HealthChoices Aggregate Rate	The sum of all behavioral health (BH) managed care organization (MCO) numerators divided by the sum of all BH MCO denominators.
HealthChoices BH MCO Average	The sum of the individual BH MCO rates divided by the total number of BH MCOs (five BH MCOs). Each BH MCO has an equal contribution to the HealthChoices BH MCO Average value.
HealthChoices County Average	The sum of the individual County rates divided by the total number of Counties (67 Counties). Each County has an equal contribution to the HealthChoices County Average value.
Rate	A proportion indicated as a percentage.
Percentage Point Difference	The arithmetic difference between two rates.
Weighted Average	Similar to an arithmetic mean (the most common type of average), where instead of each of the data points contributing equally to the final average, some data points contribute more than others.
Statistical Significance	In statistics, a result is described as statistically significant if it is unlikely to have occurred by chance. The use of the word significance in statistics is different from the standard one, which suggests that something is important or meaningful.
Z-ratio	The z-ratio expresses how far and in what direction the calculated rate diverged from the most probable result (i.e., the distribution's mean). Statistically significant differences (SSD) at the .05 level between groups are noted, as well as the percentage point difference (PPD) between the rates.



INTRODUCTION

Purpose and Background

The final rule of the Balanced Budget Act (BBA) of 1997 requires that state agencies contract with an External Quality Review Organization (EQRO) to conduct an annual external quality review (EQR) of the services provided by contracted Medicaid Managed Care Organizations (MCOs). This EQR must include an analysis and evaluation of aggregated information on quality, timeliness and access to the health care services that a MCO furnishes to Medicaid recipients.

The EQR-related activities that must be included in the detailed technical reports are as follows:

- review to determine plan compliance with structure and operations standards established by the State (42 CFR §438.358),
- validation of performance improvement projects, and
- validation of MCO performance measures.

The Commonwealth of Pennsylvania (PA) Department of Public Welfare (DPW) Office of Mental Health and Substance Abuse Services (OMHSAS) contracted with IPRO as its EQRO to conduct the 2011 EQRs for the HealthChoices Medicaid MCOs and to prepare the technical reports. This technical report includes six core sections:

- I: Structure and Operations Standards
- II: Performance Improvement Projects
- III: Performance Measures
- IV: 2010 Opportunities for Improvement - MCO Response
- V: 2011 Strengths and Opportunities for Improvement
- VI: Summary of Activities

For the Behavioral Health (BH) Medicaid MCOs, the information for the compliance with the Structure and Operations Standards section of the report is derived from monitoring conducted by OMHSAS of the BH MCOs against the Commonwealth's Program Evaluation Performance Summary (PEPS) review tools and/or Readiness Assessment Instrument (RAI), as applicable.

Information for Sections II and III of this report is derived from IPRO's validation of each BH MCO's performance improvement projects (PIPs) and performance measure submissions. Performance measure validation as conducted by IPRO includes two performance measures – Follow-up After Hospitalization for Mental Illness and Readmission Within 30 Days of Inpatient Psychiatric Discharge.

Section IV, 2010 Opportunities for Improvement – MCO Response, includes the BH MCO's responses to opportunities for improvement noted in the 2010 EQR Technical Report, and presents the degree to which the BH MCO addressed each opportunity for improvement.

Section V has a summary of the BH MCO's strengths and opportunities for improvement for this review period (2010) as determined by IPRO, and a "report card" of the BH MCO's performance as related to the Pay for Performance (P4P) measures.

Section VI provides a summary of EQR activities for the BH MCO for this review period, followed by an appendix that crosswalks PEPS standards to pertinent BBA Regulations and to OMHSAS-specific PEPS Items, and a list of literature references cited in this report.



I: STRUCTURE AND OPERATIONS STANDARDS

This section of the EQR report presents a review by IPRO of Community Behavioral HealthCare Network of Pennsylvania's (CBHNP's) compliance with the structure and operations standards. In Review Year (RY) 2010, all 67 PA Counties participated in this compliance evaluation.

Organization of HealthChoices Behavioral Health Program

OMHSAS determined that the County governments would be offered the right-of-first opportunity to enter into capitated contracts with the Commonwealth with regard to the administration of Medicaid managed care behavioral health and substance abuse services. Forty-three of the 67 Counties subcontract directly with BH MCOs to administer behavioral health services. These 43 Counties provide monitoring and oversight of the BH MCOs. The remaining 24 County contracts are managed directly by OMHSAS since the Counties elected not to bid on the HealthChoices contract directly. Each County subsequently chose a BH MCO subcontractor, which operates under the authority of that County, to administer behavioral health and substance abuse services.

Cumberland, Dauphin, Lancaster, Lebanon and Perry Counties formed an alliance called Capital Area Behavioral Healthcare (CABHC), which holds a contract with CBHNP. The North/Central County Option (NC/CO) Counties – Bedford, Blair, Clinton, Franklin, Fulton, Lycoming, and Somerset – also hold contracts with CBHNP. While Medicaid managed care members may choose a Physical Health (PH) MCO for physical health care services, each HealthChoices enrollee is assigned a BH MCO based on his or her County of residence. IPRO's EQR is based on OMHSAS reviews of CBHNP and the 12 Counties associated with the BH MCO.

Methodology

The findings in this section of the report are based on IPRO's assessment of data provided by OMHSAS resulting from the evaluation of CBHNP by OMHSAS monitoring staff within the past three years. These evaluations are performed at the BH MCO and County levels, and the findings are reported in OMHSAS' PEPS review tools for Review Year (RY) 2010. OMHSAS opts to review compliance standards on a rotating basis due to the complexities of multi-County reviews. Some standards are reviewed annually, while others are reviewed triennially. In addition to those standards reviewed annually and triennially, some Items are considered Readiness Review Items only. Items reviewed at the time of the Readiness Review upon initiation of the HealthChoices contract are documented in the RAI. If the Readiness Review occurred within the three-year timeframe under consideration, the RAI was provided to IPRO. For those Counties and BH MCOs that completed their Readiness Reviews outside of the current three-year timeframe, the Readiness Review Items were deemed as complete. As necessary, the HealthChoices Behavioral Health Program Standards and Requirements (PS&R) are also used.

Data Sources

The documents informing the current report include the review of structure and operations standards completed by OMHSAS as of October 2011 for RY 2010. Information captured within the PEPS tools informs this report. The PEPS tools are a comprehensive set of monitoring standards that OMHSAS staff reviews on an ongoing basis for each County/BH MCO. Within each standard, the tool specifies the sub-standards or Items for review, the supporting documents to be reviewed to determine compliance with each standard, the date of the review, the reviewer's initials, and an area to collect additional reviewer comments. Based on the tools, a County/BH MCO is evaluated against Items that crosswalk to pertinent BBA regulations, as well as related supplemental OMHSAS-specific PEPS Items that are part of OMHSAS' more rigorous monitoring criteria.



At the implementation of the PEPS tools in 2004, IPRO evaluated the standards in the tools and created a crosswalk to pertinent BBA regulations. For standards with multiple review Items, all of the Items within the standard informed the compliance determination of the corresponding BBA category. In 2009, as requested by OMHSAS, IPRO conducted a re-assessment of the crosswalk to distinguish the review Items required for fulfilling BBA requirements and those that are supplemental (i.e., state-specific) as part of OMHSAS' ongoing monitoring. In the amended crosswalk, the supplemental Items no longer contribute to the compliance determination of the individual BBA categories. For example, findings for PEPS Items concerning first level complaints and grievances inform the compliance determination of the BBA categories relating to Federal & State Grievance Systems Standards. All of the PEPS Items concerning second level complaints and grievances are considered OMHSAS-specific Items, and their compliance statuses are not used to make the compliance determination of the applicable BBA category. As was done for the prior technical reports, review findings pertaining to the required BBA regulations are presented in the first section of this chapter. The review findings for selected OMHSAS-specific Items are reported in the second section of this chapter. The RY 2010 crosswalk of PEPS Items to pertinent BBA regulations and a list of the OMHSAS-specific PEPS Items can be found in this report's Appendices.

Because OMHSAS reviews the Counties and their subcontracted BH MCOs on a three-year cycle, OMHSAS has the flexibility to assess compliance with the review standards on a staggered basis, provided that all BBA categories are reviewed within that time frame. The PEPS Items from RY 2010, RY 2009, and RY 2008 provided the information necessary for the 2011 assessment. Those standards not reviewed through the PEPS system in RY 2010 were evaluated on their performance based on RY 2009 and/or RY 2008 decisions, or other supporting documentation, if necessary. For those Counties that completed their Readiness Reviews within the three-year timeframe under consideration, RAI Items were evaluated when none of the PEPS Items crosswalked to a particular BBA category were reviewed.

For CBHNP, this year a total of 137 Items were identified as being required for the evaluation of County/BH MCO compliance with the BBA regulations. In addition, 11 OMHSAS-specific Items were identified as being related to, but are supplemental to, the BBA regulation requirements. It should be noted that some PEPS Items were relevant to more than one BBA regulation, or provision, and that one or more provisions apply to each of the categories listed within the subpart headings. Because of this, the same PEPS Item may contribute more than once to the total number of Items required and/or reviewed. Tables 1.1a and 1.1b provide a count of Items pertinent to BBA regulations from the relevant review years used to evaluate the performance of the CBHNP Counties against the Structure and Operations Standards for this report. Tables 1.5a to 1.5c provide a count of supplemental OMHSAS-specific Items that are not required as part of BBA regulations, but are reviewed within the three-year cycle to evaluate the BH MCO and associated Counties against other state-specific Structure and Operations Standards.



Program Evaluation Performance Summary Items Pertinent to BBA Regulations for CBHNP Counties

Table 1.1a Items Pertinent to BBA Regulations Reviewed for the CABHC Counties (Cumberland, Dauphin, Lancaster, Lebanon, and Perry)

BBA Regulation	Total # of Items	PEPS Reviewed in RY 2010	PEPS Reviewed in RY 2009	PEPS Reviewed in RY 2008	Not Reviewed*
Subpart C: Enrollee Rights and Protections					
Enrollee Rights	12	2	0	10	0
Provider-Enrollee Communications	0	0	0	0	0
Marketing Activities	0	0	0	0	0
Liability for Payment	0	0	0	0	0
Cost Sharing	0	0	0	0	0
Emergency and Post-Stabilization Services	0	0	0	0	0
Solvency Standards	0	0	0	0	0
Subpart D: Quality Assessment and Performance Improvement					
Elements of State Quality Strategies	0	0	0	0	0
Availability of Services	22	4	18	0	0
Coordination and Continuity of Care	2	0	2	0	0
Coverage and Authorization of Services	4	1	2	0	1
Provider Selection	3	0	3	0	0
Confidentiality	0	0	0	0	0
Subcontractual Relationships and Delegations	8	8	0	0	0
Practice Guidelines	6	4	2	0	0
Quality Assessment and Performance Improvement Program	23	23	0	0	0
Health Information Systems	1	1	0	0	0
Subpart F: Federal & State Grievance Systems Standards					
Statutory Basis and Definitions	7	1	0	5	1
General Requirements	10	1	0	8	1
Notice of Action	11	1	9	0	1
Handling of Grievances and Appeals	7	1	0	5	1
Resolution and Notification: Grievances and Appeals	7	1	0	5	1
Expedited Appeals Process	4	1	0	2	1
Information to Providers and Subcontractors	2	0	0	2	0
Recordkeeping and Recording Requirements	0	0	0	0	0
Continuation of Benefits Pending Appeal & State Fair Hearings	4	1	0	2	1
Effectuation of Reversed Resolutions	4	1	0	2	1

* Items "Not Reviewed" were not scheduled or not applicable for evaluation. "Not Reviewed" Items, including those that are Not Applicable, do not substantially affect the findings for any category if other Items within the category are reviewed



Table 1.1b Items Pertinent to BBA Regulations Reviewed for the NC/CO Counties (Bedford, Blair, Clinton, Franklin, Fulton, Lycoming, and Somerset)

BBA Regulation	Total # of Items	PEPS Reviewed in RY 2010	PEPS Reviewed in RY 2009	RAI Reviewed in RY 2008	Not Reviewed*
Enrollee Rights	12	2	7	3	0
Provider-Enrollee Communications	0	0	0	0	0
Marketing Activities	0	0	0	0	0
Liability for Payment	0	0	0	0	0
Cost Sharing	0	0	0	0	0
Emergency and Post-Stabilization Services	0	0	0	0	0
Solvency Standards	0	0	0	0	0
Elements of State Quality Strategies	0	0	0	0	0
Availability of Services	22	4	18	0	0
Coordination and Continuity of Care	2	0	2	0	0
Coverage and Authorization of Services	4	1	2	0	1
Provider Selection	3	0	3	0	0
Confidentiality	0	0	0	0	0
Subcontractual Relationships and Delegations	8	8	0	0	0
Practice Guidelines	6	4	2	0	0
Quality Assessment and Performance Improvement Program	23	23	0	0	0
Health Information Systems	1	1	0	0	0
Statutory Basis and Definitions	7	1	0	5	1
General Requirements	10	1	0	8	1
Notice of Action	11	1	9	0	1
Handling of Grievances and Appeals	7	1	0	5	1
Resolution and Notification: Grievances and Appeals	7	1	0	5	1
Expedited Appeals Process	4	1	0	2	1
Information to Providers and Subcontractors	2	0	0	2	0
Recordkeeping and Recording Requirements	0	0	0	0	0
Continuation of Benefits Pending Appeal & State Fair Hearings	4	1	0	2	1
Effectuation of Reversed Resolutions	4	1	0	2	1

* Items "Not Reviewed" were not scheduled or not applicable for evaluation. "Not Reviewed" Items, including those that are Not Applicable, do not substantially affect the findings for any category if other Items within the category are reviewed

For RY 2010, nine categories, 1) Provider-Enrollee Communications, 2) Marketing Activities, 3) Liability for Payment, 4) Cost Sharing, 5) Emergency and Post-Stabilization Services, 6) Solvency Standards, 7) Elements of State Quality Strategies, 8) Confidentiality, and 9) Recordkeeping and Recording Requirements were not directly addressed by the PEPS Items reviewed. As per OMHSAS' judgment, seven of the nine categories not covered directly by PEPS are covered in the HealthChoices Behavioral Health PS&R. Information pertaining to Marketing Activities is not addressed in any of the documents provided because the category is considered Not Applicable for the BH MCOs. The category of Marketing Activities is Not Applicable because as a result of the Centers for Medicare and Medicaid Services (CMS) HealthChoices waiver, DPW has been granted an allowance to offer only one BH MCO per County.



In evaluations prior to the 2008 report, the categories Solvency Standards and Recordkeeping and Recording Requirements were deemed compliant across all Counties and BH MCOs based only on the HealthChoices Behavioral Health PS&R and Readiness Review assessments, respectively. Beginning with the 2008 report, OMHSAS and IPRO revised the documentation requirements for these categories to reflect the ongoing monitoring of these categories by OMHSAS. Hence, Solvency Requirement tracking reports, Encounter Monthly Aggregate Complaint/Grievance records (EMG) and Encounter Monthly Complaint/Grievance Synopsis records (MCG) were reviewed to determine compliance with the Solvency and Recordkeeping and Recording Requirement standards, respectively.

Determination of Compliance

To evaluate County/BH MCO compliance on individual provisions, IPRO grouped the required and relevant monitoring Items by provision and evaluated the Counties and BH MCO's compliance status with regard to the PEPS Items. Each Item was assigned a value of met, partially met or not met in the PEPS tools submitted by the Commonwealth. If an Item was not evaluated for a particular County/BH MCO, it was assigned a value of Not Determined. Compliance with the BBA provisions was then determined based on the aggregate results of the PEPS Items linked to each provision. If all Items were met, the County/BH MCO was evaluated as compliant; if some were met and some were partially met or not met, the County/BH MCO was evaluated as partially compliant. If all Items were not met, the County/BH MCO was evaluated as non-compliant. If no crosswalked Items were evaluated for a given provision and no other source of information was available to determine compliance, a value of Not Applicable ("N/A") was assigned for that provision. A value of Null was assigned to a provision when none of the existing PEPS Items directly covered the Items contained within the provision, or if it was not covered in any other documentation provided. Finally, all compliance results for all provisions within a given category were aggregated to arrive at a summary compliance status for the category. For example, all provisions relating to enrollee rights are summarized under Enrollee Rights - 438.100.

Format

The format for this section of the report was developed to be consistent with the categories prescribed by BBA regulations. This document groups the regulatory requirements under subject headings that are consistent with the three subparts set out in the BBA regulations and described in the *MCO Monitoring Protocol*. Under each general subpart heading are the individual regulatory categories appropriate to those headings. IPRO's findings are presented in a manner consistent with the three subparts in the BBA regulations explained in the Protocol, i.e., Enrollee Rights and Protections, Quality Assessment and Performance Improvement (including access, structure and operation and measurement and improvement standards), and Federal and State Grievance System Standards.

This format reflects the goal of the review, which is to gather sufficient foundation for IPRO's required assessment of the County/BH MCO's compliance with BBA regulations as an element of the analysis of their strengths and weaknesses. In addition, this level of analysis avoids any redundancy with the detailed level of review found in the PEPS documents.

Findings

For CBHNP and the 12 Counties associated with the BH MCO, 137 PEPS Items were identified as required to fulfill BBA regulations. The 12 Counties were evaluated on 128 PEPS Items during the review cycle. There were nine Items that were not scheduled or not applicable for evaluation for RY 2010.



Subpart C: Enrollee Rights and Protections

The general purpose of the regulations included in this subpart is to ensure that each County/BH MCO has written policies regarding enrollee rights and complies with applicable Federal and State laws that pertain to enrollee rights, and that the County/BH MCO ensures that its staff and affiliated providers take into account those rights when furnishing services to enrollees [42 C.F.R. § 438.100 (a), (b)].

Table 1.2 Compliance with Enrollee Rights and Protections Regulations

Enrollee Rights and Protections		
Subpart C: Categories	Compliance	Comments
Enrollee Rights 438.100	Partial	12 Items were crosswalked to this category. Each County was evaluated on 12 Items. The CABHC Counties were compliant on 10 Items, and partially compliant on 2 Items. Blair, Bedford, Franklin, Fulton, and Somerset Counties were compliant on 11 Items, and partially compliant on 1 Item. Clinton and Lycoming Counties were compliant on 9 Items, and partially compliant on 3 Items.
Provider-Enrollee Communications 438.102	Compliant	Compliant as per PS&R sections E.4 (p.50) and A.3.a (p.24).
Marketing Activities 438.104	N/A	Not Applicable due to CMS HealthChoices waiver. Consumers are assigned to BH MCOs based on their County of residence.
Liability for Payment 438.106	Compliant	Compliant as per PS&R sections A.9 (p.63) and C.2 (p.34).
Cost Sharing 438.108	Compliant	Any cost sharing imposed on Medicaid enrollees is in accordance with 42 CFR 447.50-447.60.
Emergency and Post-Stabilization Services 438.114	Compliant	Compliant as per PS&R section 3.d (p.31).
Solvency Standards 438.116	Compliant	Compliant as per PS&R sections A.3 (p.60) and A.9 (p.63), and 2010-2011 Solvency Requirements tracking report.

There are seven categories in the Enrollee Rights and Protections Standards. CBHNP was compliant on five categories and partially compliant on one category. One category was considered Not Applicable as OMHSAS received a CMS waiver on the Marketing Activities category. Of the five compliant categories, four were as per the HealthChoices PS&R and one category was as per CMS Regulation 42 CFR 447.50-447.60. The category Solvency Standards was compliant based on the 2010-2011 Solvency Requirement tracking report.

Of the 12 PEPS Items that were crosswalked to Enrollee Rights and Protections Regulations, all 12 were evaluated for all CBHNP Counties. The CABHC Counties were compliant on 10 Items and partially compliant on two Items. Blair, Bedford, Franklin, Fulton, and Somerset Counties were compliant on 11 Items, and partially compliant on one Item. Clinton and Lycoming Counties were compliant on nine Items, and partially compliant on three Items. Those Items deemed partially compliant may correlate to a fewer



number of PEPS substandards deemed partially compliant. Some PEPS standards are crosswalked to more than one category.

Enrollee Rights

All of the 12 Counties that subcontract with CBHNP were partially compliant with Enrollee Rights due to partial compliance with substandards within PEPS Standards 60 and 108.

PEPS Standard 60: a) The BH MCO shall identify a lead person responsible for overall coordination of the complaint and grievance process, including the provision of information and instructions to members. (Responsibility includes Health Insurance Portability and Accountability Act (HIPAA) Privacy duties related to complaints and mechanisms for tracking and reporting of HIPAA related complaints). b) The BH MCO shall designate and train sufficient staff responsible for receiving, processing and responding to member complaints and grievances in accordance with the requirements contained in Appendix H. c) All BH MCO Staff shall be educated concerning member rights and the procedure for filing complaints and grievances.

All of the CBHNP Counties were partially compliant on one substandard of Standard 60: Substandard 2 (RY 2008).

Substandard 2: Training rosters identify that complaint and grievance staff has been adequately trained to handle and respond to member complaints and grievances. Include a copy of the training curriculum.

PEPS Standard 108: The County Contractor/BH MCO: a) incorporates consumer satisfaction information in provider profiling and quality improvement process; b) collaborates with consumers and family members in the development of an annual satisfaction survey that meets the requirements of Appendix L; c) provides the department with quarterly and annual summaries of consumer satisfaction activities, consumer issues identified and resolution to problems, and d) provides an effective problem identification and resolution process.

The CABHC Counties were partially compliant on one substandard of Standard 108: Substandard 1 (RY 2008).

Substandard 1: County/BH MCO oversight of Consumer/Family Satisfaction Team (C/FST) Program ensures HealthChoices (HC) contractual requirements are met.

Clinton and Lycoming Counties were partially compliant on two substandards of Standard 108: Substandards 6 and 7 (RY 2009).

Substandard 6: The problem resolution process specifies the role of the County, BH-MCO and C/FST and providers and results in timely follow-up of issues identified in quarterly surveys.

Substandard 7: The C/FST quarterly reports submitted to OMHSAS include the numeric results of surveys by provider, and level of care and narrative information about trends, and actions taken on behalf of individual consumers, with providers, and systemic issues, as applicable.



Subpart D: Quality Assessment and Performance Improvement Regulations

The general purpose of the regulations included under this subpart is to ensure that all services available under the Commonwealth's Medicaid managed care program are available and accessible to MCO enrollees [42 C.F.R. § 438.206 (a)].

The PEPS documents for each County include an assessment of the County/BH MCO's compliance with regulations found in Subpart D. Table 1.3 presents the findings by categories consistent with the regulations.

Table 1.3 Compliance with Quality Assessment and Performance Improvement Regulations

Quality Assessment and Performance Improvement Regulations		
Subpart D: Categories	Compliance	Comments
Elements of State Quality Strategies 438.204	Compliant	Compliant as per PS&R section G.3 (p.55).
Availability of Services (Access to Care) 438.206	Partial	22 Items were crosswalked to this category. Each County was evaluated on 22 Items, compliant on 20 Items, and partially compliant on 2 Items.
Coordination and Continuity of Care 438.208	Partial	2 Items were crosswalked to this category. Each County was evaluated on 2 items and was partially compliant on both.
Coverage and Authorization of Services 438.210	Partial	4 Items were crosswalked to this category. Each County was evaluated on 3 Items, and partially compliant on 3 Items.
Provider Selection 438.214	Compliant	3 Items were crosswalked to this category. Each County was evaluated on 3 Items and compliant on 3 Items.
Confidentiality 438.224	Compliant	Compliant as per PS&R sections D.2 (p.47), G.4 (p.55-56) and C.7.c (p.46).
Subcontractual Relationships and Delegation 438.230	Compliant	8 Items were crosswalked to this category. Each County was evaluated on 8 Items, and compliant on 8 Items.
Practice Guidelines 438.236	Partial	6 Items were crosswalked to this category. Each County was evaluated on 6 Items, compliant on 4 Items, and partially compliant on 2 Items.
Quality Assessment and Performance Improvement Program 438.240	Compliant	23 Items were crosswalked to this category. Each County was evaluated on 23 Items, and compliant on 23 Items.



Quality Assessment and Performance Improvement Regulations		
Subpart D: Categories	Compliance	Comments
Health Information Systems 438.242	Compliant	1 Item was crosswalked to this category. Each County was evaluated on 1 Item and was compliant on this Item.

There are 10 categories in the Quality Assessment and Performance Improvement Regulations Standards. CBHNP was compliant on six of the 10 categories and partially compliant on four categories. Two of the five categories that CBHNP was compliant on – Elements of State Quality Strategies and Confidentiality – were not directly addressed by any PEPS Items, but were determined to be compliant as per the HealthChoices PS&R.

For this review, 69 Items were crosswalked to Quality Assessment and Performance Improvement Regulations, and all 12 Counties associated with CBHNP were evaluated on 68 Items. There was one Item that was not scheduled or not applicable for evaluation for RY 2010. Each County was compliant on 59 Items and partially compliant on 9 Items. Those Items deemed partially compliant may correlate to a fewer number of PEPS substandards deemed partially compliant. As stated previously, some PEPS standards are crosswalked to more than one category.

Availability of Services (Access to Care)

All 12 Counties associated with CBHNP were partially compliant with Availability of Services (Access to Care) due to partial compliance with substandards within PEPS Standards 28 and 93.

PEPS Standard 28: The BH MCO has a comprehensive, defined program of care that incorporates longitudinal disease management.

All of the CBHNP Counties were partially compliant on two substandards of Standard 28: Substandards 1 and 2 (RY 2009).

Substandard 1: Clinical/chart reviews reflect appropriate consistent application of medical necessity criteria and active care management that identify and address quality of care concerns.

Substandard 2: The medical necessity decision made by the BH-MCO Physician/Psychologist Advisor is supported by documentation in the denial record and reflects appropriate application of medical necessity criteria.

Coordination and Continuity of Care

All 12 Counties associated with CBHNP were partially compliant with Coordination and Continuity of Care due to partial compliance with one substandard of PEPS Standard 28.

PEPS Standard 28: See Standard description and partially compliant substandard determination under Availability of Services (Access to Care) above.

Coverage and Authorization of Services

All 12 Counties associated with CBHNP were partially compliant with Coverage and Authorization of Services due to partial compliance with substandards of PEPS Standards 28 and 72.

PEPS Standard 28: See Standard description and partially compliant substandard determination under Availability of Services (Access to Care) above.



PEPS Standard 72: Denials or reduction of services are provided, in writing, to the member, parent/custodian of a child/adolescent, and/or County Child and Youth agency for children in substitute care. The denial note includes: a) Specific reason for denial, b) Service approved at a lesser rate, c) Service approved for a lesser amount than requested, d) Service approved for shorter duration than requested, e) Service approved using a different service or Item than requested and description of the alternate service, if given, f) Date decision will take effect, g) Name of contact person, h) Notification that member may file a grievance and/or request a DPW Fair Hearing and i) If currently receiving services, the right to continue to receive services during the grievance and/or DPW Fair Hearing process.

All of the CBHNP Counties were partially compliant on one substandard of Standard 72: Substandard 1 (RY 2010).

Substandard 1: Denial notices are issued to members in a timely manner using the required template. The content of the notices adhere to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.

Practice Guidelines

All 12 Counties associated with CBHNP were partially compliant with Practice Guidelines due to partial compliance with substandards of PEPS Standard 28.

PEPS Standard 28: See Standard description and partially compliant substandard determination under Availability of Services (Access to Care) on page 13.

Subpart F: Federal and State Grievance System Standards

The general purpose of the regulations included under this subpart is to ensure that enrollees have the ability to pursue grievances.

The PEPS documents for each County include an assessment of the County/BH MCO's compliance with regulations found in Subpart F. Table 1.4 presents the findings by categories consistent with the regulations.

Table 1.4 Compliance with Federal and State Grievance System Standards

Federal and State Grievance System Standards		
Subpart F: Categories	Compliance	Comments
Statutory Basis and Definitions 438.400	Partial	7 Items were crosswalked to this category. Each County was evaluated on 6 Items, compliant on 3 Items, and partially compliant on 3 Items.
General Requirements 438.402	Partial	10 Items were crosswalked to this category. Each County was evaluated on 9 Items, compliant on 5 Items, and partially compliant on 4 Items.
Notice of Action 438.404	Partial	11 Items were crosswalked to this category. Each County was evaluated on 10 Items, compliant on 9 Items, and partially compliant on 1 Item.



Federal and State Grievance System Standards		
Subpart F: Categories	Compliance	Comments
Handling of Grievances and Appeals 438.406	Partial	7 Items were crosswalked to this category. Each County was evaluated on 6 Items, compliant on 3 Items, and partially compliant on 3 Items.
Resolution and Notification: Grievances and Appeals 438.408	Partial	7 Items were crosswalked to this category. Each County was evaluated on 6 Items, compliant on 3 Items, and partially compliant on 3 Items.
Expedited Appeals Process 438.410	Partial	4 Items were crosswalked to this category. Each County was evaluated on 3 Items, compliant on 1 Item, and partially compliant on 2 Items.
Information to Providers & Subcontractors 438.414	Compliant	2 Items were crosswalked to this category. Each County was evaluated on 2 Items and compliant on both.
Recordkeeping and Recording Requirements 438.416	Compliant	Compliant as per 2010 Encounter Monthly Aggregate Complaint/Grievance Records (EMG) and Encounter Monthly Complaint/Grievance Synopsis Records (MCG) tracking reports.
Continuation of Benefits 438.420	Partial	4 Items were crosswalked to this category. Each County was evaluated on 3 Items, compliant on 1 Item, and partially compliant on 2 Items.
Effectuation of Reversed Resolutions 438.424	Partial	4 Items were crosswalked to this category. Each County was evaluated on 3 Items, compliant on 1 Item, and partially compliant on 2 Items.

There are 10 categories in the Federal and State Grievance System Standards. CBHNP was compliant on two of the 10 categories (Information to Providers & Subcontractors and Recordkeeping and Recording Requirements) and partially compliant on eight categories. The category Recordkeeping and Recording Requirements was compliant as per the 2010 Encounter Monthly Aggregate Complaint/Grievance Records (EMG) and Encounter Monthly Complaint/Grievance Synopsis Records (MCG) tracking reports.

For this review, 56 Items were crosswalked to Federal and State Grievance System Standards, and each CBHNP County was evaluated on 48 Items. There were eight Items that were not scheduled or not applicable for evaluation for RY 2010. Each County was compliant on 28 Items and partially compliant on 20 Items. Those Items deemed partially compliant may correlate to a fewer number of PEPS substandards deemed partially compliant. As stated previously, some PEPS standards are crosswalked to more than one category.

The 12 CBHNP Counties were deemed partially compliant with eight of the 10 categories pertaining to Federal State and Grievance System Standards due to partial compliance with substandards within PEPS Standards 60, 68, 71 and 72.



PEPS Standard 60: See Standard description and partially compliant substandard determination under Enrollee Rights.

PEPS Standard 68: Complaint rights and procedures are made known to Independent Enrollment Assistance Program (IEAP), members, BH MCO staff and the provider network through manuals, training, handbooks, etc.

All of the CBHNP Counties were partially compliant on one substandard of Standard 68: Substandard 3 (RY 2008).

Substandard 3: The Complaint Case File includes documentation of the steps taken by the BH MCO to investigate a complaint. All contacts and findings related to the involved parties are documented in the case file.

PEPS Standard 71: Grievance and Fair Hearing rights and procedures are made known to Enrollment Assistance Program (EAP), members, BH MCO Staff and the provider network through manuals, training, handbooks, etc.

All of the CBHNP Counties were partially compliant on one substandard of Standard 71: Substandard 2 (RY 2008).

Substandard 2: 100% of Grievance Acknowledgement and Decision Letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.

PEPS Standard 72: See Standard description and partially compliant substandard determination under Coverage and Authorization of Services on page 13.

Program Evaluation Performance Summary OMHSAS-Specific Items for CBHNP Counties

OMHSAS-specific items are not required to fulfill BBA requirements. In RY 2010, 11 Items were considered OMHSAS-specific monitoring standards, and were reviewed. All 11 OMHSAS-specific PEPS Items were evaluated for Blair and the CABHC counties. The remaining NC/CO Counties – Bedford, Clinton, Franklin, Fulton, Lycoming, and Somerset – were evaluated on 10 of the Items. There was one Item that was not scheduled or not applicable for evaluation for RY 2010. Tables 1.5a to 1.5c provide a count of these Items, along with the relevant categories.

Table 1.5a OMHSAS-Specific Items Reviewed for Blair County

Category (PEPS Standard)	Total # of Items	PEPS Reviewed in RY 2010	PEPS Reviewed in RY 2009	PEPS Reviewed in RY 2008	Not Reviewed
Second Level Complaints and Grievances					
Complaints (Standard 68)	4	0	0	4	0
Grievances and State Fair Hearings (Standard 71)	4	0	0	4	0
Enrollee Satisfaction					
Consumer/Family Satisfaction (Standard 108)	3	0	3	0	0



Table 1.5b OMHSAS-Specific Items Reviewed for the CABHC Counties

Category (PEPS Standard)	Total # of Items	PEPS Reviewed in RY 2010	PEPS Reviewed in RY 2009	PEPS Reviewed in RY 2008	Not Reviewed
Second Level Complaints and Grievances					
Complaints (Standard 68)	4	0	0	4	0
Grievances and State Fair Hearings (Standard 71)	4	0	0	4	0
Enrollee Satisfaction					
Consumer/Family Satisfaction (Standard 108)	3	0	0	3	0

Table 1.5c OMHSAS-Specific Items Reviewed for Bedford, Clinton, Franklin, Fulton, Lycoming, and Somerset Counties

Category (PEPS Standard)	Total # of Items	PEPS Reviewed in RY 2010	PEPS Reviewed in RY 2009	PEPS Reviewed in RY 2008	Not Reviewed*
Second Level Complaints and Grievances					
Complaints (Standard 68)	4	0	0	4	0
Grievances and State Fair Hearings (Standard 71)	4	0	0	4	0
Enrollee Satisfaction					
Consumer/Family Satisfaction (Standard 108)	3	0	2	0	1

*Not Reviewed Items, including those that are Not Applicable, do not substantially affect the findings for any category if other Items within the category are reviewed.

Format

This document groups the monitoring standards under the subject headings Second Level Complaints and Grievances, and Enrollee Satisfaction. The status of each Item is presented as it appears in the PEPS tools (i.e., met, partially met, or not met) and/or applicable RAI tools (i.e., complete or pending) submitted by OMHSAS. This format reflects the goal of this supplemental review, which is to assess the County/BH MCO's compliance on selected ongoing OMHSAS-specific monitoring standards.

Findings

The OMHSAS-specific PEPS Items relating to second level complaints and grievances are MCO-specific review standards, and all eight Items were evaluated for CBHNP. CBHNP met five Items and partially met three Items, as seen in Table 1.6.

Table 1.6 OMHSAS-Specific Requirements Relating to Second Level Complaints and Grievances for all CBHNP Counties

Category	PEPS Item	Review Year	Status
Second Level Complaints and Grievances			
Complaints	Standard 68.4	RY 2008	Met
	Standard 68.5	RY 2008	Met
	Standard 68.6	RY 2008	Partially Met
	Standard 68.7	RY 2008	Partially Met
Grievances and State Fair Hearings	Standard 71.3	RY 2008	Met
	Standard 71.4	RY 2008	Met
	Standard 71.5	RY 2008	Partially Met
	Standard 71.6	RY 2008	Met

Note: Substandards 68.4, 68.5, 68.6, and 68.7 from RY 2008 were re-numbered as Substandards 68.6, 68.7, 68.8, and 68.9, respectively, in the PEPS tools beginning and including RY 2009. Substandards 71.3, 71.4, 71.5, and 71.6 from RY 2008 were re-numbered as Substandards 71.5, 71.6, 71.7, and 71.8, respectively, in the PEPS tools beginning and including RY 2009.



PEPS Standard 68: Complaint (and BBA Fair Hearing) rights and procedures are made known to IEAP, members, BH MCO staff, and the provider network through manuals, training, handbooks, etc.

CBHNP was “partially met” on Substandards 68.6 and 68.7:

Substandard 68.6: A transcript and/or tape recording of the second level committee meeting will be maintained to demonstrate appropriate representation, familiarity with the issues being discussed and that the decision was based on input from all panel members.

Substandard 68.7: Where applicable there is evidence of County oversight and involvement in the second level complaint process.

PEPS Standard 71: Grievance and Fair Hearing rights and procedures are made known to EAP, members, BH MCO Staff and the provider network through manuals, training, handbooks, etc.

CBHNP was “partially met” on Substandard 71.5:

Substandard 71.5: A transcript and/or tape recording of the second level committee meeting will be maintained to demonstrate appropriate representation, familiarity with the issues being discussed and that the decision was based on input from all panel members.

The OMHSAS-specific Items relating to Enrollee Satisfaction are County-specific review standards. Blair County was evaluated on three items, met two Items, and partially met one Item. The CABHC Counties were evaluated on and met all three Items. Bedford, Clinton, Franklin, Fulton, Lycoming, and Somerset Counties were evaluated on two of the three Items. Bedford, Franklin, Fulton, and Somerset Counties met both Items. Clinton and Lycoming Counties met one Item and partially met one Item. Tables 1.7a to 1.7c provide a count of these Items.

Table 1.7a OMHSAS-Specific Requirements Relating to Enrollee Satisfaction for Blair County (A NC/CO County)

Category	PEPS Item	Review Year	Status
Enrollee Satisfaction			
Consumer/Family Satisfaction	Standard 108.3	RY 2009	Met
	Standard 108.4	RY 2009	Met
	Standard 108.9	RY 2009	Partially Met

Table 1.7b OMHSAS-Specific Requirements Relating to Enrollee Satisfaction for the CABHC Counties

Category	PEPS Item	Review Year	Status
Enrollee Satisfaction			
Consumer/Family Satisfaction	Standard 108.3	RY 2008	Met
	Standard 108.4	RY 2008	Met
	Standard 108.9	RY 2008	Met



Table 1.7c OMHSAS-Specific Requirements Relating to Enrollee Satisfaction for Bedford, Clinton, Franklin, Fulton, Lycoming, and Somerset Counties (All remaining NC/CO Counties)

Category	PEPS Item	Review Year	Status by County		
			Met	Partially Met	Not Reviewed
Enrollee Satisfaction					
Consumer/Family Satisfaction	Standard 108.3	RY 2009			All remaining NC/CO Counties
	Standard 108.4	RY 2009	All remaining NC/CO Counties		
	Standard 108.9	RY 2009	Bedford, Franklin, Fulton, Somerset	Lycoming, Clinton	

PEPS Standard 108:The County Contractor/BH MCO: a) incorporates consumer satisfaction information in provider profiling and quality improvement process; b) collaborates with consumers and family members in the development of an annual satisfaction survey that meets the requirements of Appendix L; c) provides the department with quarterly and annual summaries of consumer satisfaction activities, consumer issues identified and resolution to problems, and d) provides an effective problem identification and resolution process.

Blair, Lycoming and Clinton Counties were “partially met” on Substandard 108.9:

Substandard 108.9: Results of surveys by provider and level of care are reflected in BH-MCO provider profiling and have resulted in provider action to address issues identified.



II: PERFORMANCE IMPROVEMENT PROJECTS

In accordance with current BBA regulations, IPRO undertook validation of one Performance Improvement Project (PIP) for each HealthChoices BH MCO. Under the existing behavioral health agreement with OMHSAS, primary contractors (i.e., the Counties), along with the responsible subcontracted entities (i.e., BH MCOs) are required to conduct a minimum of two focused studies per year. The Counties and BH MCOs are required to implement improvement actions and to conduct follow-up including, but not limited to, subsequent studies or remeasurement of previous studies in order to demonstrate improvement or the need for further action. For the purposes of the EQR, BH MCOs were required to participate in a study selected by OMHSAS for validation by IPRO in 2011 for 2010 activities.

A new EQR PIP cycle began for BH MCOs and Counties in 2008. For this PIP cycle, OMHSAS again selected Follow-Up After Hospitalization for Mental Illness (FUH) as the PIP study topic to meet the EQR requirement. OMHSAS indicated that while some improvements were noted in the previous cycle, aggregate FUH rates have remained below the OMHSAS-established benchmark of 90%. FUH for the Medicaid Managed Care (MMC) population continues to be an area of interest for OMHSAS.

The 2011 EQR is the eighth review to include validation of PIPs. With this PIP cycle, all BH MCOs/Counties share the same baseline period and timeline. To initiate the PIP cycle in 2008, IPRO developed guidelines on behalf of OMHSAS that addressed the PIP submission schedule, the applicable study measurement periods, documentation requirements, topic selection, study indicators, study design, baseline measurement, interventions, remeasurement, and sustained improvement. Direction was given with regard to expectations for PIP relevance, quality, completeness, resubmission, and timeliness.

The BH MCOs are required by OMHSAS to submit their projects using the National Committee for Quality Assurance (NCQA™) Quality Improvement Activity (QIA) form, which is consistent with the CMS protocol for *Conducting Performance Improvement Projects*. These protocols follow a longitudinal format and capture information relating to:

- Activity Selection and Methodology
- Data/Results
- Analysis Cycle
- Interventions

Validation Methodology

IPRO's protocol for evaluation of PIPs is consistent with the protocol issued by CMS (*Validating Performance Improvement Projects, Final Protocol, Version 1.0, May 1, 2002*) and meets the requirements of the final rule on the EQR of Medicaid MCOs issued on January 24, 2003. IPRO's review evaluates each project against nine review elements:

1. Project Topic, Type, Focus Area
2. Topic Relevance
3. Quality Indicators
4. Baseline Study Design and Analysis
5. Baseline Study Population
6. Interventions Aimed at Achieving Demonstrable Improvement
7. Demonstrable Improvement
- 1S. Subsequent or Modified Interventions
- 2S. Sustained Improvement

The first seven elements relate to the baseline and demonstrable improvement phases of the project. The last two relate to sustaining improvement from the baseline measurement. Each element carries a separate weight. Scoring for each element is based on full, partial and non-compliance. Points are



awarded for the two phases of the project noted above, and are combined to arrive at an overall score. The overall score is expressed in terms of levels of compliance.

Review Element Designation/Weighting

For each review element, the assessment of compliance is determined through the weighted responses to each review item. Table 2.1 presents the terminologies used in the scoring process, their respective definitions, and their weight percentage.

Table 2.1 Review Element Scoring Designations and Definitions

Element Designation	Definition	Weight
Full	Met or exceeded the element requirements	100%
Partial	Met essential requirements but is deficient in some areas	50%
Non-compliant	Has not met the essential requirements of the element	0%

Overall Project Performance Score

The total points earned for each review element are weighted to determine the BH MCO's overall performance score for a PIP. The seven review elements for demonstrable improvement have a total weight of 80%. The highest achievable score for all seven demonstrable improvement elements is 80 points (80% x 100 points for Full Compliance).

PIPs are also reviewed for the achievement of sustained improvement. This has a weight of 20%, for a possible maximum total of 20 points. The BH MCO must sustain improvement relative to baseline after achieving demonstrable improvement. The evaluation of the sustained improvement area has two review elements.

Scoring Matrix

When the PIPs are reviewed, all projects are evaluated for the same elements. The scoring matrix is completed for those review elements where activities have occurred through 2010. At the time of the review, a project is reviewed for only the elements that are due, according to the PIP submission schedule. It will then be evaluated for the remaining elements at later dates, according to the PIP submission schedule.

Point score allocation was modified for this PIP from the CMS protocol suggested points. Review Elements 1 (Project Title, Type, Focus Area) and 3 (Quality Indicators) were pre-determined by OMHSAS. Points for Element 1 were awarded based on BH MCO attendance on the Technical Assistance webinar conducted in October 2009 to discuss the new PIP cycle and the submission instructions for the project. Points will not be awarded for Element 3 because the indicators have been defined for the BH MCOs. These points have been reallocated to Elements 4 and 6. The point score reallocation for the FUH PIP is outlined in the scoring matrix in Table 2.2.

Table 2.2 Review Element Scoring Weights

Review Element	Standard	Scoring Weight
1	Project Title, Type, Focus Area	5%
2	Topic Relevance	5%
3	Quality Indicators	0%
4	Baseline Study and Analysis	20%
5	Baseline Study Population and Baseline Measurement Performance	10%
6	Interventions Aimed at Achieving Demonstrable Improvement	20%
7	Demonstrable Improvement	20%
Total Demonstrable Improvement Score		80%



Review Element	Standard	Scoring Weight
1S	Subsequent or modified Interventions Aimed at Achieving Sustained Improvement	5%
2S	Sustained Improvement	15%
Total Sustained Improvement Score		20%
Overall Project Performance Score		100%

Findings

As per the timeline distributed by OMHSAS for this review period, BH MCOs were required to submit information for review element six: Interventions Aimed at Achieving Demonstrable Improvement. CBHNP submitted the required element of the FUH PIP for review.

The project had previously received full credit for all elements through Baseline Study Population and Baseline Measurement Performance. Of these, Topic Selection had been pre-determined by OMHSAS and pre-populated by IPRO into QIA forms that were sent to the BH MCOs in August 2009. As outlined in the PIP submission guidelines, CBHNP received credit for Topic Selection by attending IPRO's Technical Assistance webinar held on October 5, 2009.

Follow-up After Hospitalization for Mental Illness

OMHSAS selected Follow-up After Hospitalization for Mental Illness as the topic for the PIP for all BH MCOs and Counties. OMHSAS again prioritized this as an area in need of improvement based on cumulative findings from multiple performance measure and data collection activities. In addition to defining the topic, OMHSAS defined the study indicator based on the Healthcare Effectiveness Data Information Set (HEDIS[®]) Follow-up After Hospitalization measure, for both the seven and 30-day rates. The study indicator utilizes HEDIS specifications to measure the percentage of discharges for members six years and older who were hospitalized for treatment of selected mental health disorders, and who were seen on an ambulatory basis or were in day/night treatment with a mental health provider on the date of discharge up to seven days (Quality Indicator (QI) 1) and 30 days (QI 2) after hospital discharge. Two additional indicators are also calculated, which utilize the HEDIS specifications outlined above, and include additional Pennsylvania service codes to define ambulatory or day/night treatment for both the seven and 30-day rates (called QIs A and B, respectively). All indicators are updated annually as necessary to reflect any changes to HEDIS technical specifications. In addition, the PA-specific indicators (QIs A and B) are reviewed on an annual basis by OMHSAS, the Counties and BH MCOs for consideration of inclusion of additional codes. OMHSAS has determined that the rates calculated for Measurement Year (MY) 2008 using these four indicators are to be used as baseline measurements for all Counties/BH MCOs for the current PIP study cycle.

The rationale previously provided for this activity selection included literature citations and root cause analyses based on BH MCO-and County-specific data. CBHNP cited from literature review that an estimated 40-60% of patients fail to connect with outpatient clinicians, but that those who have kept follow-up appointments have been shown to have a decreased chance of being re-hospitalized than those who do not follow-up with outpatient care. The BH MCO also referenced research indicating that factors such as socio-demographic, clinical, and service utilization characteristics can be used to predict those at risk for not receiving adequate follow-up care. CBHNP stated that they continues to use these predictors to develop potential next steps and interventions.

CBHNP discussed the BH MCO's rates on the four indicators, noting that all rates remain well below the 90% OMHSAS-established benchmark. CBHNP indicated that they conducted a separate root cause analysis for each of the five County contracts (four of which are jointers) – The Capital Five Counties, Blair County, Bedford/Somerset, Clinton/Lycoming, and Franklin/Fulton. As a result, the MCO observed multiple overarching problem areas, some of which included: 1) Third Party Liability (TPL) issues, specifically cases for which CBHNP is the secondary payer and follow-up visits were completed by



providers under the primary insurance, so the claim would not have been captured by CBHNP, 2) use of Out of Network providers, 3) ineffective or lack of appointment outreach calls, 4) limited provider availability, 5) member preferences for unavailable providers, leading to lack of engagement, 6) lack of data reporting capacity, 7) hospital discharge planning issues, and 8) lack of access to transportation. CBHNP also referred to the definition used in the HEDIS measure for follow-up visits as a factor impacting the rates. Although the HEDIS definitions are used nationally, CBHNP asserted that rehabilitation services used in PA to maintain contact with a member are not included in the HEDIS measure, and decrease the rates. This issue, however, is not a root cause that can be addressed by the MCO, as the national HEDIS definition has been required for use by OMHSAS for QIs 1 and 2.

As a result of the root cause analysis findings, CBHNP proposed other factors that may prohibit members from attending follow up care, such as substance abuse issues, poor discharge planning, lack of referrals to peer support, and unstable housing. CBHNP noted that these issues appear to persist despite provider education currently in place. Additionally, in response to the issue of ineffective or lack of outreach calls, CBHNP reviewed the BH MCO's own internal process regarding how members are reminded of their appointments. As a result, the BH MCO plans to initiate new procedures to enhance collaboration with Targeted Case Managers (TCM), inpatient units, and parents or guardians.

Baseline results were calculated in 2009 for the period January 1, 2008 through December 31, 2008 and were previously presented along with analysis that would lead to interventions initiated in late 2009. The baseline results indicated a rate of 42.7% for QI 1 (HEDIS – seven days), 66.7% for QI 2 (HEDIS – 30 days), 55.8% for QI A (PA-Specific – seven days), and 73.8% for QI B (PA-Specific – 30 days). For QIs 1 and 2, the comparison goals adopted by CBHNP were the 75th percentile of the HEDIS 2007 Medicaid seven- and 30-day follow-up rates. For QIs A and B, the goals were the 90th percentile of the HEDIS 2007 Medicaid seven- and 30-day follow-up rates. Rates for all indicators were below the goals and the 90% benchmark established by OMHSAS. As part of the MCO's review of baseline data, CBHNP conducted two consecutive barrier analyses jointly for the FUH and Readmission within 30 Days of Inpatient Psychiatric Discharge measures, citing that professional literature consistently indicates a high correlation between these measures. The work group that conducted the analyses consisted of CBHNP's Chief Operating Officer, Director of Quality Improvement, a quality improvement specialist, quality improvement clinical managers, and County/provider/member stakeholder representatives. For each of the analyses, the group examined available data additional to baseline data. For the 2009 analysis, the group examined data from 2004 through June 2008. In 2010, the group examined data through June 2009. In both analyses, the MCO discussed year-to-year trends and benchmark comparison results first at the MCO-level, then by County contracts. As part of the analyses, CBHNP repeatedly noted a shortage of provider resources at select Counties/joiners, notably in the low number of available peer specialists, crisis service providers, and TCMs. Results of the workgroup review were presented at Quality Improvement Committee meetings for each of the five County contracts (Capital Five, Lycoming/Clinton, Franklin/Fulton, Bedford/Somerset, and Blair Counties.)

For 2010, CBHNP included updates for previous interventions in its discussion of barrier analysis. The BH MCO noted that a number of the monitoring mechanisms previously put in place yielded information for further intervention in 2010. One example is the quarterly review of "no show"/appointment cancellation rates per hospital for high volume providers. As a result, the MCO implemented an intervention in which Quality Improvement Project Managers provide additional education regarding discharge planning to those providers identified with high "no show"/cancellation rates. Additionally, CBHNP presented several Interventions Aimed at Achieving Demonstrable Improvement that were implemented beginning in April 2009, following the MCO's analysis of baseline. These interventions included 1) a self audit tool distributed to all inpatient facilities including items regarding discharge planning, followed by letters with reminders on the need for good discharge planning, review of possible barriers, and follow-up; 2) the MCO's Enhanced Care Management (ECM) Program, which works to improve outcomes for high-risk members by improving the linkage of high-risk members with Therapeutic Care Management (TCM) and Peer Support Services, improving inpatient discharge plans, and increasing utilization of natural and community supports; and 3) ongoing monthly provider performance reports that are sent to providers and discussed further when there are concerns.



CBHNP received full credit for the element of the study evaluated that reflected activities in 2010 (Interventions Aimed at Achieving Demonstrable Improvement). Demonstrable Improvement and Subsequent or Modified Interventions Aimed at Achieving Sustained Improvement will be evaluated in 2012, based on activities conducted in late 2010 through mid-2011.

**Table 2.3 PIP Scoring Matrix:
Follow-up After Hospitalization for Mental Illness**

Review Element	Compliance Level	Scoring Weight	Final Points Score
1. Project Title, Type, Focus Area	Full	5%	5
2. Topic Relevance	Full	5%	5
3. Quality Indicators	Full	0%	0
4. Baseline Study and Analysis (Calendar Year (CY) 2008, reported in CY 2009)	Full	20%	20
5. Baseline Study Population and Baseline Measurement Performance (CY 2008)	Full	10%	10
6. Interventions Aimed at Achieving Demonstrable Improvement (CY 2009 through 06/2010)	Full	20%	20
7. Demonstrable Improvement (CY 2010, reported in 2011)	Not Determined	20%	TBD
Total Demonstrable Improvement Score			TBD
1S. Subsequent or modified Interventions Aimed at Achieving Sustained Improvement (07/2010 through 06/2011)	Not Determined	5%	TBD
2S. Sustained Improvement (CY 2011, reported in 2012)	Not Determined	15%	TBD
Total Sustained Improvement Score			TBD
Overall Project Performance Score			TBD

**Table 2.4 PIP Year Over Year Results:
Follow-up After Hospitalization for Mental Illness**

Project	2008	2009/2010	2010	2010/2011	Comparison Benchmark for Review Year
HEDIS Indicator: Follow-up After Hospitalization for Mental Illness within seven days after discharge (QI 1)	42.7%	NA	TBD	TBD	90%
HEDIS Indicator: Follow-up After Hospitalization for Mental Illness within 30 days after discharge (QI 2)	66.7%	NA	TBD	TBD	90%
PA-Specific Indicator: Follow-up After Hospitalization for Mental Illness within seven days after discharge. (Standard HEDIS Codes and PA codes) (QI A)	55.8%	NA	TBD	TBD	90%



Project	2008	2009/2010	2010	2010/2011	Comparison Benchmark for Review Year
PA-Specific Indicator: Follow-up After Hospitalization for Mental Illness within 30 days after discharge. (Standard HEDIS Codes and PA codes) (QI B)	73.8%	NA	TBD	TBD	90%
Project Status	Baseline Study	Interventions	Remeasurement #1	Remeasurement #2	

Note: Table remains unchanged from 2009 Review Year, as no rates were evaluated for the 2010 Review Year.



III: PERFORMANCE MEASURES

In 2011, OMHSAS and IPRO conducted two EQR studies. Both the Follow-up After Hospitalization for Mental Illness and Readmission within 30 Days of Inpatient Psychiatric Discharge studies were re-measured.

Follow-up After Hospitalization for Mental Illness

This performance measure assessed the percentage of discharges for members six years of age and older who were hospitalized for treatment of selected mental health disorders, who were seen on an ambulatory basis or who were in day/night treatment with a mental health provider on the date of discharge up to seven and 30 days after hospital discharge. The measure continued to be of interest to OMHSAS for the purposes of comparing County and BH MCO rates to available national benchmarks and to prior years' rates.

In MY 2002, the initial measurement year, IPRO and OMHSAS worked together to adapt the measures from the HEDIS methodology, allowing for a significant reduction in the time period needed for indicator development. Senior medical staff at IPRO reviewed the adapted methodology in detail to ensure consistency was maintained with regard to the specifications. Project management staff at both IPRO and OMHSAS also collaborated extensively during the indicator development phase, especially with regard to which local PA codes were considered for inclusion in the list of qualifying procedure codes, while still maintaining consistency with the HEDIS measure specifications. In addition to the adapted indicators, OMHSAS expanded the measures to include services with high utilization in the HealthChoices Behavioral Health Program. For MY 2002, since two codes of interest could not be mapped to any of the standard coding used in the HEDIS measure to identify follow-up office visits, QI 3 and QI 4 were developed to capture these codes, while still generating rates for measures (i.e., QIs 1 and 2) that could be compared to national benchmarks. For the second re-measure in MY 2004, the indicator specifications were updated to reflect changes in the HEDIS 2005 Volume 2, Technical Specifications and four more local codes were added – to bring the total to six – to QIs 3 and 4. OMHSAS staff provided IPRO with a PA local code to national code mapping document to assist in this regard. The MY 2005 re-measure saw very few changes to the measure specifications, of which the main change to the methodology involved the exclusion of an expired PA local code. The MY 2006 re-measure, however, saw significant changes to QI 3 and QI 4 from prior years. Codes added to the measures as per suggestions from OMHSAS, the Counties, and BH MCOs changed the measures substantially, and rates for these indicators were no longer comparable to those from preceding measurement years. Consequently, these indicators were updated to QI A and QI B, respectively. As these indicators represented a significant deviation from HEDIS measure specifications, comparisons to HEDIS rates were not made. In addition, for MY 2006 the follow-up measure was collected for the newly implemented HealthChoices Northeast Counties – Lackawanna, Luzerne, Susquehanna, and Wyoming. These Counties were asked to collect data for the six-month time frame that they were in service for 2006 (July to December). In effect, MY 2006 was a baseline measurement year for collection of QIs A and B, and for the Northeast region across all indicators.

For MY 2007, the indicator specifications were updated to reflect changes in the HEDIS 2008 Volume 2, Technical Specifications. The primary change was the addition of a Place of Service (POS) code requirement to select Current Procedural Terminology (CPT) codes in the HEDIS and PA-specific measure specifications. In addition, all PA local codes previously mapped to standard CPT and Healthcare Common Procedure Coding System (HCPCS) codes as per HIPAA requirements were retired and removed. For the study, the follow-up measure was implemented for the 23 North/Central State Option Counties implemented in January 2007, and the 15 North/Central County Option Counties implemented in July 2007. As with the Northeast Counties for MY 2006, the North/Central County Option



Counties were asked to collect data for the six-month time frame that they were in service for 2007 (July to December).

For MY 2008, indicator specifications were again aligned to the HEDIS 2009 Volume 2, Technical Specifications. Two Diagnosis Related Group (DRG) codes were removed, and one Universal/Uniform Billing (UB) type of bill code was added to the criteria to identify non-acute care exclusions. Additionally, five POS codes were added to select CPT codes. Two procedure codes (one CPT and one HCPCS code) to identify eligible follow-up visits were added to the PA-specific measures per suggestions from OMHSAS, the Counties, and the BH MCOs. These codes were added to the existing 17 PA-specific codes, totaling 19 additional service codes that distinguish the PA-specific measure from the HEDIS measure in the MY 2008 study. Furthermore, as requested by OMHSAS, the MY 2008 findings by age are presented as three cohorts: Ages 6-20 years, Ages 21-64 years, and Ages 65 years and over. The Ages 21-64 years cohort was reported as two age ranges (Ages 21-59 years and Ages 60-64 years) in prior studies including MY 2007. As a result, the population previously reported as two cohorts are combined for comparative purposes.

For MY 2009, indicators in the study had few changes based on the HEDIS 2010 Volume 2: Technical Specifications. The primary change was the removal of CPT codes that were no longer valid, and the addition of several HCPCS codes. As requested by OMHSAS, all data analyses by region were removed, since the regional characteristics have become increasingly geographically diverse and the associated Counties are non-contiguous as the HealthChoices program has expanded beyond the initial legacy regions (Leigh/Capital, Southeast, and Southwest) over the years of re-measuring this performance indicator.

For the current study, indicators again had very few changes based on the HEDIS 2011 Volume 2: Technical Specifications. One revenue code was removed from the criteria to identify non-acute care exclusions. In all, MY 2010 is the fourth re-measurement for QIs A and B, and is the third re-measurement for the Counties in the North/Central County and State Options regions across all indicators.

Measure Selection and Description

In accordance with DPW guidelines, IPRO created the indicator specifications to resemble HEDIS specifications. For each indicator, the criteria specified to identify the eligible population were: product line, age, enrollment, anchor date, and event/diagnosis. To identify the administrative numerator positives, date of service and diagnosis/procedure code criteria were outlined, as well as other specifications as needed. Indicator rates were calculated using only the BH MCO's data systems to identify numerator positives (i.e., administratively).

This performance measure assessed the percentage of discharges for members six years of age and older who were hospitalized for treatment of selected mental health disorders, who were seen on an ambulatory basis or who were in day/night treatment with a mental health provider on the date of discharge up to seven and 30 days after hospital discharge.

There were four separate measurements related to Follow-up After Hospitalization. All utilized the same denominator, but had different numerators.

Eligible Population

The entire eligible population was used for all 67 Counties participating in the MY 2010 study.

Eligible cases were defined as those members in the HealthChoices program who met the following criteria:



- Members who had one (or more) hospital discharges from any acute care facility with a discharge date occurring between January 1 and December 1, 2010;
- A principal ICD-9-CM diagnosis code indicating one of the specified mental health disorders;
- Six years old and over as of the date of discharge; and
- Continuously enrolled from the date of hospital discharge through 30 days after discharge, with no gaps in enrollment.

I: HEDIS Indicators

Quality Indicator 1 (QI 1): Follow-up After Hospitalization for Mental Illness within Seven Days after Discharge (Calculation based on Industry Standard codes used in HEDIS):

Numerator: An ambulatory visit with a mental health practitioner on the date of discharge up to seven days after hospital discharge with one of the qualifying industry standard ambulatory service codes. The date of service must clearly indicate a qualifying ambulatory visit with a mental health practitioner or day/night treatment with a mental health practitioner.

Quality Indicator 2 (QI 2): Follow-up After Hospitalization for Mental Illness within 30 Days after Discharge (Calculation based on Industry Standard codes used in HEDIS):

Numerator: An ambulatory visit with a mental health practitioner on the date of discharge or up to 30 days after hospital discharge with one of the qualifying industry standard ambulatory service codes. The date of service must clearly indicate a qualifying ambulatory visit with a mental health practitioner or day/night treatment with a mental health practitioner.

II: PA-Specific Indicators

Quality Indicator A (QI A): Follow-up After Hospitalization for Mental Illness within Seven Days after Discharge (Calculation based on Numerator 1 codes and additional PA-specific codes not used in HEDIS):

Numerator: An ambulatory visit with a mental health practitioner or peer support network on the date of discharge or up to seven days after hospital discharge with one of the qualifying industry standard or one of the PA-specific ambulatory service codes provided. The date of service must clearly indicate a qualifying ambulatory visit with a mental health practitioner or day/night treatment with a mental health practitioner.

Quality Indicator B (QI B): Follow-up After Hospitalization for Mental Illness within 30 Days after Discharge (Calculation based on Numerator 1 codes and additional PA-specific codes not used in HEDIS):

Numerator: An ambulatory visit with a mental health practitioner or peer support network on the date of discharge or up to 30 days after hospital discharge with one of the qualifying industry standard or one of the PA-specific ambulatory service codes provided. The date of service must clearly indicate a qualifying ambulatory visit with a mental health practitioner or day/night treatment with a mental health practitioner.

Quality Indicator Significance

According to the *Global Burden of Disease: 2004 Update* released by the World Health Organization (WHO) in 2008, mental illnesses and mental disorders represent six of the 20 leading causes of disability worldwide. Among developed nations, depression is the leading cause of disability for people ages 0-59 years, followed by drug and alcohol use disorders and psychoses (e.g., bipolar disorder and schizophrenia)ⁱ. Mental disorders also contribute to excess mortality from suicide, one of the leading preventable causes of death in the United States. Additionally, patients with schizophrenia or bipolar disorder have elevated rates of preventable medical co-morbidities^{ii,iii} such as obesity, cardiovascular



diseases and diabetes, partly attributed to the epidemiology of the disorder, antipsychotic prescription patterns^{iv,v}, reduced use of preventive services^{vi} and substandard medical care that they receive^{vii,viii,ix}. Moreover, these patients are five times more likely to become homeless than those without these disorders^x. On the whole, serious mental illnesses account for more than 15 percent of overall disease burden in the U.S.^{xi}, and they incur a growing estimate of \$317 billion in economic burden through direct (e.g. medication, clinic visits, or hospitalization) and indirect (e.g., reduced productivity and income) channels^{xii}. For these reasons, timely and appropriate treatment for mental illnesses is essential.

It has long been recognized that continuity of care is critical to positive outcome and to prevent long-term deterioration in people with severe and persistent mental illness^{xiii}. As noted in its 2007 *The State of Health Care Quality* report by the NCQA, appropriate treatment and follow-up care can reduce the duration of disability from mental illnesses, and the likelihood of recurrence^{xiv}. An outpatient visit within at least 30 days (ideally seven days) of discharge ensures that the patient's transition to home and/or work is supported and that gains made during hospitalization are maintained. These types of contacts specifically allow physicians to ensure medication effectiveness and compliance, and identify complications early on to avoid more inappropriate and costly use of hospitals and emergency departments^{xv}. With the expansion of evidence-based practice in the recent decade, continuity has become a core principle in care delivery and in performance measurement for mental health services^{xvi}. And one way to improve continuity of care is to provide greater readiness of aftercare by shortening the time between discharge from the hospital and the first day of outpatient contact^{xvii}.

The difficulty in engaging psychiatric patients after inpatient hospitalization, however, has been a long standing concern of behavioral health care systems with some researchers having estimated that 40 to 60 percent of patients fail to connect with an outpatient clinician^{xviii}. Research has demonstrated that patients who do not have an outpatient appointment after discharge were two times more likely to be re-hospitalized in the same year than patients who kept at least one outpatient appointment^{xix}. Over the course of a year, patients who have kept appointments have been shown to have a decreased chance of being re-hospitalized than those who do not follow-up with outpatient care^{xx}. Patients who received follow-up care were also found to have experienced better quality of life at endpoint, better community function, lower severity of symptoms, and greater service satisfaction^{xxi}. Patients with higher functioning in turn had significantly lower community costs, and improved provider continuity was associated with lower hospital^{xxii} and Medicaid costs^{xxiii}.

There are various measures of treatment efficacy, such as service satisfaction, functional status and health outcomes. Among them, re-hospitalization rates continue to be used as a reliable indicator of the effectiveness of inpatient treatment^{xxiv}. Inpatient readmission is clearly a step backward in treatment and a costly alternative to effective and efficient ambulatory care. Timely follow-up care, therefore, is an important component of comprehensive care, and is an effective means to control the cost and maximize the quality of mental health services.

Methodology

A cross-sectional quality improvement study design was employed. The source for all information was administrative data provided to IPRO by the BH MCOs for each County participating in the current study. The source for all administrative data was the BH MCOs' transactional claims systems. Each BH MCO was also required to submit the follow-up rates calculated for the four indicators along with their data files for validation purposes. The BH MCOs were given the opportunity for resubmission, as necessary.

Performance Goals

Performance goals were set for this review year at the OMHSAS designated gold standard of 90% for all measures. In addition, the HEDIS measures were compared to industry benchmarks, in that the aggregate and BH MCO indicator rates were compared to the *HEDIS 2010 Audit Means, Percentiles and Ratios*. These benchmarks contained means, 10th, 25th, 50th (median), 75th and 90th percentiles, and the enrollment ratios for nearly all HEDIS measures. There were tables published by product line (i.e., Commercial, Medicaid, and Medicare). The appropriate Medicaid benchmarks available for the



measurement year were used for comparison. As indicated previously, the PA-specific measures were not comparable to these industry benchmarks.

Data Analysis

The quality indicators were defined as rates, based on a numerator and a denominator. The denominator equaled the number of discharges eligible for the quality indicator, while the numerator was the total number of members for which the particular event occurred. The overall, or aggregate, performance rate for each indicator was the total numerator divided by the total denominator. The aggregate rate represented the rate derived from the total population of members that qualified for the indicator (i.e., the aggregate value). Year-to-year comparisons to MY 2009 data were provided where applicable. Additionally, as appropriate, disparate rates were calculated for various categories in the current study. The significance of the difference between two independent proportions was determined by calculating the z-ratio. Statistically significant differences (SSD) at the .05 level between groups are noted, as well as the percentage point difference (PPD) between the rates.

Findings

BH MCO and County Results

The results are presented at the BH MCO and County level when multiple Counties are represented by a single BH MCO. The BH MCO-specific rates were calculated using the numerator and denominator for that particular BH MCO (i.e., across Counties with the same contracted BH MCO). The County-specific rates were calculated using the numerator and denominator for that particular County. For each of these rates, the 95% Confidence Interval (CI) was reported. Both the HealthChoices BH MCO Average and HealthChoices County Average rates were also calculated for the indicators.

BH MCO-specific rates were compared to the HealthChoices BH MCO Average to determine if they were statistically significantly above or below that value. Whether or not a BH MCO performed statistically significantly above or below the average was determined by whether or not that BH MCO's 95% CI included the HealthChoices BH MCO Average for the indicator. Statistically significant BH MCO differences are noted.

County-specific rates were compared to the HealthChoices County Average to determine if they were statistically significantly above or below that value. Whether or not a County performed statistically significantly above or below the average was determined by whether or not that County's 95% CI included the HealthChoices County Average for the indicator. Statistically significant county-specific differences are noted.

Table 3.1 MY 2010 HEDIS Indicator Rates with Year-to-Year Comparisons

	MY 2010							MY 2009	RATE COMPARISON MY 2010 to MY 2009	
	(N)	(D)	%	LOWER 95% CI	UPPER 95% CI	HEALTH- CHOICES BH MCO AVERAGE	HEALTH- CHOICES COUNTY AVERAGE	%	PPD	SSD
QI 1										
HealthChoices	17,109	37,093	46.1%	45.6%	46.6%	45.4%	48.9%	45.6%	0.5	NO
CBHNP	1,716	4,111	41.7%	40.2%	43.3%			43.2%	-1.5	NO
Bedford	35	95	36.8%	26.6%	47.1%			28.6%	8.2	NO
Blair	267	555	48.1%	43.9%	52.4%			50.8%	-2.7	NO
Clinton	39	89	43.8%	32.9%	54.7%			46.0%	-2.2	NO



	MY 2010							MY 2009	RATE COMPARISON MY 2010 to MY 2009	
	(N)	(D)	%	LOWER 95% CI	UPPER 95% CI	HEALTH- CHOICES BH MCO AVERAGE	HEALTH- CHOICES COUNTY AVERAGE	%	PPD	SSD
Cumberland	117	278	42.1%	36.1%	48.1%			46.3%	-4.2	NO
Dauphin	292	832	35.1%	31.8%	38.4%			40.0%	-4.9	NO
Franklin	132	266	49.6%	43.4%	55.8%			39.5%	10.1	YES
Fulton	13	28	46.4%	26.2%	66.7%			48.2%	-1.8	NO
Lancaster	441	1,082	40.8%	37.8%	43.7%			40.2%	0.6	NO
Lebanon	153	315	48.6%	42.9%	54.2%			55.6%	-7.0	NO
Lycoming	115	303	38.0%	32.3%	43.6%			43.6%	-5.6	NO
Perry	36	70	51.4%	39.0%	63.9%			42.2%	9.2	NO
Somerset	76	198	38.4%	31.4%	45.4%			36.4%	2.0	NO
QI 2										
HealthChoices	24,820	37,093	66.9%	66.4%	67.4%	66.2%	72.5%	65.6%	1.3	YES
CBHNP	2,692	4,111	65.5%	64.0%	66.9%			66.2%	-0.7	NO
Bedford	63	95	66.3%	56.3%	76.4%			58.0%	8.3	NO
Blair	410	555	73.9%	70.1%	77.6%			79.1%	-5.2	NO
Clinton	64	89	71.9%	62.0%	81.8%			73.6%	-1.7	NO
Cumberland	189	278	68.0%	62.3%	73.7%			64.9%	3.1	NO
Dauphin	481	832	57.8%	54.4%	61.2%			60.1%	-2.3	NO
Franklin	213	266	80.1%	75.1%	85.1%			73.5%	6.6	NO
Fulton	21	28	75.0%	57.2%	92.8%			66.7%	8.3	NO
Lancaster	654	1,082	60.4%	57.5%	63.4%			61.0%	-0.6	NO
Lebanon	235	315	74.6%	69.6%	79.6%			77.2%	-2.6	NO
Lycoming	195	303	64.4%	58.8%	69.9%			64.0%	0.4	NO
Perry	49	70	70.0%	58.6%	81.4%			65.6%	4.4	NO
Somerset	118	198	59.6%	52.5%	66.7%			61.4%	-1.8	NO

Caution should be exercised when interpreting results for small denominators as they produce rates that are less stable. Rates produced for small denominators are subject to greater variability. For small populations, large differences in rates do not necessarily mean there is a statistically significant difference in rates.

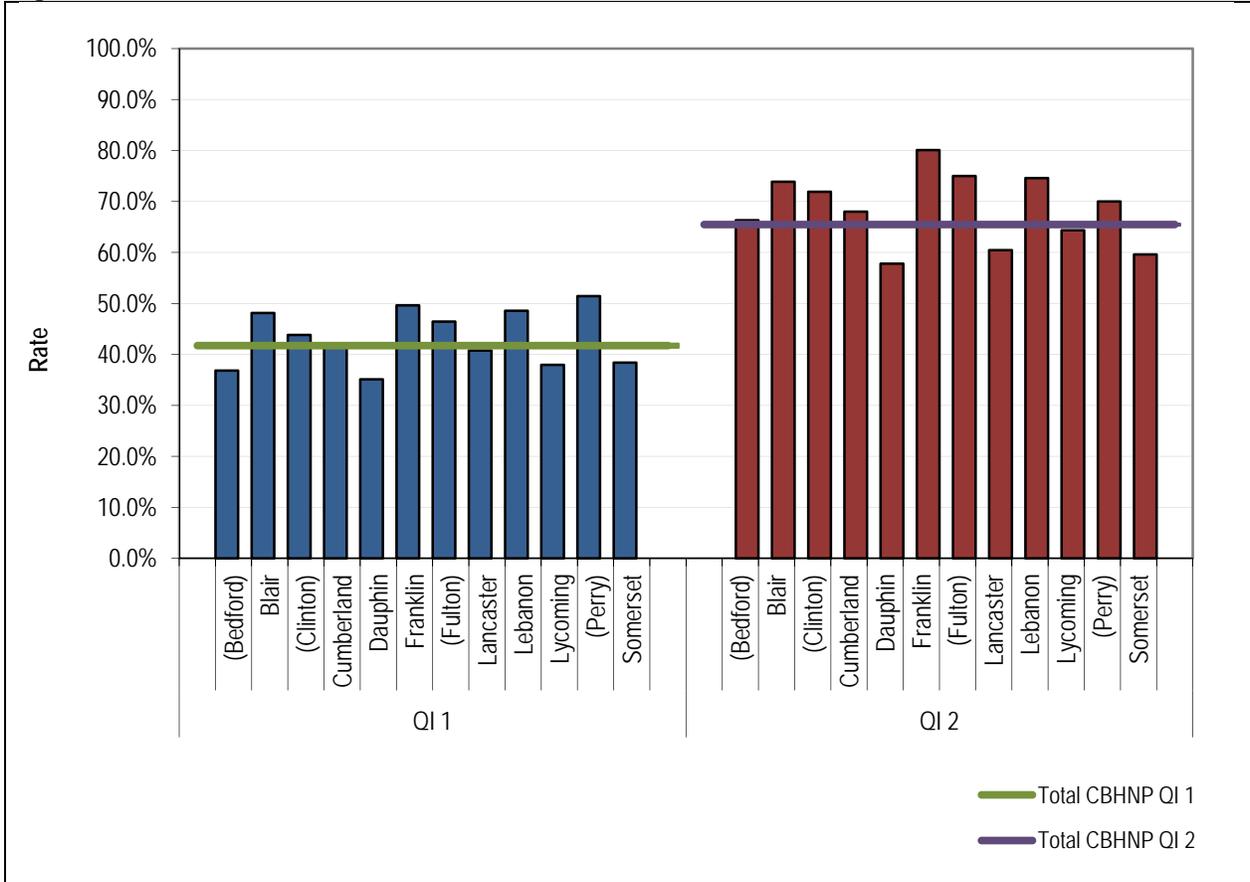
The MY 2010 HealthChoices behavioral health rates were 46.1% for QI 1 and 66.9% for QI 2. The QI 2 rate was statistically significantly higher than MY 2009. CBHNP's MY 2010 QI 1 rate was 41.7% and QI 2 rate was 65.5%; neither rate statistically significantly differed from the prior year.

The MY 2010 HealthChoices BH MCO Averages for QI 1 and QI 2 were 45.4% and 66.2%, respectively. For MY 2010, CBHNP's QI 1 rate was statistically significantly lower than the QI 1 HealthChoices BH MCO Average by 3.7 percentage points. The MY 2010 QI 2 rate did not differ statistically significantly from the QI 2 HealthChoices BH MCO Average.

As presented in Table 3.1, 12 Counties were contracted with CBHNP in MY 2010. For QI 1, the MY 2010 rate for Franklin County increased statistically significantly by 10.1 percentage points as compared to the prior measurement year. The MY 2010 QI 1 rates for the remaining 11 CBHNP Counties, and the QI 2 rates for all 12 CBHNP Counties, were not statistically significantly different from their respective MY 2009 rates.

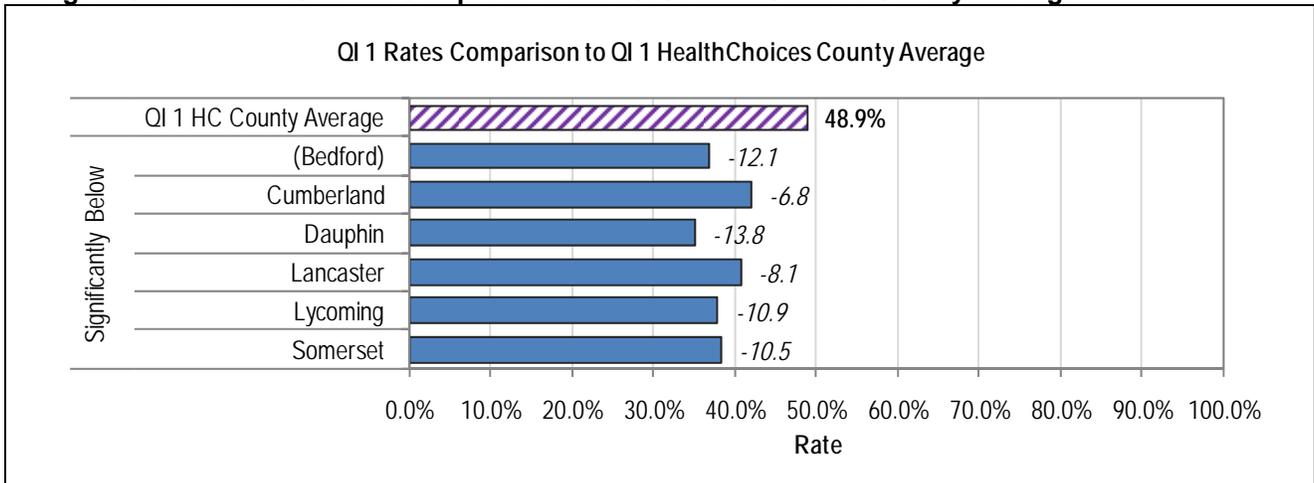
Figure 3.1 displays a graphical representation of the MY 2010 HEDIS follow-up rates for CBHNP and its associated Counties. Figure 3.2 presents the individual CBHNP Counties that performed statistically significantly above or below the HealthChoices County Averages for Q1 1 and Q1 2.

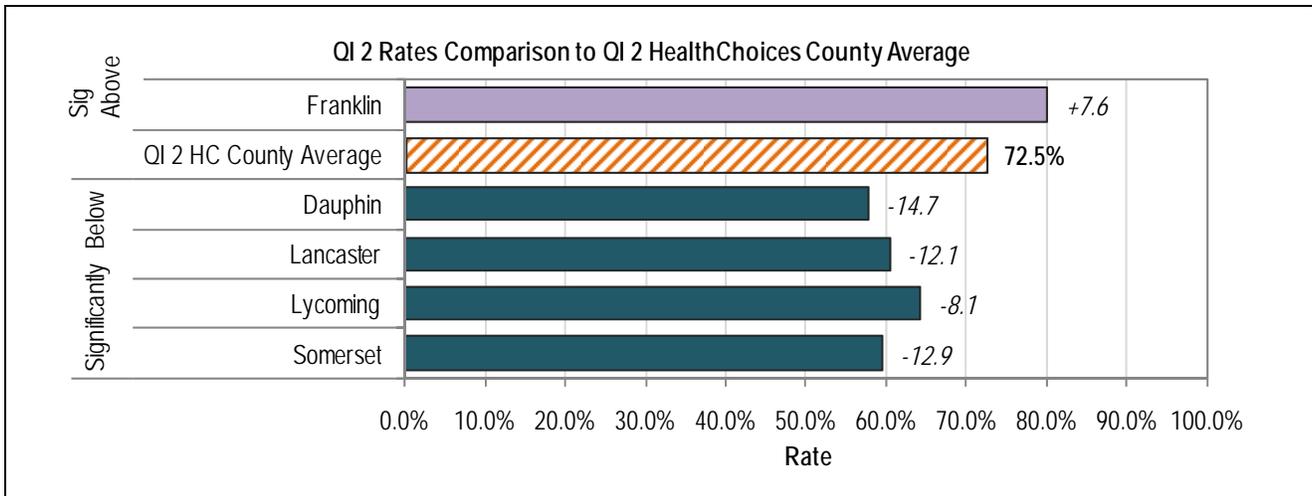
Figure 3.1 MY 2010 HEDIS Indicator Rates



Note: Rates represented by less than 100 discharges are indicated in parentheses.

Figure 3.2 HEDIS Rates Compared to MY 2010 HealthChoices County Average





Note: Rates represented by less than 100 discharges are indicated in parentheses.

In MY 2010, the QI 1 rate for Bedford, Cumberland, Dauphin, Lancaster, Lycoming, and Somerset Counties were statistically significantly below the MY 2010 QI 1 HealthChoices County Average of 48.9%. As for QI 2, the rate for Franklin County was statistically significantly higher, while the rates for Dauphin, Lancaster, Lycoming, and Somerset Counties were statistically significantly lower than the MY 2010 QI 2 HealthChoices County Average of 72.5%. Percentage point differences from the respective averages for QI 1 and QI 2 are noted in Figure 3.2.

Table 3.2 MY 2010 PA-Specific Indicator Rates with Year-to-Year Comparisons

	MY 2010							MY 2009	RATE COMPARISON MY 2010 to MY 2009	
	(N)	(D)	%	LOWER 95% CI	UPPER 95% CI	HEALTH- CHOICES BH MCO AVERAGE	HEALTH- CHOICES COUNTY AVERAGE	%	PPD	SSD
QI A										
HealthChoices	21,551	37,093	58.1%	57.6%	58.6%	57.5%	60.6%	58.9%	-0.8	YES
CBHNP	2,230	4,111	54.2%	52.7%	55.8%			56.3%	-2.1	NO
Bedford	53	95	55.8%	45.3%	66.3%			52.7%	3.1	NO
Blair	316	555	56.9%	52.7%	61.1%			60.5%	-3.6	NO
Clinton	52	89	58.4%	47.6%	69.2%			59.8%	-1.4	NO
Cumberland	154	278	55.4%	49.4%	61.4%			62.8%	-7.4	NO
Dauphin	486	832	58.4%	55.0%	61.8%			60.9%	-2.5	NO
Franklin	161	266	60.5%	54.5%	66.6%			54.2%	6.3	NO
Fulton	15	28	53.6%	33.3%	73.8%			51.9%	1.7	NO
Lancaster	525	1,082	48.5%	45.5%	51.5%			50.3%	-1.8	NO
Lebanon	182	315	57.8%	52.2%	63.4%			61.7%	-3.9	NO
Lycoming	142	303	46.9%	41.1%	52.6%			53.3%	-6.4	NO
Perry	36	70	51.4%	39.0%	63.9%			53.1%	-1.7	NO
Somerset	108	198	54.6%	47.4%	61.7%			50.6%	4.0	NO



	MY 2010							MY 2009	RATE COMPARISON MY 2010 to MY 2009	
	(N)	(D)	%	LOWER 95% CI	UPPER 95% CI	HEALTH- CHOICES BH MCO AVERAGE	HEALTH- CHOICES COUNTY AVERAGE	%	PPD	SSD
QI B										
HealthChoices	27,679	37,093	74.6%	74.2%	75.1%	74.1%	78.9%	75.0%	-0.4	NO
CBHNP	2,992	4,111	72.8%	71.4%	74.2%			74.8%	-2.0	YES
Bedford	73	95	76.8%	67.8%	85.8%			77.7%	-0.9	NO
Blair	432	555	77.8%	74.3%	81.4%			82.0%	-4.2	NO
Clinton	70	89	78.7%	69.6%	87.7%			78.2%	0.5	NO
Cumberland	206	278	74.1%	68.8%	79.4%			78.1%	-4.0	NO
Dauphin	618	832	74.3%	71.2%	77.3%			76.1%	-1.8	NO
Franklin	222	266	83.5%	78.8%	88.1%			81.0%	2.5	NO
Fulton	24	28	85.7%	71.0%	100.0%			70.4%	15.3	NO
Lancaster	702	1,082	64.9%	62.0%	67.8%			67.7%	-2.8	NO
Lebanon	248	315	78.7%	74.1%	83.4%			81.8%	-3.1	NO
Lycoming	212	303	70.0%	64.6%	75.3%			69.0%	1.0	NO
Perry	49	70	70.0%	58.6%	81.4%			71.9%	-1.9	NO
Somerset	136	198	68.7%	62.0%	75.4%			71.0%	-2.3	NO

Caution should be exercised when interpreting results for small denominators as they produce rates that are less stable. Rates produced for small denominators are subject to greater variability. For small populations, large differences in rates do not necessarily mean there is a statistically significant difference in rates.

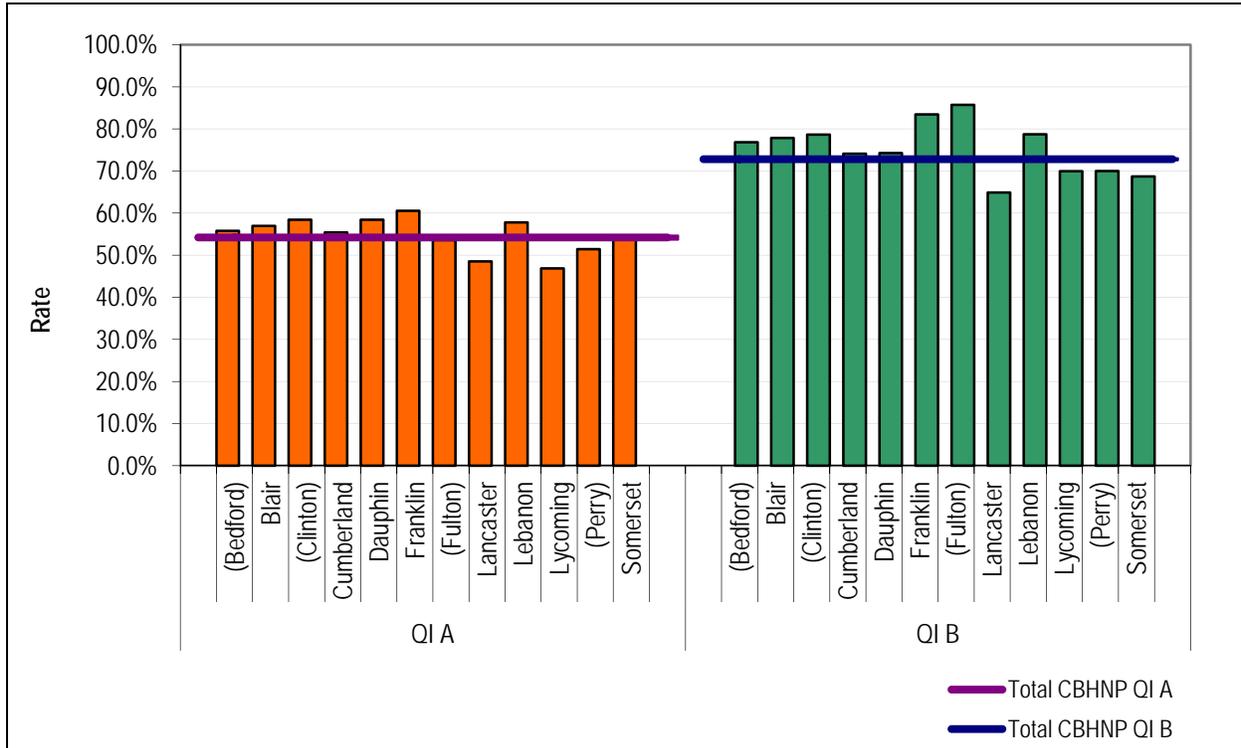
The MY 2010 HealthChoices behavioral health rates were 58.1% for QI A and 74.6% for QI B. The year-to-year decrease from MY 2009 was statistically significant for QI A. CBHNP's MY 2010 QI A rate was 54.2% and QI B rate was 72.8%. The QI B rate was a statistically significant decrease of two percentage points from the prior year.

As presented in Table 3.2, there were no statistically significant County rate changes between MY 2009 and MY 2010. Figure 3.3 displays a graphical representation of the MY 2010 PA-specific follow-up rates for CBHNP and its respective Counties. Figure 3.4 presents the individual CBHNP Counties that performed statistically significantly above or below the MY 2010 QI A and QI B HealthChoices County Averages.

The QI A rates for Lancaster and Lycoming were statistically significantly lower than the MY 2010 QI A HealthChoices County Average of 60.6%. The QI A rates for the remaining CBHNP Counties did not differ statistically significantly from the MY 2010 QI A HealthChoices County Average.

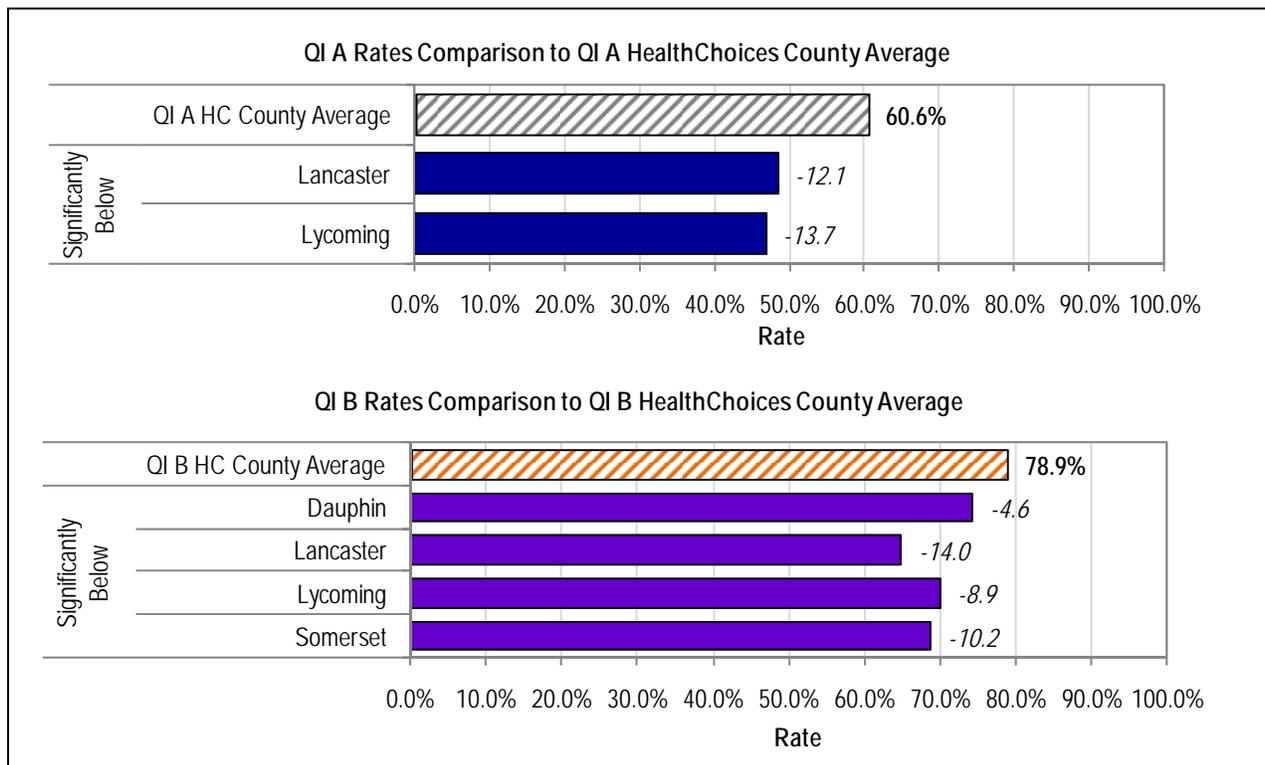
For QI B, the rates for Dauphin, Lancaster, Lycoming, and Somerset Counties were statistically significantly below the MY 2010 QI B HealthChoices County Average of 78.9%. The QI B rates for the remaining CBHNP Counties did not differ statistically significantly from the MY 2010 QI B HealthChoices County Average.

Figure 3.3 MY 2010 PA-Specific Indicator Rates



Note: Rates represented by less than 100 discharges are indicated in parentheses.

Figure 3.4 PA-Specific County Rates Compared to MY 2010 HealthChoices County Average





Comparison to HEDIS® Medicaid Benchmarks

The HealthChoices HEDIS indicator rates and BH MCO rates were compared to the *HEDIS 2010 Audit Means, Percentiles and Ratios* published by NCQA. The reference rates for national normative data contain means, 10th, 25th, 50th, 75th and 90th percentiles, and the enrollment ratios for nearly all HEDIS measures. There are tables by product lines (i.e., Commercial, Medicaid, and Medicare), so that the appropriate Medicaid benchmarks were used for comparison. NCQA's means and percentiles for each product line are generated annually using HMO, POS, and HMO/POS combined products from MCOs that underwent a HEDIS Compliance Audit™. Data were included from MCOs, regardless of whether the MCO did or did not report individual HEDIS rates publicly. The means and percentiles displayed in the *HEDIS 2010 Audit Means, Percentiles and Ratios* tables are based on data from the 2009 measurement year. The benchmark values are presented in Table 3.3.

Table 3.3 HEDIS 2010 Medicaid Benchmarks

MEDICAID	SUMMARY STATISTICS FOR RATES ACROSS MCOS					
	MEAN	10TH %ILE	25TH %ILE	MEDIAN	75TH %ILE	90TH %ILE
Follow-up After Hospitalization for Mental Illness – 7 Days	42.9	18.2	29.6	43.5	59.1	64.3
Follow-up After Hospitalization for Mental Illness – 30 Days	60.2	31.8	49.0	62.6	74.3	83.6

For MY 2010, the HealthChoices rates were 46.1% for QI 1 and 66.9% for QI 2. As compared to the HEDIS 2010 Medicaid benchmarks, the rates for both QI 1 and QI 2 fell between the 50th and 75th percentiles. In MY 2009, the QI 1 rate of 45.6% and QI 2 rate of 65.6% also fell between the 50th and 75th percentiles of the HEDIS 2009 Medicaid benchmarks.

When comparing the MY 2010 CBHNP rates to the HEDIS 2010 benchmarks, the QI 1 rate of 41.7% fell between the 25th and 50th percentiles, and the QI 2 rate of 65.5% fell between the 50th and 75th percentiles. Similarly, in MY 2009, CBHNP's QI 1 rate of 43.2% also fell between the 25th and 50th percentiles, and the QI 2 rate of 66.2% between the 50th and 75th percentile ranges of the HEDIS 2009 benchmarks.

BH MCO rates for various breakouts including race, ethnic groups, age cohorts, and gender were provided in the Follow-up After Hospitalization for Mental Illness EQR final report.

Conclusion and Recommendations

The study concluded that efforts should continue to be made to improve performance with regard to Follow-up After Hospitalization for Mental Illness particularly for those BH MCOs that performed below the HealthChoices BH MCO Average.

In response to the 2011 study, which represented results for MY 2010, the following general recommendations were made to all five participating BH MCOs:

Recommendation 1: The purpose of this re-measurement study is to inform OMHSAS, the Counties and the BH MCOs of the effectiveness of the interventions implemented between MY 2009 and MY 2010 to promote continuous quality improvement with regard to follow-up care after psychiatric hospitalization. The information contained within this study should be used to further develop strategies for improving the likelihood that at-risk members will receive follow-up care. The Counties and BH MCOs participating in this study should continue to evaluate the current interventions in place with respect to their follow-up rates to assess how these interventions affected change in follow-up rates from the prior measurement



years MY 2009 and MY 2008. The Counties and BH MCOs should continue to conduct additional root cause and barrier analyses to identify further impediments in receiving follow-up care, and then implement action and monitoring plans to further increase their rates.

Recommendation 2: The findings of this re-measurement indicate that disparities in rates between demographic populations continue to persist as seen in prior studies. It is clear that the OMHSAS contracted Counties and their subcontracted BH MCOs are working to improve their overall follow-up rates, but it is important for these entities to continue to target the demographic populations that do not perform as well as their counterparts. Furthermore, it is essential to ensure that improvements are consistent, sustained across measurement years, and applicable to all groups. It is recommended that BH MCOs and Counties continue to focus interventions on populations that continue to exhibit lower follow-up rates (e.g., Black/African American population). Possible reasons for these rate disparities include access, cultural differences and financial factors, which should all be considered and evaluated to determine their potential impact on performance. Additionally, the BH MCOs should be encouraged to initiate targeted interventions to address disparate rates between study populations.

Recommendation 3: BH MCO and Counties are encouraged to review the findings of the follow-up study in conjunction with inpatient psychiatric readmission rates, as professional literature consistently indicate a high correlation between these measures. Focused review of those individuals that had an inpatient psychiatric readmission in less than 30 days is recommended to determine the extent to which those individuals either had or did not have evidence of ambulatory follow-up/aftercare visit(s) during the interim period.

Recommendation 4: Additional analyses of each BH MCO's data should be conducted in order to determine if any other trends are noted. For example, lower follow-up rates may be associated with individuals with particular diagnoses, or with co-occurring conditions such as substance abuse and/or addiction. After evaluating the BH MCO data for trends, subject-specific findings should be transmitted to BH MCO and/or County care managers for implementation of appropriate action.

Additional recommendations for the 67 Counties and their subcontracted MCOs can be found in the 2011 Follow-up After Hospitalization for Mental Illness EQR final report.

Readmission within 30 Days of Inpatient Psychiatric Discharge

In addition to Follow up After Hospitalization for Mental Illness, OMHSAS elected to re-measure the Readmission within 30 Days of Inpatient Psychiatric Discharge indicator for this year's EQR. As directed by OMHSAS, IPRO developed the performance measure for implementation in 2008. Although initiated in 2008, OMHSAS requested that the first study in this area be focused on MY 2006 data. OMHSAS required the BH MCOs to perform another data collection and re-measurement of the performance measure for validation soon thereafter for MY 2007, then for MY 2008. Similarly, in 2010, a re-measurement study was conducted on MY 2009 data. The MY 2010 study conducted in 2011 was the fourth re-measurement of this indicator, and the indicator specification had no significant changes as compared to MY 2009. This measure continued to be of interest to OMHSAS for the purposes of comparing County and BH MCO rates to the OMHSAS performance goal and to baseline rates.

This study examined behavioral health services provided to members participating in the HealthChoices Behavioral Health Program. For the indicator, the criteria specified to identify the eligible population were product line, age, enrollment, anchor date, and event/diagnosis. To identify the administrative numerator positives, date of service and diagnosis/procedure code criteria were outlined, as well as other specifications as needed. This measure's calculation was based on administrative data only.

This performance measure assessed the percentage of discharges for enrollees from inpatient acute psychiatric care that were subsequently followed by an inpatient acute psychiatric care readmission within 30 days of the previous discharge.



Eligible Population

The entire eligible population was used for all 67 Counties participating in the MY 2010 study.

Eligible cases were defined as those members in the HealthChoices program who met the following criteria:

- Members with one (or more) hospital discharges from any inpatient acute psychiatric care facility with a discharge date occurring between January 1 and December 1, 2010;
- A principal ICD-9-CM diagnosis code indicating one of the specified mental health disorders;
- Enrolled on date of discharge from the first hospitalization event and on the date of admission of the second discharge event;
- The claim must be clearly identified as a discharge.

The numerator was comprised of members who were readmitted to inpatient acute psychiatric care within 30 days of the previous inpatient psychiatric discharge.

Methodology

A cross-sectional quality improvement study design was employed. The source for all information was administrative data provided to IPRO by the BH MCOs. The source for all administrative data was the BH MCOs' transactional claims systems.

Performance Goals

OMHSAS designated the performance measure goal as better than (i.e. less than) or equal to 10.0% for the participating BH MCOs and Counties. **This measure is an inverted rate, in that lower rates are preferable.**

Findings

BH MCO and County Results

The results are presented at the BH MCO and then County level when multiple Counties contract with a single BH MCO. Year-to-year comparisons of MY 2010 to MY 2009 data are provided. Additionally, as appropriate, disparate rates were calculated for various categories in the current study. The significance of the difference between two independent proportions was determined by calculating the z-ratio. SSD at the .05 level between groups are noted, as well as the PPD between the rates.

Individual rates are also compared to the categorical average. Rates statistically significantly above and below the average are indicated. The average takes the sum of the individual rates and divides the sum by the total number of sub-groups within the category. Therefore, all averages presented in this study are *not* weighted. Whether or not an individual rate performed statistically significantly above or below average was determined by whether or not that rate's 95% CI included the average for the indicator.

Lastly, aggregate rates are compared to the OMHSAS-designated performance measure goal of 10.0%. Individual BH MCO, County, and region rates are *not* required to be statistically significantly below 10.0% in order to meet the performance measure goal.



Table 3.4 MY 2010 Readmission Rates with Year-to-Year Comparisons

	MY 2010							MY 2009	RATE COMPARISON MY 2010 to MY 2009	
	(N)	(D)	%	LOWER 95% CI	UPPER 95% CI	HEALTH- CHOICES BH MCO AVERAGE	HEALTH- CHOICES COUNTY AVERAGE	%	PPD	SSD
HealthChoices	5,957	48,884	12.2%	11.9%	12.5%	12.4%	10.3%	12.1%	0.1	NO
CBHNP	680	5,236	13.0%	12.1%	13.9%			13.1%	-0.1	NO
Bedford	15	112	13.4%	6.6%	20.1%			11.0%	2.4	NO
Blair	60	690	8.7%	6.5%	10.9%			6.4%	2.3	NO
Clinton	12	112	10.7%	4.5%	16.9%			7.9%	2.8	NO
Cumberland	42	349	12.0%	8.5%	15.6%			16.3%	-4.3	NO
Dauphin	182	1,111	16.4%	14.2%	18.6%			13.7%	2.7	NO
Franklin	38	338	11.2%	7.7%	14.8%			12.5%	-1.3	NO
Fulton	2	31	6.5%	0.0%	16.7%			19.4%	-12.9	NO
Lancaster	216	1,398	15.5%	13.5%	17.4%			15.6%	-0.1	NO
Lebanon	34	356	9.6%	6.4%	12.7%			12.4%	-2.8	NO
Lycoming	39	400	9.8%	6.7%	12.8%			10.2%	-0.4	NO
Perry	7	87	8.1%	1.8%	14.3%			13.4%	-5.3	NO
Somerset	33	252	13.1%	8.7%	17.5%			12.8%	0.3	NO

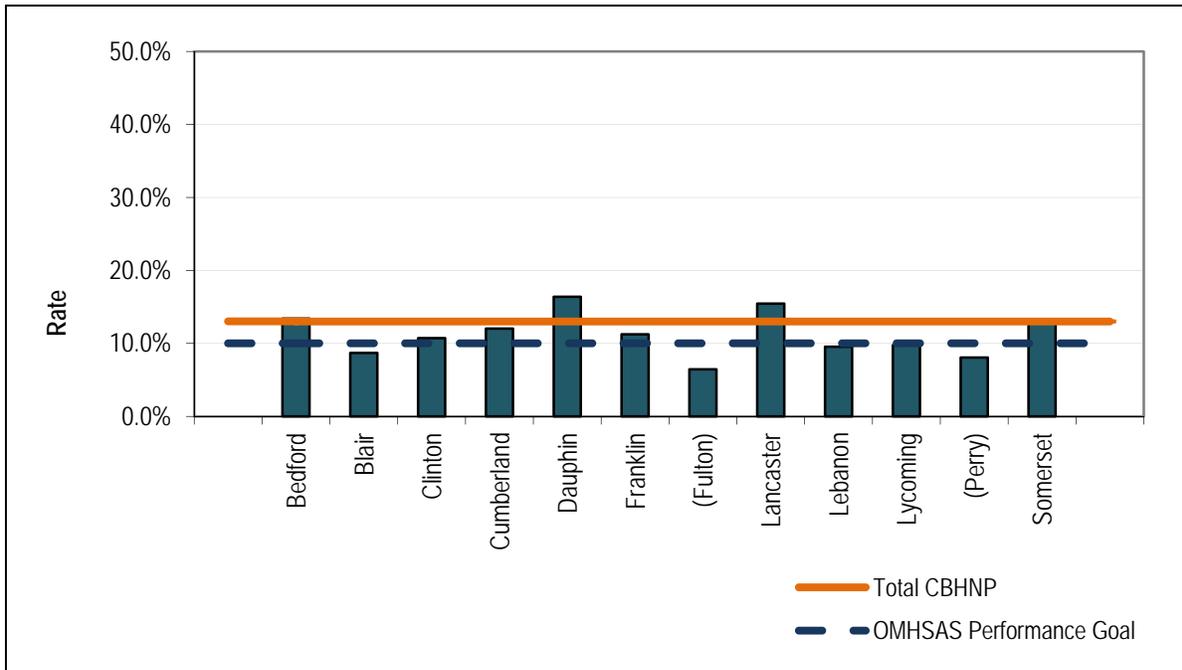
Caution should be exercised when interpreting results for small denominators as they produce rates that are less stable. Rates produced for small denominators are subject to greater variability. For small populations, large differences in rates do not necessarily mean there is a statistically significant difference in rates.

The aggregate MY 2010 HealthChoices readmission rate was 12.2%. CBHNP's readmission rate was 13.0%, although higher than, did not differ statistically significantly from the HealthChoices BH MCO Average of 12.4%, and did not meet the designated performance goal. Note that this measure is an inverted rate, in that lower rates are preferable.

As presented in Table 3.4, 12 Counties were contracted with CBHNP in MY 2010. None of the County rates changed statistically significantly from MY 2009.

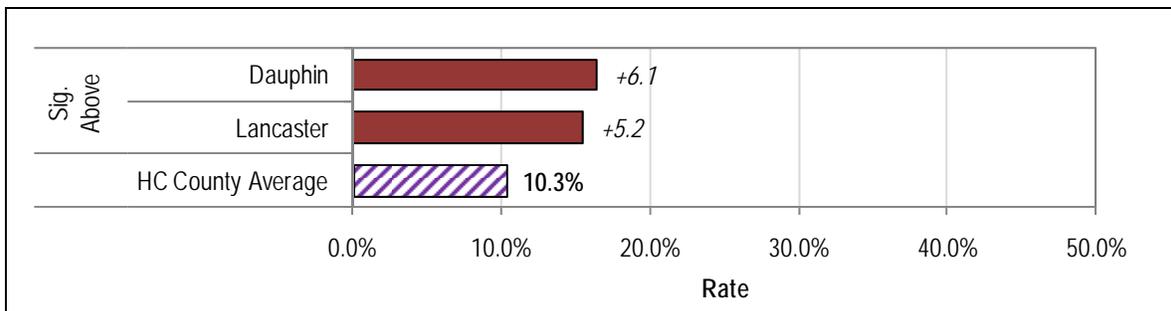
Figure 3.5 displays a graphical representation of the MY 2010 readmission rates for the CBHNP Counties. For MY 2010, the rates for Blair, Fulton, Lebanon, Lycoming, and Perry Counties met the performance goal of better than or equal to 10.0%. As compared to the MY 2010 HealthChoices County Average of 13.0%, the rate for Dauphin and Lancaster Counties were statistically significantly above (poorer than) the average. Note that this measure is an inverted rate, in that lower rates are preferable. Percentage point differences compared to the HealthChoices County Average are noted in Figure 3.6.

Figure 3.5 MY 2010 Readmission Rates



Note: Rates represented by less than 100 admissions are indicated in parentheses.

Figure 3.6 MY 2010 Readmission Rates Compared to HealthChoices County Average



Conclusion and Recommendations

The study concluded that continued efforts should be made to improve performance with regard to Readmission within 30 Days of Inpatient Psychiatric Discharge, particularly for those BH MCOs such as CBHNP that did not meet the performance goal, and/or performed below the HealthChoices BH MCO Average.

BH MCO rates for various breakouts including race, ethnic groups, age cohorts, and gender were provided in the Readmission within 30 Days of Inpatient Psychiatric Discharge final report.

In response to the MY 2010 study, the following general recommendations were made to all five participating BH MCOs:

- Given that no significant improvement was noted for any of the BH MCOs, IPRO recommends that the Counties and BH MCOs participating in this study conduct root cause analyses to help determine



what factors are negatively impacting readmission rates, and develop interventions that target specific barriers to improving the readmission rates.

- Each BH MCO should conduct additional analyses of the data in order to determine if any other trends are noted. For example, higher readmission rates may be associated with those individuals with particular diagnoses or co-occurring conditions such as substance abuse and/or addiction. Targeted analyses such as these should be evaluated as part of any root cause analysis. In addition, BH MCOs and Counties are encouraged to review the findings of the readmission study in conjunction with follow-up after hospitalization rates.
- Given the statistically different readmission rates observed for Black/African American and the White populations, which is driven by the Philadelphia County population, IPRO recommends that a performance improvement project that focuses on Disparities in Healthcare, with a focus on Philadelphia County, be undertaken. Fifty-six percent of all African American discharges occur in Philadelphia County.
- IPRO recommends continued annual evaluation of Inpatient Readmission after Psychiatric Discharge rates for OMHSAS contracted Counties and their subcontracted BH MCOs.
- Case management consideration should be given to those individuals who appear to be the highest utilizers of inpatient acute psychiatric care and have shown to be at risk for frequent readmission.
- Considerable variation by county was observed for all of the BH MCOs. BH MCOs should evaluate individual County rates, explore the underlying causes of variance by County, and identify those County practices or systems that may contribute to lower readmission rates.



IV: 2010 OPPORTUNITIES FOR IMPROVEMENT MCO RESPONSE

Current and Proposed Interventions

The general purpose of this section is to assess the degree to which each BH MCO has effectively addressed the opportunities for improvement cited by IPRO in the 2010 EQR Technical Reports, which were distributed in March 2011. The 2011 EQR Technical Report is the fourth report to include descriptions of current and proposed interventions from each BH MCO that address the 2010 recommendations.

The BH MCOs are required by OMHSAS to submit descriptions of current and proposed interventions using the Opportunities for Improvement form developed by IPRO to ensure that responses are reported consistently across the Pennsylvania Medicaid BH MCOs. These activities follow a longitudinal format, and are designed to capture information relating to:

- Follow-up actions that the BH MCO has taken through September 30, 2011 to address each recommendation;
- Future actions that are planned to address each recommendation;
- When and how future actions will be accomplished;
- The expected outcome or goals of the actions that were taken or will be taken; and
- The BH MCO's process(es) for monitoring the action to determine the effectiveness of the actions taken.

The documents informing the current report include the responses submitted to IPRO as of October 2011, as well as any additional relevant documentation provided by CBHNP.

Table 4.1 Current and Proposed Interventions: Opportunities for Improvement

Reference Number	Opportunity for Improvement	MCO Response
Structure and Operations Standards		
CBHNP 1	Within Subpart C: Enrollee Rights and Protections Regulations, CBHNP was partially compliant on one out of seven categories – Enrollee Rights.	<p><u>Follow Up Actions Taken Through 09/30/11</u></p> <p>5/10: CBHNP created a Consumer/family informational sheet that can be mailed out when a complaint or grievance is opened to review the enrollee rights that were discussed. Forms submitted to OMHSAS for review and approval.</p> <p>2010: Annual retraining of C & G staff</p> <p>2010: Annual retraining of Clinical staff (CCMs and MSS); Claims and PR staff</p> <p>During the past year, internal peer auditing occurred on a monthly basis to ensure rights were clearly explained and documented in the file. Audit results served to inform of the need for additional department training and/or increased individual supervision and training.</p> <p>During the past year, C & G department meetings continued on a weekly basis with the intent to ensure all staff are up to date on current processes and policies giving reminders on the expectations of how to handle complaints and grievances.</p> <p>10/10: Obtained approval from OMHSAS on the Consumer/family informational sheet and implemented use of the form with the expectation this process form would aid in increasing Consumer and families understanding of the process. Due to the volume of information provided verbally at the time of filing, the informational sheet can provide the necessary information for Consumers and families to assist in them through the process. This is not replacing the contact with from C&G staff and Consumers and families in providing assistance, but an addition to it and can be available to Consumers/families for repeated reference as needed throughout the process.</p> <p>1/11: CBHNP hired a psychiatrist dedicated to the resolution of grievances at the lowest level and resolving Member complaints with maximum Member satisfaction</p>



Reference Number	Opportunity for Improvement	MCO Response
		<p>as a goal. Psychiatrist left CBHNP 8/11. During the period, no survey results indicated dissatisfaction with the C & G process.</p> <p>Future Actions Planned The Complaint and Grievance Department continues to operate with 5 staff (1 Manager, 1 Lead Coordinator, 1 Coordinator/CFAS; 2 Coordinators; and 1 administrative assistant). 10/11: C & G Annual Training 11/11: MSS Annual Training 12/11: Regional Offices, CCMs, Claims and PR will receive annual retraining in C & G.</p>
CBHNP 2	<p>CBHNP was partially compliant on six out of 10 categories within Subpart D: Quality Assessment and Performance Improvement Regulations. The partially compliant categories were:</p> <ol style="list-style-type: none"> 1) Availability of Services (Access to Care), 2) Coordination and Continuity of Care, 3) Coverage and Authorization of Services, 4) Subcontractual Relationships and Delegation, 5) Practice Guidelines, and 6) Quality Assessment and Performance Improvement Program. 	<p>Follow Up Actions Taken Through 09/30/11 Network enhancements: 167 new practitioners, 80 psychiatrists, 2 RTF; 1 MH OP; 1 MH IP; 1 SAOP; 1 SA Res.; 1 MH PHP; 1 Psych Rehab; 2 PSS Programs, offering new alternatives to all. 1/11: Implemented revised clinical documentation review tool to evaluate CCMs ability to apply MNC & encourage active CM practices. Directs CCM to make quality of care referrals. 1/11: Established quality rate setting group to develop a process to incent providers to offer quality care giving consideration to the complexity of Members served. First LOC - RTF. 2/11: Implemented a PA documentation review process, conducted by QI, to evaluate the documentation of a rationale to support the decision & evaluate the appropriate application of MNC. Training/educational material is provided to PAs to ensure appropriate documentation. 3/11: Conducted a barrier analysis of access to BHRS, evaluating outcomes, identify remaining barriers and plan interventions to further improve over the next year 3/11: Implemented case reviews among the Physician/Psychologist advisors group to review MNC decision resulting in denial which lead to grievance. 4/11: Developed denial triggers to inform PA's of the need to reconsider prior to issuing denial and quality of care triggers to inform CCM's of the need to refer issues to QI for further review. 4/11: Formal Peer to Peer Consultation program established. 6/11: Expanded IRR testing to evaluate the consistency of decision making among PA's in addition to CCM's. Maintained moderate or better ratings for both CCM and PA's. Case consultations occur, as needed with the Medical Director regarding these cases. 7/11: Implemented CCM case conferencing for the presentation and discussion of complex cases by CCMs and the Medical Director. 7/11: Incorporated the review of provider profiling into BHRS quarterly meetings with providers. 8/11: Conducted a joint barrier analysis review of follow up after hospitalization and readmission rates to evaluate successful outcomes, identify remaining barriers and plan interventions to further improve over the next year. 2011: The development of evidence based/promising practices as service alternatives was a focus across the network to improve availability of services to Members. 2011: Evaluator education continued in the form of an electronic toolkit to inform evaluators of local alternatives to an over-utilized BHR service and stress the importance of the use of the least restrictive services with swift transfer of skills to natural supports.</p> <p>Future Actions Planned 10/11: Release Best Practice Guidelines for BHRS (TSS, MT, BSC) and Conducting</p>



Reference Number	Opportunity for Improvement	MCO Response
		<p>FBA's; twodocuments which have been in production throughout 2011 and are in the final stages of approvalwith OMHSAS. These guidelines should serve to assist providers in improving access to careand ensuring continuity of care.</p> <p>1/12: Scheduled to release update provider profiling results for all levels of care withenhancements in identifying performance measures and goals.</p> <p>4/12: Provider Relations representatives to being on-site visits to providers to share profilingresults with them and monitor their individual results toward improvement.</p> <p>2012: Implement the approved quality rate setting process (contingent upon OMHSAS approval)which will include a reliance on individual provider profiling results.</p> <p>2012: Finalize report development to improve outcomes reporting for exceptions services andalternative services.</p>
CBHNP3	<p>CBHNP was partially compliant on eight out of 10 categories within Subpart F: Federal and State Grievance System Standards Regulations. The partially compliant categories were:</p> <ol style="list-style-type: none"> 1) Statutory Basis and Definitions, 2) General Requirements, 3) Notice of Action, 4)Handling of Grievances and Appeals, 5)Resolution and Notification: Grievances and Appeals, 6) Expedited Appeals Process, 7) Continuation of Benefits, and 8)Effectuation of Reversed Resolutions. 	<p><u>Follow Up Actions Taken Through 09/30/11</u></p> <p>6/11: The transcription of level two grievances was brought in-house for completion with the discontinuation of a contract with an external source to improve the quality of transcriptions. Temporary administrative support was secured to address transcriptions until training could occur</p> <p>10/11: Permanent CBHNP staff assigned to this task within the C & G department.</p> <p>10/11: Confirmation that transcription and/or tape recording of the second level grievance meetings are maintained consistently within C & G documentation and is managed by the C & G administrative support staff.</p> <p>10/11: Confirmed evidence of participation and involvement in level two grievance meetings by County oversight via transcriptions and meeting sign in documentation.</p> <p>1/11: Grievance format is structured so that consumer satisfaction is paramount.</p> <p><u>Future Actions Planned</u></p> <p>10/11: Permanent administrative support to the C & G unit is in the process of being trained to complete future transcriptions.Continued monitoring of transcriptions and involvement of county oversight.</p>
Performance Measures		
CBHNP4	<p>CBHNP's rate for the MY 2009 Follow-up After Hospitalization for Mental Illness HEDIS indicator QI 1 was statistically significantly lower than the QI 1 HealthChoices BH MCO Average by two percentage points.</p>	<p><u>Follow Up Actions Taken Through 09/30/11</u></p> <p>Updated QI1 2010 results showed improvement for Bedford, Franklin, Fulton, Lancaster, Perry and Somerset but a decrease for Blair, Clinton, Cumberland, Dauphin, Lebanon and Lycoming. PR reps are currently working individually with the four providers with the worst follow up rates -All Seasons 50%, Holy Spirit 68%, Primary Network 69%, and Somerset 71%. The Meadows also initiated Child Telepsychiatry appointments in 2010 to meet the medicine check needs of members that were not able to be seen by their own psychiatrist for two months post discharge.</p> <p>8 – 10/10: Discharge planning/process documentation audit of MHIP Visits included wrap up discussion of findings, notification to facilities of results and a summary report with recommendations for improvement.</p> <p>6 – 8/11: Member Surveys were conducted to assess Member satisfaction with the discharge process in some contracts and will be repeated in 2011.</p> <p>Quarterly: Correlations drawn between facility and follow up rates where LGH and LRMC have shown a continued struggle which has lead to discussion to develop a bridge appointment in conjunction with a local outpatient program. Ongoing meetings are occurring with Lancaster MHMR/CBHNP and all area hospitals to</p>



Reference Number	Opportunity for Improvement	MCO Response
		<p>discuss issues on the unit and follow up rates.</p> <p>Future Actions Planned 10-11/11: The MHIP discharge planning/process documentation audit is being repeated. Approximately half of the facilities have been reviewed to date and are showing significant improvement in their results. Final results are forthcoming. Study individual correlations which can be targeted over time such as assessing the impact of TCM involvement or history of Substance Abuse Provider Relations did provide results of appointment availability survey, however, results were inconclusive. The survey was modified and will be repeated periodically throughout the year.</p> <p>Telepsychiatry was added in Lycoming/Clinton in 2010 thru CSG and is available in the Capital area thru NHS. F/F supports the use of Telepsychiatry through NHS if Members are interested in traveling to the Cumberland County site. Bedford/Somerset expanded Telepsychiatry in December, 2010.</p>
CBHNP5	<p>CBHNP's rate for the MY 2009 Follow-up After Hospitalization for Mental Illness PA-specific indicator QI A was statistically significantly lower than the QI A HealthChoices BH MCO Average by 2.3 percentage points.</p>	<p>Follow Up Actions Taken Through 09/30/11 Finalization of comprehensive mechanized report request remains pending, creating the need for the manual review of data by county/age/gender. Trends are identifying the need for individual correlations which can be targeted over time such as assessing the impact of TCM involvement or history of Substance Abuse. Example under Action section QI A results for 2010 show improvement for Bedford, Franklin, Fulton, and Somerset. However Blair, Clinton, Cumberland, Dauphin, Lancaster, Lebanon Lycoming and Perry decreased in this 7 day follow up rate The Top 4 Providers who did not provide an appointment within standard receiving assistance from PR Reps at the present time. The discharge planning/process documentation audit of MHIP was completed and included onsite discussion of results, letter of notification to the facility giving results and score, and a summary report of all findings with recommendations for improvement.</p> <p>The Member Survey is being restructured in attempt to gather more conclusive results and will be repeated in 2011. Correlations between facility and follow up rates continue on a quarterly basis. Lancaster General and LRMC have shown a continued struggle which has lead to discussion to develop a bridge appointment in conjunction with a local outpatient program.</p> <p>Future Actions Planned Repeat MHIP discharge planning/process documentation audit Educate providers on the use of TCM/Peer Support and mobile Psych when appropriate, following the MHIP Audit of 2010. One barrier noted in the 2010 audit was that Peer Support was not always available. In response to this, oversight funded peer support training.</p> <p>Ongoing conversations with Peer Support specialists who are willing to education MH IP providers with the possibility of PSS staff attending MHIP level of care meetings hosted by CBHNP and/or making education visits to MHIP units. Mobile psychiatric nursing is being expanded in several contracts.</p>
CBHNP6	<p>CBHNP's rate for the MY 2009 Readmission within 30 Days of Inpatient Psychiatric Discharge performance measure did not meet the OMHSAS</p>	<p>Follow Up Actions Taken Through 09/30/11 5/10: Implemented Fax Blast – Notifying all CM units of newly admitted Members via fax on a daily basis which enables CM to offer support to Members during inpatient as well as assisting in discharge/transitioning to aftercare. 6/11: Planning for Peer Support providers to further educate MH IP providers on the significant role Peer Support plays in MH IP.</p>



Reference Number	Opportunity for Improvement	MCO Response
	designated performance goal of 10.0%.	<p>9/11: Lancaster County Provider is in early discussion to establishing a Bridge appointment in Lancaster County. Similar service already exists in Cumberland/Perry and Dauphin. B/S is also in the preliminary planning stages, giving consideration to a Bridge appointment.</p> <p>9/11: Implementation of a crisis diversion unit in B/S.</p> <p>Ongoing: Continued efforts to increase awareness of co-occurring treatment issues through annual treatment record reviews.</p> <p>Future Actions Planned</p> <p>2012: Initiation of an RFP to increase Mobile Psych Nursing in some of counties noted to have higher readmission rates.</p> <p>2012: CBHNP Level of Care meetings for MH IP will include PSS presentations to educate providers on the significant role PSS can play in this level of care.</p> <p>2012: Emphasis on developing behavioral health service delivery in FQHC's throughout the network to expand service options and afford Members the opportunity to access integrated services at a single location.</p> <p>9 – 10/11: Completion of second round of MH IP discharge planning/recovery oriented documentation audit. At present approximately half of the facilities have been reviewed and are all showing improvement from round one scoring.</p> <p>10/11 PSS Education tool being created at the present time.</p>

Corrective Action Plan

When deficiencies were noted during the PEPS reviews, a Corrective Action Plan response was required from the BH MCO addressing those issues requiring follow-up action. CBHNP was not required to implement any corrective action plans in calendar year 2010.

Root Cause Analysis and Action Plan

The 2011 EQR is the third for which BH MCOs were required to prepare a Root Cause Analysis and Action Plan for performance measures performing statistically significantly poorer than the BH MCO average and/or as compared to the prior measurement year. The performance measures that were noted as opportunities for improvement in the 2010 EQR Technical Report required that the MCO submit:

- A goal statement;
- Root cause analysis and analysis findings;
- Action plan to address findings;
- Implementation dates; and
- A monitoring plan to assure action is effective and to address what will be measured and how often that measurement will occur.

IPRO reviewed each submission, and offered technical assistance to BH MCO staff. The BH MCOs were given the opportunity to revise and re-submit response forms as needed and as time permitted. For the 2011 EQR, CBHNP was required to prepare a Root Cause Analysis and Action Plan for the following performance measures and quality indicators:

- Follow-up After Hospitalization for Mental Illness QI 1 (HEDIS 7 Day)
- Follow-up After Hospitalization for Mental Illness QI A (PA-Specific 7 Day)

CBHNP submitted an initial Root Cause Analysis and Action Plan in March 2011, and a follow-up status update response to IPRO in October 2011.



Table 4.2 Root Cause Analysis for CBHNP – Follow-up After Hospitalization for Mental Illness HEDIS 7-Day Quality Indicator 1

Performance Measure																											
Follow-up After Hospitalization for Mental Illness QI 1 (HEDIS 7 Day)																											
Goal Statement																											
<p>Short Term goal: Increase Num 1 Territory (All 12 Counties combined) Rate for Follow Up after discharge by 7% (The 2009 rate for the Territory was 43.2% and the rate will increase to 46.2%) by the end of 2011.</p> <p>Long Term goal: Increase Num 1 Territory (All 12 Counties combined) Rate for Follow Up after discharge to equal or exceed current interim HEDIS goal of 57.4% by the end 2013.</p>																											
Policies	Initial Response																										
(e.g., data systems, delivery systems, provider facilities) <ol style="list-style-type: none"> 1. CBHNP Fee Schedule 2. CBHNP Credentialing Process 3. CBHNP Policy & Procedures 4. HIPAA 5. HealthChoices Contracts 6. Data Systems 7. Provider Network 	<ul style="list-style-type: none"> • Num 1 results for all Counties: <table border="1" style="margin-left: 40px;"> <thead> <tr> <th>County</th> <th>HEDIS_7%</th> </tr> </thead> <tbody> <tr><td>BD</td><td>28.6%</td></tr> <tr><td>BL</td><td>50.8%</td></tr> <tr><td>CT</td><td>46.0%</td></tr> <tr><td>CU</td><td>46.3%</td></tr> <tr><td>DA</td><td>39.9%</td></tr> <tr><td>FR</td><td>39.5%</td></tr> <tr><td>FU</td><td>48.1%</td></tr> <tr><td>LA</td><td>40.2%</td></tr> <tr><td>LB</td><td>55.6%</td></tr> <tr><td>LY</td><td>43.6%</td></tr> <tr><td>PE</td><td>42.2%</td></tr> <tr><td>SO</td><td>36.4%</td></tr> </tbody> </table> • The current fee schedule for inpatient facilities allows for individually negotiated per diems; current fees are in line with MA FFS; minimal requests are received annually; and of those received, all are agreed upon by CBHNP and provider. No known reimbursement issues are identified. • The current credentialing process presents no known barriers for inpatient facilities that would impact their rate of follow up. Out of network arrangements are always permitted to ensure continuity of care and/or the need for emergent or specialized care to meet Member need. Such arrangements afford adequate reimbursement. • The current policies related to MH inpatient or readmission such as CM-032 Decision Making, Clinical guidelines, Ethical standards and CM-011 Clinical Care Management Decision Making and Trigger Lists support active care management strategies and do not impede admissions and/or follow up care. • Current HIPAA regulations prevent emailing critical Member information which challenges providers when attempting to communicate quickly and easily. Providers typically do not have highly secure email systems. • Current HealthChoices contracts do not allow for consequences to Members who do not show for follow up appointments and providers feel Member's recognize this. Providers feel this rule creates a negative impact on follow up as it does not encourage participation in aftercare. Reported at 2/2/11 Provider Meeting. • The current reporting capacity is limited to Num results, hospital correlations, county and age comparisons but other details such as TCM, substance abuse history; high risk designation, readmission details and race must be all compiled manually. Trends cannot be determined, limiting interventions which can be constructed. The manual handling of data is not feasible for some of the 12 counties due to high admission rates. 	County	HEDIS_7%	BD	28.6%	BL	50.8%	CT	46.0%	CU	46.3%	DA	39.9%	FR	39.5%	FU	48.1%	LA	40.2%	LB	55.6%	LY	43.6%	PE	42.2%	SO	36.4%
County	HEDIS_7%																										
BD	28.6%																										
BL	50.8%																										
CT	46.0%																										
CU	46.3%																										
DA	39.9%																										
FR	39.5%																										
FU	48.1%																										
LA	40.2%																										
LB	55.6%																										
LY	43.6%																										
PE	42.2%																										
SO	36.4%																										

	<p><i>Root Cause: Limited reportable data in meeting the 7 day HEDIS standards. Minimal actions can be taken to focus on correlations that may be preventing follow up within 7 days.</i></p> <ul style="list-style-type: none"> • 2009 Follow Up Report data identifies the following Top 5 Providers who did not provide an appointment within standard: <ul style="list-style-type: none"> ○ Holy Spirit (Cumberland) 49%, Summit Behavioral Health (Franklin) 47%, Nulton (Blair/Bedford/Somerset) 41%, Altoona Regional (Blair) 37.5% and Behavioral Health Specialist (Lancaster) 35%. • Provider Network has several reported issues including limited psychiatrist time, limited child and adolescent appointments available within 7 days and specifically in Dauphin County limited OP as reported in the brainstorming session with Providers held on 2/2/11. <p><i>Root Cause: MH IP providers report when they ask for an appointment within 7 days. Not all providers' children services preventing follow up within standard 7 days.</i></p>
	<p><i>Follow-up Status Response</i></p> <p>Finalization of comprehensive mechanized report request remains pending, creating the need for the manual review of data by county/age/gender. Trends are identifying the need for individual correlations which can be targeted over time such as assessing the impact of TCM involvement or history of Substance Abuse. Example under Action section</p> <p>Updated Num 1 2010 results for all counties are as follows: BD 36.8%, Blair 48.1%, CT 43.8% Cu 42.1%, DA 35.1%, FR 49.6%, FU 46.4%, LA 40.8%, LB 48.6%, LY 38.0%, PE 51.4% SO 38.4%. The rates for the following counties improved Bedford, Franklin, Fulton, Lancaster, Perry and Somerset. Blair, Clinton, Cumberland, Dauphin, Lebanon and Lycoming decreased in the 7 day follow up rate. Finalization of comprehensive mechanized report request remains pending, however, manual workaround has been manageable for trending by county/age/gender. Trends are identifying the need for individual correlations which can be targeted over time such as assessing the impact of TCM involvement or history of Substance Abuse.</p> <p>2010 Follow Up report identifies the following Top 4 MH OP Providers who did not provide an appointment within standard: All Seasons 50%, Holy Spirit 68%, Primary Network 69%, and Somerset MHMR 71% PR reps have been asked to follow up with providers individually.</p> <p>2010 Follow up detail report identified that Dauphin County providers do not have an issue with provide the follow up appointment within 7 days. Dauphin County currently has 19 Mental Health Outpatient sites and one Partial Hospitalization program for Children. HEDIS rates are not improving in Dauphin County but this does not appear to be a capacity issue. Further analysis of the 7 day follow will be reviewed for this County. One option maybe a lack of flexibility of Scheduling. The improved BHRS process may impact the children/adolescent rates in 2011 for all counties.</p>
<p><i>Procedures</i> (e.g., payment/reimbursement, credentialing/collaboration)</p> <ol style="list-style-type: none"> 1. Communication 2. Transportation 	<p><i>Initial Response</i></p> <ul style="list-style-type: none"> • In 2010 the records of 18 MH IP hospitals (moderate to high volume hospitals from all 12 counties) were reviewed for discharge planning/process documentation. Only 67% of the records reflected collaboration with family/friends. • The above stated record review identified that MH IP providers were not fully collaborating with other MH providers consequently, only 69% of the records reviewed reflected communications that could have assisted Members in making treatment decisions while on the inpatient unit which, in turn, could have improved

	<p>the success of follow up.</p> <ul style="list-style-type: none"> • A Member survey developed specifically for the Root Cause Analysis incorporating all counties was completed in 2/11 which also asked Members if family/friends were included in the discharge planning. 50% of the 22 Members surveyed reported they did NOT have collaboration which may have hindered follow up. • In Franklin and Fulton County an independent survey was also completed in November of 2010. The survey focused on Member satisfaction and discharge process after an inpatient stay with 54 Members participation. The survey findings reported that only 63% of the Members remember having more than one conversation about discharge planning which is a significant finding in itself. The Members were also asked during the discharge process if they had family/friend support and of the 44 Members who responded yes only 36 of the Members had family/friends contacted to assist in the discharge planning indicating a breakdown in good discharge planning. • Members continue to report ongoing transportation such as van rides which are too long; vans not on time, making Members late for appointments; and limited access to MATP in rural areas. This is a barrier for treatment and is discussed at the county level for ways to improve the system. <p><i>Root Cause: a lack of communication and collaboration with family/friends and other MH OP providers has impacted Member attending within 7 days after discharge creating an additional barrier to treatment.</i></p> <p>Follow-up Status Response</p> <p>In 2011, the discharge planning/process documentation audit of MHIP is being repeated. Approximately half of the facilities have been reviewed to date and are showing significant improvement in their results. Final results are forthcoming.</p> <p>The Member Survey is being restructured in attempt to gather more conclusive results and will be repeated in 2011.</p> <p>See Action Steps for additional information.</p>
<p>People (e.g., personnel, provider network, patients)</p> <ol style="list-style-type: none"> 1. Clinical Care Managers 2. Follow Up Specialists 3. Members 4. Providers 	<p>Initial Response</p> <ul style="list-style-type: none"> • Feedback was obtained from Clinical Care Managers (CCM) at CBHNP in meetings held on 2/4 and 2/16/11 to discuss barriers to treatment from a Clinical Care Managers perspective. CCMs reported Members are not included in the discharge process and are unsure of their follow up appointments. They also report Members sometimes inform the MH IP provider that they already have a scheduled appointment previously made but the IP facilities do not verify the appointment. Some IP units give CCM false information related to follow up appointments. • Data from the 2009 Follow Up reporting indicates that 1789 (41%) Members (adult and child) did attend an appointment within 7 days but 813 (19%) of the Members either declined, were a no show, were a no show but rescheduled outside the 7 days, cancelled, cancelled but rescheduled outside the 7 days, went AMA or AWOL from MH IP or the MH OP agency denied record of the appointment. These are all Member choice assertions which are largely beyond the control of the provider or the MCO, however, perhaps could be impacted by creating a strong therapeutic alliance between Members and treating provider. • Follow-Up Specialist completed a 22 Member survey in 2/11 and noted that 27% of the Members surveyed were not in agreement with follow up appointments and only 50% remember being asked about barriers to treatment at the time the appointment was being scheduled. The MH IP record review substantiates this claim by noting 38% of the Members were in agreement or present when their appointments were made and 43% of Members had documentation of barriers identified and addressed during

the admission process.

- In Franklin and Fulton County an independent survey was also completed in November of 2010. The survey focused on Member satisfaction and discharge process after an inpatient stay with 54 Members participation. Follow up after 7 days was measured and of the 54 Members 46 Members reported they did have an appointment set up for them after discharge but only 34 (63%) had an appointment within 7 days. Eight Members were unsure and four did not have an appointment with 7 days. These finding further substantiate the breakdown in good discharge planning only slightly higher than half were seen in 7 days.
- Providers also offered additional feedback in the 2/2/11 brainstorming session. Levels of care represented in attendance included MH IP, OP and TCM providers. Findings from provider experience or Member surveys and support that some Members refuse a 7 day appointment, some Members feel Peer Support is too intrusive, housing issues are increasing in the past two years, the benefit of follow up is not clear to the Member, Members feel discharge instructions are too confusing, some Members prefer going to a PCP instead of a psychiatrist and that it is hard for Members to go to a new provider who is unknown to them. MH IP Providers reported being unaware of Members having TCM and TCMs are reporting being aware that their Members are on an inpatient unit which further contributes to poor collaboration. * 2010, Follow Up Specialist initiated a fax to all TCM providers with a list of their Members who were admitted to an IP unit. This was initiated to improved TCM involvement which was a need noted in the 2009 RCA.
- QI Clinical Managers report quarterly correlations between follow up rates and hospitals. Data indicates some vertically integrated systems have better follow-up numbers which suggests that partnerships, linkages, formal agreements are key, for every hospital system even if they don't provide OP services. The table below offers an example of non-follow up rates of 8 hospitals and whether they offer continuity of care.

Hospitals with Continuity	Hospitals with Limited to No Continuity
18% - Philhaven	41% - Lancaster Regional
21% - Pennsylvania Psychiatric Institute	38% - Lancaster General
18% - Altoona Regional	45% - Divine Providence
21% - Somerset	38% - Brooke Glen

- CBHNP proactively initiated a Telephonic Care Management (TCARE) which is a pilot designed to reduce readmissions to inpatient care and improve Member attendance at aftercare treatments. The TCARE pilot was implemented in Blair County for an enrollment period of 3 months from 11/1/10-1/31/11. The pilot was designed to contact Members while they were still on the unit to begin a relationship with the Member which would continue after their discharge from the unit. Post discharge, weekly calls, for a period of up to 12 weeks, would be made to assist the Member in identifying and resolving barriers to attending aftercare appointments. Results of TCARE will be compared to the outcomes of admissions to inpatient care in the same county from the previous year 11/1/09-1/31/10. Results are pending but 20 (34%) Members opted to participate in TCARE out of 58 who were either contacted and decline or no contact was able to be made. Out of the 20 Members discharged 14 attended an appointment within 7 days and 3 additional Members attended before 30 days for a success rate of 85%.

Root Cause: Although MH IP providers are educating Members on the significance of aftercare and report they are addressing barriers while on the unit, barriers continue to exist for Members and the no show rate remains too high.

	Follow-up Status Response											
	<p>For the first six months of 2011, data from 2010 Follow Up report indicates: 892 (47%) of Members – Adult and Child, did attend an appointment within 7 days, however, 828 (43%) Members either declined, were a no show, rescheduled outside of the 7 days, cancelled, were AMA/AWOL from MHIP or the MHOP denied record of the appointment. The remaining 10% included readmissions, PCP follow up, Prison, level to level transfers, or admissions to Halfway House, CRR HH or RTF.</p> <p>In the above mentioned Member Survey, Follow up Specialists will be completing a new survey in 2011 which will include a question about barriers to treatment.</p> <p>Correlations between facility and follow up rates continue on a quarterly basis. Lancaster General and LPMC have shown a continued struggle which has lead to discussion to develop a bridge appointment in conjunction with a local outpatient program. Ongoing meetings are occurring with Lancaster MHMR/ CBHNP and all area hospitals to discuss issues on the unit and follow up rates.</p>											
	<table border="1"> <thead> <tr> <th>Hospitals with Continuity</th> <th>Hospitals with Limited to No Continuity</th> </tr> </thead> <tbody> <tr> <td>9% - Philhaven</td> <td>49% - Lancaster Regional</td> </tr> <tr> <td>24% - Pennsylvania Psychiatric Institute</td> <td>39% - Lancaster General</td> </tr> <tr> <td>23% - Altoona Regional</td> <td>58% - Divine Providence</td> </tr> <tr> <td>22% - Somerset</td> <td>54% - Brooke Glen</td> </tr> </tbody> </table>		Hospitals with Continuity	Hospitals with Limited to No Continuity	9% - Philhaven	49% - Lancaster Regional	24% - Pennsylvania Psychiatric Institute	39% - Lancaster General	23% - Altoona Regional	58% - Divine Providence	22% - Somerset	54% - Brooke Glen
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<p>Some hospitals continue to struggle but rates are also influenced by third party insurance, appropriate substance abuse treatment and PCP follow up which counted in this rate. Divine Providence rate is influenced by claim issues on the hospital's part.</p> <p>While initial T-Care results were considered favorable, expansion of the pilot has not occurred pending further investigation of staffing resources and addressing administrative barriers verbalized by providers during the pilot.</p>												
Initial Response												
<ul style="list-style-type: none"> Limited electronic medical records use and/or permitted exchange of treatment information (some due to SA confidentiality) across all providers Lack of authority at the MCO to dictate exchange of information protocols among providers. Inability for MCO to consider positive co-occurring treatment options when Member follow up is with an SA provider. Not all providers are following protocol and faxing discharge instruction sheets to other providers which hinders continuity of care. 												
Provisions (e.g., screening tools, medical record forms, provider and enrollee educational materials)	Follow-up Status Response											
	No follow-up needed.											
Other	Initial Response											
	None											
	Follow-up Status Response											
None												
Action and Monitoring Plan												
Action Plan	Implementation Date	Monitoring Plan										
<i>Root Cause: Limited reportable data in meeting</i>		<i>Initial Response</i>										

the 7 day HEDIS standards. Minimal actions can be taken to focus on correlations that may be preventing follow up within 7 days.

Action: Modification of current report has been requested through IT and results will be analyzed and current Provider rates and trends will be collected quarterly. It is important to note that the two lowest Num 1 results in 2009 (Bedford/Somerset) were acknowledge and in 2010 Tele-psychiatry was initiated and therapist hours were increased significantly at the largest Provider for these counties. These actions have impacted significantly the 2010 rates for both counties.

1. Quality Improvement Project Managers (QPMs) discussed information that may be needed and made a collective request for information to the IT department in the spring of 2010. Request currently pending on list of projects to be completed.
2. QPMs will meet with IT business analysts to review reporting changes when report is scheduled for development by IT.
3. QPMs will vet changes in reporting by county and implement validated report
4. QPMs will monitor report quarterly and observe for specific trends that may impact follow up.
5. QPMs will review findings with PR Team to discuss corrective actions plans for Providers who are not able to offer appointments within 7 days.

QPM will advocate prioritizing the data request to collect additional needed information to properly assess, monitor and trend identified factors related to follow up.

- QPMs will monitor quarterly both the MH IP provider results of Members who did not follow up with treatment and review quarterly the MH OP provider specifics details noted in the Follow Up Report which measures the 7 day standard compliance
- QPMs will monitor HEDIS rates Num 1 quarterly and analyze for trends based on race, readmissions, substance treatment and current open authorizations when the data becomes available

Follow-up Status Response

Finalization of comprehensive mechanized report request remains pending, creating the need for the manual review of data by county/age/gender. Trends are identifying the need for individual correlations which can be targeted over time such as assessing the impact of TCM involvement or history of Substance Abuse. A sample report is as follows:



Root Cause: Some providers are reporting limited capacity for MH OP and children services preventing follow up within standard 7 days.

Action: A survey of current Mental Health Outpatient (MH OP) providers' capacity needs to be completed to assess the correlation between capacity and providers offering appointments within the 7 day standard.

1. Current data only allows for a retrospective view of providers not offering within 7 days and is not proactive. Actions this year will need to include a clearer picture of network capabilities opposed to MH OP Providers not offering flexibility.
2. QI PM will develop a survey for Provider Relations to distribute and collect to all MH OP providers in network by April of 2011. QI

- QPMs will monitor quarterly both the MH IP provider follow up rates of Members who did not follow up with treatment and review quarterly the MH OP provider specifics details noted in the Follow Up Report which measures the 7 day standard compliance
- QPMs will monitor HEDIS rates Num 1 quarterly and analyze for trends per county per provider.

Follow-up Status Response

Provider Relations did provide results of appointment availability survey, however, results were inconclusive. The survey was modified and will be repeated periodically throughout the year.

MHIP follow rates of those Members who did not follow up and the correlating discharge hospital are reviewed quarterly and outreach to the hospitals with high no-follow up rates is completed by a PR Rep.



<p>to collect, compile and report results.</p> <p>3. QI PM will complete analysis of survey findings and compare capacity with a sample of OP authorizations from 2010.</p> <p>4. QI PM will offer recommendations based on data to Management team to determine actions that can be taken to improve the 7 day standard.</p>		<p>For the first six months of 2011, data from 2010 Follow Up report indicates the following measure of compliance within the 7 day standard:</p> <p>892 (47%) of Members – Adult and Child, did attend an appointment within 7 days, however, 828 (43%) Members either declined, were a no show, rescheduled outside of the 7 days, cancelled, were AMA/AWOL from MHIP or the MHOP denied record of the appointment. The remaining 10% included readmissions, PCP follow up, Prison, level to level transfers, or admissions to Halfway House, CRR HH or RTF.</p> <p>Telepsychiatry was added in Bedford/Somerset in 2010 with 2 providers in each county Bedford/Somerset MH/MR and Nulton Diagnostic. Lycoming/Clinton in 2010 thru CSG and Franklin/Fulton has telepsychiatry now available through NHS. The Meadows also initiated Child Telepsychiatry appointments in 2010 to meet the medicine check needs of members that were not able to be seen by their own psychiatrist for two months post discharge.</p> <p>Updated Num 1 2010 Validated Rates for all counties are as follows:BD 36.8%, Blair 48.1%, CT 43.8% Cu 42.1%, DA 35.1%, FR 49.6%, FU 46.4%, LA 40.8%, LB 48.6%, LY 38.0%, PE 51.4% SO 38.4%. The rates for the following counties improved Bedford, Franklin, Fulton, Lancaster, Perry and Somerset. Blair, Clinton, Cumberland, Dauphin, Lebanon and Lycoming decreased in the 7 day follow up rate.</p> <p>2010 Follow Up report identifies the following Top 4 MH OP Providers who did not provide an appointment within standard:All Seasons 50%, Holy Spirit 68%, Primary Network 69%, and Somerset MHMR 71% PR reps have been asked to follow up with providers individually.</p> <p>2010 Follow up detail report identified that Dauphin County providers do not have an issue with provide the follow up appointment within 7 days. Dauphin County currently has 19 Mental Health Outpatient sites and one Partial Hospitalization program for Children. HEDIS rates are not improving in Dauphin County but this does not appear to be a capacity issue. Further analysis of the 7 day follow will be reviewed for this County. One option maybe a lack of flexibility of Scheduling. The improved BHRS process may impact the children/adolescent rates in 2011 for all counties.</p>
<p><i>Root Cause: A lack of communication and collaboration with family/friends and other MH OP providers has impacted Member attending within 7 days after discharge creating an additional barrier to treatment.</i></p>		<p>Initial Response</p> <ul style="list-style-type: none"> QI PM will monitor MH IP audit results based on the same 10 indicators from the record review in 2010. Outcomes will be measured for differences from previous year per provider and for the network

<p>Action: Follow up from response to a previous educational opportunity in 2010 with MH IP providers to determine success or need for further interventions and implement new procedure to enhance collaboration and lessen barriers.</p> <ol style="list-style-type: none"> 1. From 8/10 to 10/10, 18 high to moderate volume MH IP providers received an onsite record review to monitor discharge process and use of recovery principles. Immediate education and feedback was given with a follow up letter to the CEO of the facility and the nurse manager. A record review in 9/11 will be initiated to determine effectiveness of the previous educational opportunity. 2. Follow Up Specialist will repeat the Member Survey from 9/10 and expand the scope to correlate the Member's perception of their discharge experience and if collaboration with family and friends occurred. 3. CBHNP will initiate a pilot study in April through June of 2011 with 2 Capital hospitals and 2 North Central hospitals who will fax their discharge instruction sheet to the OP provider and CBHNP. Internally, QI staff will review the discharge instruction sheet for completion and review for accuracy between what the MH IP provider verbally reported to Clinical Care Mangers and was subsequently placed in the eCura system and what is on the discharge sheet. Additionally, QI will request MH OP Providers acknowledge if they have received the discharge instruction sheet to measure follow through by the IP Provider. Follow Up Specialist will call the Member within 72 hours of discharge to review the follow up plans and clarify if there are any current barriers for follow up to occur. If barriers are identified, the Follow Up specialist will assist in solutions. 		<p>system.</p> <ul style="list-style-type: none"> • QI PM will monitor the Member Survey results on the same 5 indicators from the 2/11 survey and compare and report results and note changes in the data. • QI PM will measure outcomes of success from the pilot based on total number of discharge instruction sheet faxed to CBHNP, to MH OP providers and the accuracy of the information between the fax and verbal discharge information. If successful, the requirement for faxing d/c summaries to all entities will be required. Additional outcomes will be based on the hospital correlation/follow up rate and the Num results by county who are involved which are done quarterly by the Clinical Care Managers. <p>Follow-up Status Response</p> <p>In 2011, the discharge planning/process documentation audit of MHIP is being repeated. Approximately half of the facilities have been reviewed to date and are showing significant improvement in their results. Final results are forthcoming.</p> <p>In the above mentioned Member Survey, Follow up Specialists will be completing a new survey in 2011 which will include a question about barriers to treatment.</p> <p>The pilot study of discharge appointment accuracy provided the following data:</p> <ul style="list-style-type: none"> • Total unique Members – N = 72 • Total number of appointments = 95 • Appointments offered with 7 days 74 (78%) • 81% of discharge sheets matched eCura • 80% of aftercare providers confirmed accuracy of appointment (SA confidentiality regs impeded our ability to fully assess) <p>Unfortunately only eleven Members were successfully contacted during the survey and of those two identified barriers to treatment; however, the MHIP facility did not offer solutions to the barrier prior to discharge. We are not presently planning to repeat this pilot due to positive results and negative feedback from providers while attempt to complete the survey.</p> <p>Blair County CFST completed a member survey in July 2011 regarding their MH inpatient stay. 65 surveys were completed. 36.9% reported communicating barriers to attending follow up appointments, and only 50% of those that identified barriers felt the inpatient hospital staff were helpful in eliminating those barriers.</p> <p>In 8/11 CABHC completed their own Member Survey through the System Impact Committee base on "Discharge experience of those members who were discharged and readmitted". Results pending.</p>
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<p><i>Root Cause: Although MH IP providers are educating Members on the significance of aftercare and report they are addressing barriers while on the unit, barriers continue to exist for Members and the no show rate remains too high</i></p> <p>Action: A focus on Member education and the significance of aftercare needs to be addressed by the MH IP facilities and barriers need to be addressed and corrected prior to discharge by relying on community resources and natural supports.</p> <ol style="list-style-type: none"> 1. In September of 2010, a letter to Members was developed and sent to all MH IP providers. The accompanying instruction requested MH IP providers to distribute to all CBHNP Members at time of discharge. The letter was directed at educating all Members on the significance of follow up and encouraged contacting CBHNP if rescheduling was necessary. The letter also offered the MATP numbers if transportation was an issue. The actual success of this project is difficult to assess. Additionally in 2010, a report was requested to the Informatics Department which would capture the barriers data reported by Clinical Care Managers which is currently in our eCura system but not assessable. 2. To address false reporting of follow up reports, all MH IP providers will be requested to verify with the OP provider the correct date and time of the appointment. This will be reviewed in the next MH IP Provider meeting 3. Record review to be completed in September of 2011 to validate the addressing of barriers as well as the Member Survey which also addresses barriers will specifically ask for confirmation of receipt of CBHNP letter at time of discharge. 4. Will remind MHIP providers of the necessity of utilizing the Member letter at time of discharge at the spring level of care meetings to improve outcome of 2011 record review results. 5. Explore the opportunity of offering training on Building a Therapeutic Alliance versus providing a tool kit on Therapeutic Alliance. 6. Consider changing MH IP Provider Meeting to a different format that would allow Philadelphia hospitals to meet centrally and Lancaster hospitals to meet locally so that the appropriate staff are in attendance such as QI Managers or Nurse managers. 		<p>Initial Response</p> <ul style="list-style-type: none"> • QI PM will measure (quarterly) the number of false appointments received by Clinical Care Managers at time of discharge. • Record Review and Member Survey outcome results will be reviewed in comparison to the previous results. • Improvement of the quarterly correlation between MH IP providers and their follow up rate will be expected. • Num 1 quarterly results will be reviewed and reported per county per hospital. • QI PM will review, compile and report barrier results when developed • Continue T-Care as previously described and monitor for results and make recommendations based on outcomes. Discuss options of expanding to other counties. <p>Follow-up Status Response</p> <p>In the above mentioned Member Survey, Follow up Specialists will be completing a new survey in 2011 which will include a question about barriers to treatment and whether or not they were addressed on the inpatient unit.</p> <p>While initial T-Care results were considered favorable, expansion of the pilot has not occurred pending further investigation of staffing resources and addressing administrative barriers verbalized by providers during the pilot.</p> <p>Pilot study indicated that 80% of appointments were accurate therefore; no additional resources are dedicated to reviewing for false appointments.</p> <p>Barrier report development remains pending and so a work around was completed 8/11 by Follow Up Specialist. Summary of results are pending.</p> <p>See hospital correlations as stated above in the analysis section</p> <p>HEDIS Num 1 Results (see above)</p> <p>Member Letters to be handed out at time of discharge by the MH IP letter will be reviewed during the MH IP audit of 2011. The MH IP provider will be asked if they gave the letter to the member and rated accordingly. Results pending but preliminary results are not positive since most providers are not aware of the letter.</p> <p>A Therapeutic Alliance Tool Kit is currently in development and there emails will be placed on the portal and sent via email to MH IP Providers and other LOC. The Tool Kit will include</p> <ol style="list-style-type: none"> 1. Three components 2. Tips on how to establish
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<p>Additionally this will allow for issues to be review specific to that area.</p> <p>7. Continue T-Care as previously described and monitor for results and make recommendations based on outcomes. Discuss options of expanding to other counties.</p>		<p>3. Instrument to measure 4. Research</p> <p>Centralized MH IP LOC meetings have been discussed internal and agreed upon. An email to Philadelphia hospitals and a separate email to Lancaster hospitals will be sent 10/11 to discuss this as an option to provide more current up to date information and to be more proactive with area concerns.</p>
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Table 4.3 Root Cause Analysis for CBHNP – Follow-up After Hospitalization for Mental Illness PA-specific 7-Day Quality Indicator A

Performance Measure																											
Follow-up After Hospitalization for Mental Illness QI A (PA-specific 7 Day)																											
Goal Statement																											
Short Term goal: Increase Num A Territory (All 12 Counties combined) Rate for Follow Up after discharge by 7% (The 2009 rate for the Territory was 56.3% and the rate will increase to 60.2%) by the end of 2011.																											
Long Term goal: Increase Num A Territory (All 12 Counties combined) Rate for Follow Up after discharge to equal or exceed current interim HEDIS goal of 65.4% by the end 2013.																											
<i>Policies</i>	<i>Initial Response</i>																										
<p>(e.g., data systems, delivery systems, provider facilities)</p> <ol style="list-style-type: none"> 1. CBHNP Fee Schedule 2. CBHNP Credentialing Process 3. CBHNP Policy & Procedures 4. HIPPA 5. HealthChoices Contracts 6. Data Systems 7. Provider Network 	<ul style="list-style-type: none"> • Num B results for all counties <table border="1" data-bbox="597 982 932 1440"> <thead> <tr> <th>County</th> <th>PA_7 %</th> </tr> </thead> <tbody> <tr><td>BD</td><td>52.7%</td></tr> <tr><td>BL</td><td>60.5%</td></tr> <tr><td>CT</td><td>59.8%</td></tr> <tr><td>CU</td><td>62.8%</td></tr> <tr><td>DA</td><td>60.9%</td></tr> <tr><td>FR</td><td>54.2%</td></tr> <tr><td>FU</td><td>51.9%</td></tr> <tr><td>LA</td><td>50.3%</td></tr> <tr><td>LB</td><td>61.7%</td></tr> <tr><td>LY</td><td>53.3%</td></tr> <tr><td>PE</td><td>53.1%</td></tr> <tr><td>SO</td><td>50.6%</td></tr> </tbody> </table> <ul style="list-style-type: none"> • The current fee schedule for inpatient facilities allows for individually negotiated per diems; current fees are in line with MA FFS; minimal requests are received annually; and of those received, all are agreed upon by CBHNP and provider. No known reimbursement issues are identified. • The current credentialing process presents no known barriers for inpatient facilities that would impact their rate of follow up. Out of network arrangements are always permitted to ensure continuity of care and/or the need for emergent or specialized care to meet Member need. Such arrangements afford adequate reimbursement. • The current policies related to MH inpatient or readmission such as CM-032 Decision Making, Clinical guidelines, Ethical standards and CM-011 Clinical Care Management Decision Making and Trigger Lists support active care management strategies and do not impede admissions and/or follow up care. • Current HIPPA regulations prevent emailing critical Member information which challenges providers when attempting to communicate quickly and easily. Providers 	County	PA_7 %	BD	52.7%	BL	60.5%	CT	59.8%	CU	62.8%	DA	60.9%	FR	54.2%	FU	51.9%	LA	50.3%	LB	61.7%	LY	53.3%	PE	53.1%	SO	50.6%
County	PA_7 %																										
BD	52.7%																										
BL	60.5%																										
CT	59.8%																										
CU	62.8%																										
DA	60.9%																										
FR	54.2%																										
FU	51.9%																										
LA	50.3%																										
LB	61.7%																										
LY	53.3%																										
PE	53.1%																										
SO	50.6%																										

	<p>typically do not have highly secure email systems.</p> <ul style="list-style-type: none"> • Current HealthChoices contracts do not allow for consequences to Members who do not show for follow up appoints and providers feel Member's recognize this. Providers feel this rule creates a negative impact on follow up as it does not encourage participation in aftercare. Reported at 2/2/11 Provider Meeting. • The current reporting capacity is limited to Num results, hospital correlations, county and age comparisons but other details such as TCM, substance abuse history; high risk designation, readmission details and race must be all compiled manually. Trends cannot be determined, limiting interventions which can be constructed. The manual handling of data is not feasible for some of the 12 counties due to high admission rates. <p><i>Root Cause: Limited reportable data in meeting the 7 day HEDIS standards. Minimal actions can be taken to focus on correlations that may be preventing follow up within 7 days.</i></p> <ul style="list-style-type: none"> • 2009 Follow Up Report data identifies the following Top 5 Providers who did not provide an appointment within standard: <ul style="list-style-type: none"> ○ Holy Spirit (Cumberland) 49%, Summit Behavioral Health (Franklin) 47%, Nulton (Blair/Bedford/Somerset) 41%, Altoona Regional (Blair) 37.5% and Behavioral Health Specialist (Lancaster) 35%. • Provider Network has several reported issues including limited psychiatrist time, limited child and adolescent appointments available within 7 days and specifically in Dauphin County limited OP as reported in the brainstorming session with Providers held on 2/2/11. <p><i>Root Cause: MH IP providers report when they ask for an appointment within 7 days not all providers children services preventing follow up within standard 7 days.</i></p> <p>Follow-up Status Response</p> <p>Finalization of comprehensive mechanized report request remains pending, creating the need for the manual review of data by county/age/gender. Trends are identifying the need for individual correlations which can be targeted over time such as assessing the impact of TCM involvement or history of Substance Abuse. Example under Action section</p> <p>Num A results for 2010 Validated Rates are as follows: BD 55.8%, BL 56.9%, CT 58.4%, CU 54.4%, DA 58.4%, 60.5%, FU 53.6%, LA 48.5%, LB 57.8%, LY 46.9%, PE 51.4%, SO 54.5%. The rates for the following counties improved Bedford, Franklin, Fulton, and Somerset. However Blair, Clinton, Cumberland, Dauphin, Lancaster, Lebanon Lycoming and Perry decreased in this 7 day follow up rate</p> <p>2010 Follow Up report identifies the following Top 4 Providers who did not provide an appointment within standard: All Seasons 50%, Holy Spirit 68%, Primary Network 69%, and Somerset MHMR 71% PR reps have been asked to follow up with providers individually. We will continue to encourage providers to be flexible in scheduling. The improved BHRS process may impact the children/adolescent rates in 2011 for all counties</p> <p>2010 Follow up detail report identified that Dauphin County providers do not have an issue with provide the follow up appointment within 7 days. Dauphin County currently has 19 Mental Health Outpatient sites and one Partial Hospitalization program for Children. HEDIS rates are not improving in Dauphin County but this does not appear to be a capacity issue. Further analysis of the 7 day follow will be reviewed for this County. One option maybe a lack of flexibility of Scheduling.</p>
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	<p>The improved BHRS process may impact the children/adolescent rates in 2011 for all counties.</p>
<p>Procedures (e.g., payment/reimbursement, credentialing/collaboration)</p> <ol style="list-style-type: none"> 1. Communication 2. Transportation 	<p>Initial Response</p> <ul style="list-style-type: none"> • In 2010 the records of 18 MH IP hospitals (moderate to high volume hospitals from all 12 counties) were reviewed for discharge planning/process documentation. Only 67% of the records reflected collaboration with family/friends. • The above stated record review identified that MH IP providers were not fully collaborating with other MH providers consequently, only 69% of the records reviewed reflected communications that could have assisted Members in making treatment decisions while on the inpatient unit which, in turn, could have improved the success of follow up. • A Member survey developed specifically for the Root Cause Analysis was completed in 2/11 which also asked Members if family/friends were included in the discharge planning. Only 50% of the 22 Members surveyed reported they did NOT have collaboration which may have hindered follow up. • In Franklin and Fulton County an independent survey was also completed in November of 2010. The survey focused on Member satisfaction and discharge process after an inpatient stay with 54 Members participation. The survey findings reported that only 63% of the Members remember having more than one conversation about discharge planning which is a significant finding in itself. The Members were also asked during the discharge process if they had family/friend support and of the 44 Members who responded yes only 36 of the Members had family/friends contacted to assist in the discharge planning indicating a breakdown in good discharge planning. <p><i>Root Cause: a lack of communication and collaboration with family/friends and other MH OP providers has impacted Member attending within 7 days after discharge creating an additional barrier to treatment.</i></p> <ul style="list-style-type: none"> • Members continue to report ongoing transportation such as van rides which are too long; vans not on time, making Members late for appointments; and limited access to MATP in rural areas. This is a barrier for treatment and is discussed at the county level for ways to improve the system. <p>Follow-up Status Response</p> <p>In 2011, the discharge planning/process documentation audit of MHIP is being repeated. Approximately half of the facilities have been reviewed to date and are showing significant improvement in their results. Final results are forthcoming.</p> <p>The Member Survey is being restructured in attempt to gather more conclusive results and will be repeated in 2011.</p> <p>See Action Steps for additional information.</p>
<p>People (e.g., personnel, provider network, patients)</p> <ol style="list-style-type: none"> 1. Clinical Care Managers 2. Follow Up Specialists 3. Members 4. Providers 	<p>Initial Response</p> <ul style="list-style-type: none"> • Feedback was obtained from Clinical Care Managers (CCM) at CBHNP in meetings held on 2/4 and 2/16/11 to discuss barriers to treatment from a Clinical Care Managers perspective. CCMs reported Members are not included in the discharge process and are unsure of their follow up appointments. They also report Members sometimes inform the MH IP provider that they already have a scheduled appointment previously made but the IP facilities do not verify the appointment. Some IP units give CCM false information related to follow up appointments. • Data from the 2009 Follow Up reporting indicates that 1789 (41%) Members (adult and child) did attend an appointment within 7 days but 813 (19%) of the Members either declined, were a no show, were a no show but rescheduled outside the 7 days,

cancelled, cancelled but rescheduled outside the 7 days, went AMA or AWOL from MH IP or the MH OP agency denied record of the appointment. These are all Member choice assertions which are largely beyond the control of the provider or the MCO, however, perhaps could be impacted by creating a strong therapeutic alliance between Members and treating provider.

- A number of Members who did not follow up within 7 days were noted to have had to reschedule (by the Agency) the Member outside of the 7 days. CCMS also feel Members are not being referred to Peer Support, Mobile Psychiatric Nursing (Capital contract) and TCM. The MH IP record review substantiates this claim where only 65% of the records provided evidence of referrals when appropriate.
- Follow-Up Specialist completed a 22 Member survey in 2/11 and noted that 27% of the Members surveyed were not in agreement with follow up appointments and only 50% remember being asked about barriers to treatment at the time the appointment was being scheduled. The MH IP record review substantiates this claim by noting 38% of the Members were in agreement or present when their appointments were made and 43% of Members had documentation of barriers identified and addressed during the admission process.
- In Franklin and Fulton County an independent survey was also completed in November of 2010. The survey focused on Member satisfaction and discharge process after an inpatient stay with 54 Members participation. Follow up after 7 days was measured and of the 54 Members 46 Members reported they did have an appointment set up for them after discharge but only 34 (63%) had an appointment within 7 days. Eight Members were unsure and four did not have an appointment with 7 days. These findings further substantiate the breakdown in good discharge planning only slightly higher than half were seen in 7 days.
- Providers also offered additional feedback in the 2/2/11 brainstorming session. Levels of care represented in attendance included MH IP, OP and TCM providers. Findings from provider experience or Member surveys and support that some Members refuse a 7 day appointment, some Members feel Peer Support is too intrusive, housing issues are increasing in the past two years, the benefit of follow up is not clear to the Member, Members feel discharge instructions are too confusing, some Members prefer going to a PCP instead of a psychiatrist and that it is hard for Members to go to a new provider who is unknown to them. MH IP Providers reported being unaware of Members having TCM and TCMs are reporting being aware that their Members are on an inpatient unit which further contributes to poor collaboration. * 2010, Follow Up Specialist initiated a fax to all TCM providers with a list of their Members who were admitted to an IP unit. This was initiated to improve TCM involvement which was a need noted in the 2009 RCA.
- QI Clinical Managers report quarterly correlations between follow up rates and hospitals. Data indicates some vertically integrated systems have better follow-up numbers which suggests that partnerships, linkages, formal agreements are key, for every hospital system even if they don't provide OP services. The table below offers an example of non-follow up rates of 8 hospitals and whether they offer continuity of care.

Hospitals with Continuity	Hospitals with Limited to No Continuity
18% - Philhaven	41% - Lancaster Regional
21% - Pennsylvania Psychiatric Institute	38% - Lancaster General
18% - Altoona Regional	45% - Divine Providence
21% - Somerset	38% - Brooke Glen

- CBHNP proactively initiated a Telephonic Care Management (TCARE) which is a pilot designed to reduce readmissions to inpatient care and improve Member attendance at aftercare treatments. The TCARE pilot was implemented in Blair County for an

enrollment period of 3 months from 11/1/10-1/31/11. The pilot was designed to contact Members while they were still on the unit to begin a relationship with the Member which would continue after their discharge from the unit. Post discharge, weekly calls, for a period of up to 12 weeks, would be made to assist the Member in identifying and resolving barriers to attending aftercare appointments. Results of TCARE will be compared to the outcomes of admissions to inpatient care in the same county from the previous year 11/1/09-1/31/10. Results are pending but 20 (34%) Members opted to participate in TCARE out of 58 who were either contacted and decline or no contact was able to be made. Out of the 20 Members discharged 14 attended an appointment within 7 days and 3 additional Members attended before 30 days for a success rate of 85%.

Root Cause: Although MH IP providers are educating Members on the significance of aftercare and report they are addressing barriers while on the unit, barriers continue to exist for Members and the no show rate remains too high. Additionally, referrals to TCM/Peer Support and Mobile Psych (Capital only) are not always included in discharge planning process. Additionally, MH OP providers are not always able to offer appointments within 7 days.

Follow-up Status Response

For the first six months of 2011, data from 2010 Follow Up report indicates:

- *892 (47%) of Members – Adult and Child, did attend an appointment within 7 days, however, 828 (43%) Members either declined, were a no show, rescheduled outside of the 7 days, cancelled, were AMA/AWOL from MHIP or the MHOP denied record of the appointment. The remaining 10% included readmissions, PCP follow up, Prison, level to level transfers, or admissions to Halfway House, CRR HH or RTF.*

In the above mentioned Member Survey, Follow up Specialists will be completing a new survey in 2011 which will include a question about barriers to treatment.

Correlations between facility and follow up rates continue on a quarterly basis. Lancaster General and LRMC have shown a continued struggle which has lead to discussion to develop a bridge appointment in conjunction with a local outpatient program. Ongoing meetings are occurring with Lancaster MHMR/ CBHNP and all area hospitals to discuss issues on the unit and follow up rates.

Hospitals with Continuity	Hospitals with Limited to No Continuity
9% - Philhaven	49% - Lancaster Regional
24% - Pennsylvania Psychiatric Institute	39% - Lancaster General
23% - Altoona Regional	58% - Divine Providence
22% - Somerset	54% - Brooke Glen

Some hospitals continue to struggle but rates are also influenced by third party insurance, appropriate substance abuse treatment and PCP follow up which counted in this rate. Divine Providence rate is influenced by claim issues on the hospital's part.

While initial T-Care results were considered favorable, expansion of the pilot has not occurred pending further investigation of staffing resources and addressing administrative barriers verbalized by providers during the pilot.

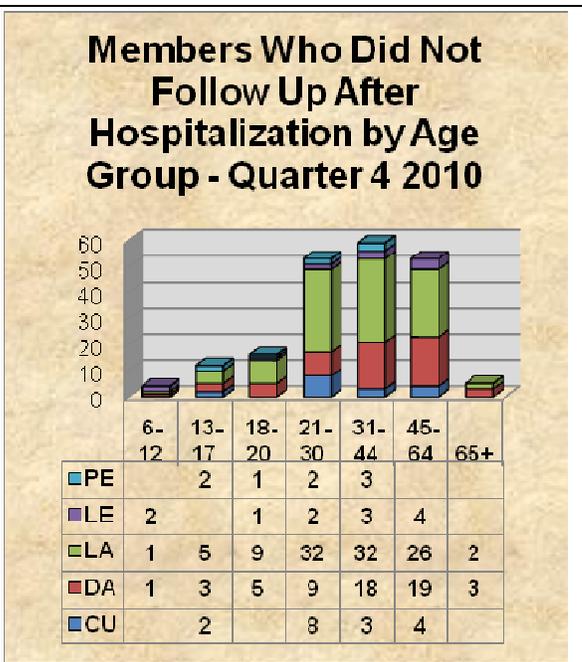
Educated providers on the use of TCM/Peer Support and mobile Psych when appropriate, following the MHIP Audit of 2010. One barrier noted in the 2010 audit was that Peer Support was not always available. In response to this, oversight funded peer support



	<p><i>training.</i></p> <p><i>Ongoing conversations with Peer Support specialists who are willing to education MH IP providers with the possibility of PSS staff attending MHIP level of care meetings hosted by CBHNP and/or making education visits to MHIP units.</i></p> <p><i>Mobile psychiatric nursing is being expanded in several contracts.</i></p>	
<p>Provisions (e.g., screening tools, medical record forms, provider and enrollee educational materials)</p> <ol style="list-style-type: none"> 1. Medical Records 2. Discharge process 	<p>Initial Response</p> <ul style="list-style-type: none"> • Limited electronic medical records use and/or permitted exchange of treatment information (some due to SA confidentiality) across all providers • Lack of authority at the MCO to dictate exchange of information protocols among providers. • Inability for MCO to consider positive co-occurring treatment options when Member follow up is with an SA provider. • Not all providers are following protocol and faxing discharge instruction sheets to other providers which hinders continuity of care 	
	<p>Follow-up Status Response</p> <p>No follow up needed at this time.</p>	
<p>Other</p>	<p>Initial Response</p> <p>None</p>	
	<p>Follow-up Status Response</p> <p>None</p>	
<p>Action and Monitoring Plan</p>		
<p>Action Plan</p>	<p>Implementation Date</p>	<p>Monitoring Plan</p>
<p><i>Root Cause: Limited reportable data in meeting the 7 day HEDIS standards. Minimal actions can be taken to focus on correlations that may be preventing follow up within 7 days.</i></p> <p>Action: Modification of current report has been requested through IT and results will be analyzed and current Provider rates and trends will be collected quarterly. As in Num 1 Somerset County had one of the lowest rates. The County worked proactively by initiating Tele-psychiatry and increased Therapist hours at their largest provider. This action has improved their 2010 Num rates. The second lowest rate is Lancaster County who continues to struggle in 2010. Two hospitals with a high correlation of Members who did not follow up and a lack of continuity of care provided at these hospitals has impacted these rates. Additionally one hospital went under staffing changes which may impact good discharge process. Ongoing discussion occurred with CBHNP, Lancaster County MHMR and both hospitals and there was preliminary discussion about bridge appointments and expansion of services at the hospital to incorporate outpatient.</p> <ol style="list-style-type: none"> 1. Quality Improvement Project Managers (QPMs) discussed information that may be 		<p>Initial Response</p> <ul style="list-style-type: none"> • QPM will advocate prioritizing the data request to collect additional needed information to properly assess, monitor and trend identified factors related to follow up. • QPMs will monitor quarterly both the MH IP provider results of Members who did not follow up with treatment and review quarterly the MH OP provider specifics details noted in the Follow Up Report which measures the 7 day standard compliance • QPMs will monitor HEDIS rates Num A quarterly and analyze for trends based on race, readmissions, substance treatment and current open authorizations when the data becomes available <p>Follow-up Status Response</p> <p><i>Finalization of comprehensive mechanized report request remains pending, creating the need for the manual review of data by county/age/gender. Trends are identifying the need for individual correlations which can be targeted over time such as assessing the impact of TCM involvement or history of Substance Abuse. A sample report is as follows:</i></p>

needed and made a collective request for information to the IT department in the spring of 2010. Request currently pending on list of projects to be completed.

- QPMs will meet with IT business analysts to review reporting changes when report is scheduled for development by IT.
- QPMs will vet changes in reporting by county and implement validated report
- QPMs will monitor report quarterly and observe for specific trends that may impact follow up.
- QPMs will review findings with PR Team to discuss corrective actions plans for Providers who are not able to offer appointments within 7 days.



Root Cause: Some providers are reporting limited capacity for MH OP and children services preventing follow up within standard 7 days.

Action: A survey of current Mental Health Outpatient (MH OP) providers' capacity needs to be completed to assess the correlation between capacity and providers offering appointments within the 7 day standard.

- Current data only allows for a retrospective view of providers not offering within 7 days and is not proactive. Actions this year will need to include a clearer picture of network capabilities opposed to MH OP Providers not offering flexibility.
- QI PM will develop a survey for Provider Relations to distribute and collect to all MH OP providers in network by April of 2011. QI to collect, compile and report results.
- QI PM will complete analysis of survey findings and compare capacity with a sample of OP authorizations from 2010.
- QI PM will offer recommendations based on data to Management team to determine actions that can be taken to improve the 7 day standard.

Initial Response

- QPMs will monitor quarterly both the MH IP provider follow up rates of Members who did not follow up with treatment and review quarterly the MH OP provider specifics details noted in the Follow Up Report which measures the 7 day standard compliance
- QPMs will monitor HEDIS rates Num A quarterly and analyze for trends per county per provider.

Follow-up Status Response

Provider Relations did provide results of appointment availability survey, however, results were inconclusive. The survey was modified and will be repeated periodically throughout the year.

MHIP follow rates of those who did not follow up routinely are as follows are as above. Correlation will continue quarterly with outreach to the hospitals with high no-follow up rates by the PR Rep.

For the first six months of 2011, data from 2010 Follow Up report indicates the following measure of compliance within the 7 day standard:

892 (47%) of Members – Adult and Child, did attend an appointment within 7 days, however, 828 (43%) Members either declined, were a no show, rescheduled outside of the 7 days, cancelled, were AMA/AWOL from MHIP or the MHOP denied record of the appointment. The remaining 10% included readmissions, PCP follow up, Prison, level to level transfers, or admissions to Halfway House, CRR HH or RTF.

		<p>Telepsychiatry was added in Bedford/Somerset in 2010 with 2 providers in each county Bedford/Somerset MH/MR and Nulton Diagnostic. Lycoming/Clinton in 2010 thru CSG and Franklin/Fulton has telepsychiatry now available through NHS. The Meadows also initiated Child telepsychiatry appointments in 2010 to meet the medicine check needs of members that were not able to be seen by their own psychiatrist for two months post discharge.</p> <p>Updated Num 1 2010 results for all counties are as follows: BD 36.8%, Blair 48.1%, CT 43.8% Cu 42.1%, DA 35.1%, FR 49.6%, FU 46.4%, LA 40.8%, LB 48.6%, LY 38.0%, PE 51.4% SO 38.4%. The rates for the following counties improved Bedford, Franklin, Fulton, Lancaster, Perry and Somerset. Blair, Clinton, Cumberland, Dauphin, Lebanon and Lycoming decreased in the 7 day follow up rate.</p> <p>2010 Follow Up report identifies the following Top 4 MH OP Providers who did not provide an appointment within standard: All Seasons 50%, Holy Spirit 68%, Primary Network 69%, and Somerset MHRM 71% PR reps have been asked to follow up with providers individually.</p> <p>2010 Follow up detail report identified that Dauphin County providers do not have an issue with provide the follow up appointment within 7 days. Dauphin County currently has 19 Mental Health Outpatient sites and one Partial Hospitalization program for Children. HEDIS rates are not improving in Dauphin County but this does not appear to be a capacity issue. Further analysis of the 7 day follow will be reviewed for this County. One option maybe a lack of flexibility of Scheduling. The improved BHRS process may impact the children/adolescent rates in 2011 for all counties</p> <p>The improved BHRS process may impact the children/adolescent rates in 2011 for all counties.</p>
<p><i>Root Cause: A lack of communication and collaboration with family/friends and other MH OP providers has impacted Member attending within 7 days after discharge creating an additional barrier to treatment.</i></p> <p>Action: Follow up from response to a previous educational opportunity in 2010 with MH IP providers to determine success or need for further interventions and implement new procedure to enhance collaboration and lessen barriers.</p> <p>1. From 8/10 to 10/10 18 high to moderate volume MH IP providers received an onsite record review to monitor discharge process and use of recovery principles. Immediate</p>		<p>Initial Response</p> <ul style="list-style-type: none"> • QI PM will monitor Follow Up audit results based on the same 10 indicators from the record review in 2010. Outcomes will be measured for differences from previous year per provider and for the network system. • QI PM will monitor the Member Survey results on the same 5 indicators from the 2/11 survey and compare and report results and note changes in the data. <p>QI PM will measure outcomes of success from the pilot based on total number of discharge instruction sheet faxed to CBHNP, to MH OP providers and the accuracy of the information between the fax and verbal discharge information. If successful, the requirement for faxing d/c summaries to all entities will be required. Additional</p>



<p>education and feedback was given with a follow up letter to the CEO of the facility and the nurse manager. A record review in 9/11 will be initiated to determine effectiveness of the previous educational opportunity.</p> <ol style="list-style-type: none"> 2. Follow Up Specialist will repeat the Member Survey from 9/10 and expand the scope to correlate the Member's perception of their discharge experience and if collaboration with family and friends occurred. 3. CBHNP will initiate a pilot study in April through June of 2011 with 2 Capital hospitals and 2 North Central hospitals who will fax their discharge instruction sheet to the OP provider and CBHNP. Internally, QI staff will review the discharge instruction sheet for completion and review for accuracy between what the MH IP provider verbally reported to Clinical Care Managers and was subsequently placed in the eCura system and what is on the discharge sheet. Additionally, QI will request MH OP Providers acknowledge if they have received the discharge instruction sheet to measure follow through by the IP Provider. Follow Up Specialist will call the Member within 72 hours of discharge to review the follow up plans and clarify if there are any current barriers for follow up to occur. If barriers are identified, the Follow Up specialist will assist in solutions. 		<p>outcomes will be based on the hospital correlation/follow up rate and the Num results by county who are involved which are done quarterly by the Clinical Care Managers.</p> <p>Follow-up Status Response</p> <p>In 2011, the discharge planning/process documentation audit of MHIP is being repeated. Approximately half of the facilities have been reviewed to date and are showing significant improvement in their results. Final results are forthcoming.</p> <p>In the above mentioned Member Survey, Follow up Specialists will be completing a new survey in 2011 which will include a question about barriers to treatment.</p> <p>The pilot study of discharge appointment accuracy provided the following data:</p> <ul style="list-style-type: none"> • Total unique Members – N = 72 • Total number of appointments = 95 • Appointments offered with 7 days 74 (78%) • 81% of discharge sheets matched eCura • 80% of aftercare providers confirmed accuracy of appointment (SA confidentiality regs impeded our ability to fully assess) <p>Addressed false reporting of dates/times for outpatient appointments as communicated by the Member in April, 2011 level of care meetings by asking MHIP providers to consider verifying the accuracy of information reported by the Member.</p> <p>Unfortunately only eleven Members were successfully contacted during the survey and of those two identified barriers to treatment; however, the MHIP facility did not offer solutions to the barrier prior to discharge. We are not presently planning to repeat this pilot due to positive results and negative feedback from providers while attempt to complete the survey. Blair County CFST completed a member survey in July 2011 regarding their MH inpatient stay. 65 surveys were completed. 36.9% reported communicating barriers to attending follow up appointments, and only 50% of those that identified barriers felt the inpatient hospital staff were helpful in eliminating those barriers.</p> <p>In 8/11 CABHC completed their own Member Survey through the System Impact Committee base on "Discharge experience of those members who were discharged and readmitted". Results pending.</p>
<p><i>Root Cause: Although MH IP providers are educating Members on the significance of aftercare and report they are addressing barriers while on the unit, barriers continue to exist for Members and the no show rate remains too high.</i></p>		<p>Initial Response</p> <ul style="list-style-type: none"> • QI PM will measure (quarterly) the number of false appointments received by Clinical Care Managers at time of discharge. • Record Review and Member Survey outcome results



<p><i>Additionally, referrals to TCM/Peer Support and Mobile Psych (Capital only) are not always included in discharge planning process. Additionally, MH OP providers are not always able to offer appointments within 7 days.</i></p> <p>Action: A focus on Member education and the significance of aftercare needs to be addressed by the MH IP facilities and barriers need to be addressed and corrected prior to discharge by relying on community resources and natural supports. Additionally, a focus on improving referrals to TCM, Peer Supports and Mobile Psych is needed by improving education of the roles of these levels of care.</p> <ol style="list-style-type: none"> 1. In September of 2010, a letter to Members was developed and sent to all MH IP providers. The accompanying instruction requested MH IP providers to distribute to all CBHNP Members at time of discharge. The letter was directed at educating all Members on the significance of follow up and encouraged contacting CBHNP if rescheduling was necessary. The letter also offered the MATP numbers if transportation was an issue. The actual success of this project is difficult to assess. Additionally in May of 2010 a Fax Blast was initiated by the Outpatient Manager that is sent to all TMC with a list of all their Members that were admitted to a MH IP unit. Additionally in 2010, a report was requested to the Informatics Department which would capture the barriers data reported by Clinical Care Managers which is currently in our eCura system but not assessable. 2. To address false reporting of follow up reports, all MH IP providers will be requested to verify with the OP provider the correct date and time of the appointment. This will be reviewed in the next MH IP Provider meeting 3. Record review to be completed in September of 2011 to validate the addressing of barriers as well as the Member Survey which also addresses barriers will specifically ask for confirmation of receipt of CBHNP letter at time of discharge. 4. Will remind MHIP providers of the necessity of utilizing the Member letter at time of discharge at the spring level of care meeting to improve outcome of 2011 record review results. 5. Explore the opportunity of offering training on Building a Therapeutic Alliance versus providing a tool kit on Therapeutic Alliance. 		<p>will be reviewed in comparison to the previous results.</p> <ul style="list-style-type: none"> • Improvement of the quarterly correlation between MH IP providers and their follow up rate will be expected. • Num A quarterly results will be reviewed and reported per county per hospital. • QI PM will review, compile and report barrier results when developed. <p>QI PM to review, compile and report results of T-Care program and recommendations to change program to end or expand.</p> <p>Follow-up Status Response</p> <p>While initial T-Care results were considered favorable, expansion of the pilot has not occurred pending further investigation of staffing resources and addressing administrative barriers verbalized by providers during the pilot.</p> <p>The Pilot study to measure bogus appointments indicated that 80% of appointments were accurate therefore; no additional resources are dedicated to reviewing for false appointments.</p> <p>Barrier report development remains pending and so a work around was completed 8/11 by Follow Up Specialist. Summary of results are pending.</p> <p>See hospital correlations as stated above in the analysis section HEDIS Num 1 Results (see above)</p> <p>Member Letters to be handed out at time of discharge by the MH IP letter will be reviewed during the MH IP audit of 2011. The MH IP provider will be asked if they gave the letter to the member and rated accordingly. Results pending but preliminary results are not positive since most providers are not aware of the letter.</p> <p>A Therapeutic Alliance Tool Kit is currently in development and there emails will be placed on the portal and sent via email to MH IP Providers and other LOC. The Tool Kit will include</p> <ol style="list-style-type: none"> 1. Three components 2. Tips on how to establish 3. Instrument to measure 4. Research <p>Centralized MH IP LOC meetings have been discussed internal and agreed upon. An email to Philadelphia hospitals and a separate email to Lancaster hospitals will be sent 10/11 to discuss this as an option to provide more current up to date information and to be more proactive with area concerns.</p> <p>Preliminary discussions with providers to consider alternatives for TCM intake appointments. One provider has expressed interest in continuing discussions.</p>
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<ol style="list-style-type: none"> 6. Consider changing MH IP Provider Meeting to a different format that would allow Philadelphia hospitals to meet centrally and Lancaster hospitals to meet locally so that the appropriate staff are in attendance such as QI Managers or Nurse managers. Additionally this will allow for issues to be review specific to that area. 7. Continue T-Care as previously described and monitor for results and make recommendations based on outcomes. Discuss options of expanding to other counties. 8. Consider flexibility in TCM intake appointments by either providing walk in or to allow TCM to the units prior to discharge to engage the Member. 9. Consider expanding Mobile Psych Nursing in to other counties 10. QPM will provide MH IP facilities with a short write up on the benefits of Peer Support to give to Members. Additionally, CBHNP will assist in coordinating efforts to provide support in obtaining a Certified Peer Specialist for educational presentation to MHIP units on the benefits of Peer Support. 11. QPM will discuss with Clinical and PR Team the possibility of a "bridge appointment" as a means of increasing Member participation in after care and elimination of some barriers. Proposal of a pilot with two hospitals would be discussed and initiated by 6/11 with a focus on the hospitals or counties with the lowest follow up rate. Such a proposal will consider the substantive nature of the appointment to ensure the quality of the contact. 		<p>Correlations between facility and follow up rates continue on a quarterly basis. Lancaster General and LRMC have shown a continued struggle which has lead to discussion to develop a bridge appointment in conjunction with a local outpatient program. Ongoing meetings are occurring with Lancaster MHMR/ CBHNP and all area hospitals to discuss issues on the unit and follow up rates.</p> <p>Current "bridge appointments" include Dauphin and Cumberland/Perry with Meadows providing a Children's med check through Telepsychiatry until the Member can be seen through their regular Psychiatrist.</p>
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V: 2011 STRENGTHS AND OPPORTUNITIES FOR IMPROVEMENT

The review of CBHNP's 2011 (MY 2010) performance against structure and operations standards, performance improvement projects and performance measures identified strengths and opportunities for improvement in the quality outcomes, timeliness of and access to services for Medicaid members served by this BH MCO.

Strengths

- CBHNP submitted one PIP for validation in 2011 and received full credit for the element of the study evaluated that reflected activities in 2010 (Interventions Aimed at Achieving Demonstrable Improvement).

Opportunities for Improvement

- Review of compliance with standards conducted by the Commonwealth in RY 2008, RY 2009, and RY 2010 found CBHNP to be partially compliant with all three Subparts associated with Structure and Operations Standards.
 - Within Subpart C: Enrollee Rights and Protections Regulations, CBHNP was partially compliant on one out of seven categories – Enrollee Rights.
 - CBHNP was partially compliant on four out of 10 categories within Subpart D: Quality Assessment and Performance Improvement Regulations. The partially compliant categories were: 1) Availability of Services (Access to Care), 2) Coordination and Continuity of Care, 3) Coverage and Authorization of Services, and 4) Practice Guidelines.
 - CBHNP was partially compliant on eight out of 10 categories within Subpart F: Federal and State Grievance System Standards Regulations. The partially compliant categories were: 1) Statutory Basis and Definitions, 2) General Requirements, 3) Notice of Action, 4) Handling of Grievances and Appeals, 5) Resolution and Notification: Grievances and Appeals, 6) Expedited Appeals Process, 7) Continuation of Benefits, and 8) Effectuation of Reversed Resolutions.
- CBHNP's rate for the MY 2010 Follow-up After Hospitalization for Mental Illness HEDIS indicator QI 1 was statistically significantly lower than the QI 1 HealthChoices BH MCO Average by 3.7 percentage points.
- CBHNP's rate for the MY 2010 Follow-up After Hospitalization for Mental Illness PA-specific indicator QI B rate was a statistically significant decrease of two percentage points from MY 2009.
- CBHNP's rate for the MY 2010 Readmission within 30 Days of Inpatient Psychiatric Discharge performance measure did not meet the OMHSAS designated performance goal of 10.0%.

Additional strengths and targeted opportunities for improvement can be found in the BH MCO-specific 2011 (MY 2010) Performance Measure Matrix that follows.



PERFORMANCE MEASURE MATRIX

The Performance Measure (PM) Matrix provides a comparative look at quality indicators (QIs) included in the External Quality Review (EQR) evaluation for Quality Performance of the HealthChoices Behavioral Health Managed Care Organization. The matrix:

- Compares the Behavioral Health Managed Care Organization's (BH MCO's) own measure performance over the two most recent reporting years (Measurement Year (MY) 2010 and MY 2009); and
- Compares the BH MCO's MY 2010 performance measure rates to the MY 2010 HealthChoices BH MCO Average.

The table is a three-by-three matrix. The horizontal comparison represents the BH MCO's performance as compared to the applicable HealthChoices BH MCO Average. When comparing a BH MCO's rate to the HealthChoices BH MCO Average for each indicator, the BH MCO rate can be above average, equal to the average or below average. Whether or not a BH MCO performed statistically significantly above or below average is determined by whether or not that BH MCO's 95% confidence interval for the rate included the HealthChoices BH MCO Average for the specific indicator.

The vertical comparison represents the BH MCO's performance for each measure in relation to its prior year's rates for the same indicator. The BH MCO's rate can trend up (▲), have no change, or trend down (▼). For these year-to-year comparisons, the significance of the difference between two independent proportions was determined by calculating the z-ratio. A z-ratio is a statistical measure that quantifies the difference between two percentages when they come from two separate study populations.

The matrix is color-coded to indicate when the findings for these measures are notable and whether there is cause for action:

-  The green box (A) indicates that performance is notable. The BH MCO's MY 2010 rate is statistically significantly above the MY 2010 HealthChoices BH MCO Average and trends up from MY 2009.
-  The light green boxes (B) indicate either that the BH MCO's MY 2010 rate is equal to the MY 2010 HealthChoices BH MCO Average and trends up from MY 2009 or that the BH MCO's MY 2010 rate is statistically significantly above the MY 2010 HealthChoices BH MCO Average but there is no change from MY 2009.
-  The yellow boxes (C) indicate that the BH MCO's MY 2010 rate is statistically significantly below the MY 2010 HealthChoices BH MCO Average and trends up from MY 2009 or that the BH MCO's MY 2010 rate is equal to the MY 2010 HealthChoices BH MCO Average and there is no change from MY 2009 or that the BH MCO's MY 2010 rate is statistically significantly above the MY 2010 HealthChoices BH MCO Average but trends down from MY 2009. *No action is required although MCOs should identify continued opportunities for improvement.*
-  The orange boxes (D) indicate either that the BH MCO's MY 2010 rate is statistically significantly below the MY 2010 HealthChoices BH MCO Average and there is no change from MY 2009 or that the BH MCO's MY 2010 rate is equal to the MY 2010 HealthChoices BH MCO Average and trends down from MY 2009. *A root cause analysis and plan of action is required.*
-  The red box (F) indicates that the BH MCO's MY 2010 rate is statistically significantly below the MY 2010 HealthChoices BH MCO Average and trends down from MY 2009. *A root cause analysis and plan of action is required.*



Community Behavioral HealthCare Network of Pennsylvania (CBHNP)

KEY POINTS

■ **A - No CBHNP performance measure rate fell into this comparison category.**

■ **B - No CBHNP performance measure rate fell into this comparison category.**

■ **C - No action required although BH MCO should identify continued opportunities for improvement.**

Measures that had no statistically significant changes from MY 2009 to MY 2010 and were not statistically significantly different from the MY 2010 HealthChoices BH MCO Averages are:

- Follow-up After Hospitalization for Mental Illness QI 2 (HEDIS 30 Day)
- Readmission within 30 Days of Inpatient Psychiatric Discharge¹

■ **D - Root cause analysis and plan of action required.**

Measures that had no statistically significant change from MY 2009 to MY 2010 but were statistically significantly below the MY 2010 HealthChoices BH MCO Averages are:

- Follow-up After Hospitalization for Mental Illness QI 1 (HEDIS 7 Day)
- Follow-up After Hospitalization for Mental Illness QI A (PA-Specific 7 Day)

Measure that statistically significantly decreased from MY 2009 to MY 2010 but was not statistically significantly different from the MY 2010 HealthChoices BH MCO Average was:

- Follow-up After Hospitalization for Mental Illness QI B (PA-Specific 30 Day)

■ **F - No CBHNP performance measure rate fell into this comparison category.**

¹ Readmission within 30 Days of Inpatient Psychiatric Discharge is an inverted measure. Lower rates are preferable, indicating better performance.



Figure 1: Performance Measure Matrix – CBHNP

		HealthChoices BH MCO Average Statistical Significance Comparison		
Trend		Below / Poorer than Average	Average	Above / Better than Average
Year to Year Statistical Significance Comparison	↑	C	B	A
	No Change	D Follow-up After Hospitalization for Mental Illness QI 1 (HEDIS 7 Day) Follow-up After Hospitalization for Mental Illness QI A (PA-Specific 7 Day)	C Follow-up After Hospitalization for Mental Illness QI 2 (HEDIS 30 Day) Readmission within 30 Days of Inpatient Psychiatric Discharge ²	B
	↓	F	D Follow-up After Hospitalization for Mental Illness QI B (PA-Specific 30 Day)	C

Key to the Performance Measure Matrix Comparison
A: Performance is notable. No action required. BH MCOs may have internal goals to improve.
B: No action required. BH MCOs may identify continued opportunities for improvement.
C: No action required although BH MCOs should identify continued opportunities for improvement.
D: Root cause analysis and plan of action required.
F: Root cause analysis and plan of action required.

² Readmission within 30 Days of Inpatient Psychiatric Discharge is an inverted measure. Lower rates are preferable, indicating better performance.



Performance measure rates for MY 2008, MY 2009, and MY 2010 are displayed in Figure 2. Whether or not a statistically significant difference was indicated between reporting years is shown using the following symbols:

- ▲ Statistically significantly higher than the prior year,
- ▼ Statistically significantly lower than the prior year, or
- = No change from the prior year.

Figure 2: Performance Measure Rates – CBHNP

Quality Performance Measure	MY 2008 Rate	MY 2009 Rate	MY 2010 Rate	MY 2010 HC BH MCO Average
Follow-up After Hospitalization for Mental Illness QI 1 (HEDIS 7 Day)	42.7%	43.2% =	41.7% =	45.4%
Follow-up After Hospitalization for Mental Illness QI 2 (HEDIS 30 Day)	66.7%	66.2% =	65.5% =	66.2%
Follow-up After Hospitalization for Mental Illness QI A (PA-Specific 7 Day)	55.8%	56.3% =	54.2% =	57.5%
Follow-up After Hospitalization for Mental Illness QI B (PA-Specific 30 Day)	73.8%	74.8% =	72.8% ▼	74.1%
Readmission within 30 Days of Inpatient Psychiatric Discharge ³	13.6%	13.1% =	13.0% =	12.4%

³ Readmission within 30 Days of Inpatient Psychiatric Discharge is an inverted measure. Lower rates are preferable, indicating better performance.



VI: SUMMARY OF ACTIVITIES

Structure and Operations Standards

- CBHNP was partially compliant on Subparts C, D, and F. As applicable, compliance review findings from RY 2010, RY 2009, and RY 2008 were used to make the determinations.

Performance Improvement Projects

- CBHNP submitted one PIP for validation in 2011 and received full credit for the element of the study evaluated that reflected activities in 2010 (Interventions Aimed at Achieving Demonstrable Improvement).

Performance Measures

- CBHNP reported all performance measures and applicable quality indicators in 2011.

2010 Opportunities for Improvement MCO Response

- CBHNP provided a response to the opportunities for improvement issued in 2010, and submitted a root cause analysis and action plan response in 2011.

2011 Strengths and Opportunities for Improvement

- Both strengths and opportunities for improvement were noted for CBHNP in 2011. The BH MCO will be required to prepare a response for the noted opportunities for improvement in 2012.



APPENDIX

Appendix A: Crosswalk of Required PEPS Items to Pertinent BBA Regulations

BBA Category	PEPS Reference	PEPS Language
§438.100 Enrollee rights	Standard 60.1	Table of Organization identifies lead person responsible for overall coordination of Complaint and Grievance process and adequate staff to receive, process and respond to member complaints and grievances.
	Standard 60.2	Training rosters identify that complaint and grievance staff has been adequately trained to handle and respond to member complaints and grievances. Include a copy of the training curriculum.
	Standard 60.3	Training rosters identify that current and newly hired BH-MCO staff has been trained concerning member rights and the procedures for filing a complaint and grievance. Include a copy of the training curriculum.
	Standard 104.1	The BH-MCOs must measure and report its performance using standard measures required by DPW.
	Standard 104.2	The BH-MCO must submit to the DPW data specified by the DPW, that enables the measurement of the BH-MCO's performance QM program description must outline timeline for submission of QM program description, work plan, annual QM Summary/evaluation, and member satisfaction including Consumer Satisfaction Team reports to DPW.
	Standard 108.1	County/BH-MCO oversight of C/FST Program ensures HC contractual requirements are met.
	Standard 108.2	C/FST budget is sufficient to: hire staff proportionate to HC covered lives, has adequate office space, purchase equipment, travel and attend on-going training.
	Standard 108.5	The C/FST has access to providers and HC members to conduct surveys and employs of a variety of survey mechanisms to determine member satisfaction e.g. provider specific reviews, mailed surveys, focus meetings, outreach to special populations, etc.
	Standard 108.6	The problem resolution process specifies the role of the County, BH-MCO and C/FST and providers and results in timely follow-up of issues identified in quarterly surveys.
	Standard 108.7	The C/FST quarterly reports submitted to OMHSAS include the numeric results of surveys by provider, and level of care and narrative information about trends, and actions taken on behalf of individual consumers, with providers, and systemic issues, as applicable.
	Standard 108.8	The Annual Mailed/Telephonic survey results are representative of HC membership, identify systemic trends and actions have been taken to address areas found deficient, as applicable.
Standard 108.10	The C/FST Program is an effective independent organization that is able to identify and influence quality improvement on behalf of individual members and system improvement.	
§438.206 Availability of Service	Standard 1.1	<ul style="list-style-type: none"> • A complete listing of all contracted and credentialed providers. • Maps to demonstrate 30 minutes (20 miles) urban, and 60 minutes (45 miles) rural access timeframes (the mileage standard is used by DOH) for each level of care. • Group all providers by type of service, e.g. all outpatient providers should be listed on the same page or consecutive pages. • Excel or Access data base with the following information: Name of Agency (include satellite sites). Address of Agency (and satellite sites) with zip codes. Level of Care (e.g. Partial Hospitalization, D&A Outpatient, etc). Population served (adult, child & adolescent). Priority Population. Special Population.
	Standard 1.2	100% of members given choice of 2 providers at each level of care within 30/60 urban/rural met.



BBA Category	PEPS Reference	PEPS Language
	Standard 1.3	Provider Exception report submitted & approved when choice of two providers is not given.
	Standard 1.4	BH-MCO has identified & addressed any gaps in provider network (e.g. cultural, special priority, needs pops or specific services).
	Standard 1.5	BH-MCO has notified DPW of any drop in provider network. <ul style="list-style-type: none"> • Monitor provider turnover. • Network remains open where needed.
	Standard 1.6	BH-MCO must require providers to notify BH-MCO when they are at capacity or not excepting any new enrollees.
	Standard 1.7	Confirm FQHC providers.
	Standard 23.1	BH-MCO has assessed if 5% requirement is applicable.
	Standard 23.2	BH-MCO phone answering procedures provides instruction for non-English members if 5% requirement is met.
	Standard 23.3	List of interpreters is available for non-English Speakers.
	Standard 24.1	BH-MCO provides application includes information about handicapped accessibility.
	Standard 24.2	Provider network data base contains required information for ADA compliance.
	Standard 24.3	BH-MCO phone answering uses TTY or PA telecommunication relay services.
	Standard 24.4	BH-MCO is able to access to interpreter services.
	Standard 24.5	BH-MCO has the ability to accommodate people who are hard of hearing.
	Standard 24.6	BH-MCO can make alternate formats available upon request.
	Standard 28.1	Clinical/chart reviews reflect appropriate consistent application of medical necessity criteria and active care management that identify and address quality of care concerns.
	Standard 28.2	The medical necessity decision made by the BH-MCO Physician/Psychologist Advisor is supported by documentation in the denial record and reflects appropriate application of medical necessity criteria.
	Standard 93.1	The BH-MCO reports monitoring results for Access to Services (routine, urgent & emergent), Provider network adequacy and Penetration rates.
	Standard 93.2	The BH-MCO reports monitoring results for Appropriateness of service authorization and Inter-rater Reliability.
	Standard 93.3	The BH-MCO reports monitoring results for Authorization and complaint, grievance and appeal process, denial rates and grievance upheld and overturn rates.
	Standard 93.4	The BH-MCO reports monitoring results for Treatment Outcomes: Readmission Rates, Follow up after hospitalization rates, Consumer satisfaction, Changes in employment/educational /vocational status and Changes in living status.
§438.208 Coordination and Continuity of Care	Standard 28.1	Clinical/chart reviews reflect appropriate consistent application of medical necessity criteria and active care management that identify and address quality of care concerns.
	Standard 28.2	The medical necessity decision made by the BH-MCO Physician/Psychologist Advisor is supported by documentation in the denial record and reflects appropriate application of medical necessity criteria.
§438.210 Coverage and authorization of services	Standard 28.1	Clinical/chart reviews reflect appropriate consistent application of medical necessity criteria and active care management that identify and address quality of care concerns.
	Standard 28.2	The medical necessity decision made by the BH-MCO Physician/Psychologist Advisor is supported by documentation in the denial record and reflects appropriate application of medical necessity criteria.
	Standard 72.1	Denial notices are issued to members in a timely manner using the required template. The content of the notices adhere to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.
	Standard 72.2	Denial case files include complete and appropriate documentation according to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.
§438.2104	Standard 10.1	100% of credentialed files should contain licensing or certification required by PA law,



BBA Category	PEPS Reference	PEPS Language
Provider Selection		verification of enrollment in the MA and/or Medicare program with current MA provider agreement, malpractice/liability insurance, disclosure of past or pending lawsuits or litigation, board certification or eligibility BH-MCO on-site review, as applicable.
	Standard 10.2	100% of decisions made within 180 days of receipt of application.
	Standard 10.3	Recredentialing incorporates results of provider profiling.
§438.230 Subcontractual relationships and delegation	Standard 99.1	The BH-MCO reports monitoring results for Quality of individualized service plans and treatment planning.
	Standard 99.2	The BH-MCO reports monitoring results for Adverse Incidents.
	Standard 99.3	The BH-MCO reports monitoring results for collaboration and cooperation with member complaints, grievance and appeal procedures, as well as, other medical and human services programs.
	Standard 99.4	The BH-MCO reports monitoring results for administrative compliance.
	Standard 99.5	The BH-MCO has implemented a provider profiling process which includes performance measures, baseline thresholds and performance goals.
	Standard 99.6	Provider profiles and individual monitoring results are reviewed with providers.
	Standard 99.7	Providers are evaluated based on established goals and corrective action taken as necessary.
	Standard 99.8	The BH-MCO demonstrates that provider profiling results are incorporated into the network management strategy.
§438.236 Practice guidelines	Standard 28.1	Clinical/chart reviews reflect appropriate consistent application of medical necessity criteria and active care management that identify and address quality of care concerns.
	Standard 28.2	The medical necessity decision made by the BH-MCO Physician/Psychologist Advisor is supported by documentation in the denial record and reflects appropriate application of medical necessity criteria.
	Standard 93.1	The BH-MCO reports monitoring results for Access to Services (routine, urgent & emergent), Provider network adequacy and Penetration rates.
	Standard 93.2	The BH-MCO reports monitoring results for Appropriateness of service authorization and Inter-rater Reliability.
	Standard 93.3	The BH-MCO reports monitoring results for Authorization and complaint, grievance and appeal process, denial rates and grievance upheld and overturn rates.
	Standard 93.4	The BH-MCO reports monitoring results for Treatment Outcomes: Readmission Rates, Follow up after hospitalization rates, Consumer satisfaction, Changes in employment/educational /vocational status and Changes in living status.
§438.240 Quality assessment and performance improvement program	Standard 91.1	QM program description outlines the ongoing quality assessment and performance improvement activities, Continuous Quality Improvement process and places emphasis on, but not limited to High volume/high-risk services and treatment and Behavioral Health Rehabilitation services.
	Standard 91.2	QM work plan includes goal, aspect of care/ service, scope of activity, frequency, data source, sample size, responsible person and performance goal, as applicable.
	Standard 91.3	QM work plan outlines: The specific activities related to coordination and interaction with PH-MCO.
	Standard 91.4	QM work plan outlines, the joint studies to be conducted.
	Standard 91.5	The QM work plan includes the specific monitoring activities conducted to evaluate the effectiveness of the services received by members (access to services, provider network adequacy, penetration rates, appropriateness of service authorizations, inter-rater reliability, complaint, grievance and appeal process, denial rates, grievance upheld and overturn rates and treatment outcomes).
	Standard 91.6	The QM work plan includes a Provider Profiling process.
	Standard 91.7	The QM work plan includes the specific monitoring activities conducted to evaluate the quality and effectiveness of internal processes (telephone access and responsiveness rates, overall utilization patterns and trends including BHRS and other HV/HR services).

BBA Category	PEPS Reference	PEPS Language
	Standard 91.8	The QM work plan includes monitoring activities conducted to evaluate the quality and performance of the provider network (quality of individualized service plans and treatment planning, adverse incidents, collaboration and cooperation with member complaints, grievance, and appeal procedures as well as other medical and human services programs and administrative compliance).
	Standard 91.9	The QM work plan includes a process for determining provider satisfaction with the BH-MCO.
	Standard 91.10	The QM work plan outlines the specific performance improvement projects conducted to evaluate the BH-MCO's performance related to the following: Performance based contracting selected indicator for : ---Mental Health ---Substance Abuse External Quality Review: ---Follow up After Mental Health Hospitalization QM Annual Summary Report
	Standard 91.11	The identified Performance Improvement Projects must include the following: 1. Measurement of performance using objective quality indicators. 2. Implementation of system interventions to achieve improvement in quality. 3. Evaluation of the effectiveness of the interventions. 4. Planning and initiation of activities for increasing or sustaining improvement. 5. Timeline for reporting status and results of each project to DPW. 6. Completion of each performance Improvement project in a reasonable time period to allow information on the success of performance improvement projects to produce new information on quality of care each year.
	Standard 91.12	The QM work plan outlines other performance improvement activities to be conducted based on the findings of the Annual Summary Report and any Corrective Actions required from previous reviews.
	Standard 91.13	The BH-MCO has a process for its own evaluation of the impact and effectiveness of its quality management program annually. A report of this evaluation will be submitted to DPW by April 15 th .
	Standard 93.1	The BH-MCO reports monitoring results for Access to Services (routine, urgent & emergent), Provider network adequacy and Penetration rates.
	Standard 93.2	The BH-MCO reports monitoring results for Appropriateness of service authorization and Inter-rater Reliability.
	Standard 93.3	The BH-MCO reports monitoring results for Authorization and complaint, grievance and appeal process, denial rates and grievance upheld and overturn rates.
	Standard 93.4	The BH-MCO reports monitoring results for Treatment Outcomes: Readmission Rates, Follow up after hospitalization rates, Consumer satisfaction, Changes in employment/educational /vocational status and Changes in living status.
	Standard 98.1	The BH-MCO reports monitoring results for Telephone access standard and responsiveness rates. Standard: Abandonment rate <5%, average speed of answer < 30 seconds
	Standard 98.2	The BH-MCO reports monitoring results for Overall Utilization Patterns and Trends including BHRS service utilization and other high volume/high risk services Patterns of over or under utilization identified. BH MCO takes action to correct utilization problems including patterns of over and under Utilization.
	Standard 98.3	The BH-MCO reports monitoring results for Coordination with Other Service Agencies and School.
	Standard 104.1	The BH-MCOs must measure and report its performance using standard measures required by DPW.
	Standard 104.2	The BH-MCO must submit to the DPW data specified by the DPW, that enables the



BBA Category	PEPS Reference	PEPS Language
		measurement of the BH-MCO's performance QM program description must outline timeline for submission of QM program description, work plan, annual QM Summary/evaluation, and member satisfaction including Consumer Satisfaction Team reports to DPW.
	Standard 104.3	Performance Improvement Plans status reported within the established time frames.
\$438.242 Health information systems	Standard 120.1	The county/BH-MCO uses the required reference files as evidence through correct, complete and accurate encounter data.
\$438.400 Statutory basis and definitions	Standard 68.1	Interview with Complaint Coordinator demonstrates a clear understanding of the complaint process including how complaint rights procedures are made known to members, BH-MCO staff and the provider network. <ul style="list-style-type: none"> • BBA Fair Hearing • 1st Level • 2nd Level • External
	Standard 68.2	100% of Complaint Acknowledgement and Decision Letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Standard 68.3	Complaint decisions letters are written in clear, simple language that includes each issue identified in the member's complaint and a corresponding explanation and reason for the decision(s).
	Standard 68.4	The Complaint Case File includes documentation of the steps taken by the BH-MCO to investigate a complaint. All contacts and findings related to the involved parties are documented in the case file.
	Standard 68.5	Complaint case files include documentation of any referral of complaint issues, especially valid complaint issues to County/BH-MCO Committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff either by inclusion in the complaint case file or reference in the case file to where the documentation can be obtained for review.
	Standard 71.1	Procedures are made known to members, BH-MCO staff and the provider network. <ul style="list-style-type: none"> • BBA Fair Hearing • 1st Level • 2nd Level • External • Expedited
	Standard 71.2	100% of Grievance Acknowledgement and Decision Letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Standard 71.3	Grievance decision letters must be written in clear, simple language that includes a statement of all services reviewed and a specific explanation and reason for the decision including the medical necessity criteria utilized.
	Standard 71.4	Grievance case files must include documentation of any referrals to County/BH-MCO committees for further review and follow up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff either by inclusion in the grievance case file or reference in the case file to where the documentation can be obtained for review.
	Standard 72.1	Denial notices are issued to members in a timely manner using the required template. The content of the notices adhere to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.
Standard 72.2	Denial case files include complete and appropriate documentation according to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality	



BBA Category	PEPS Reference	PEPS Language
		Management Denial Summary Report for the respective review year.
§438.402 General requirements	Standard 60.1	Table of Organization identifies lead person responsible for overall coordination of Complaint and Grievance process and adequate staff to receive, process and respond to member complaints and grievances.
	Standard 60.2	Training rosters identify that complaint and grievance staff has been adequately trained to handle and respond to member complaints and grievances. Include a copy of the training curriculum.
	Standard 60.3	Training rosters identify that current and newly hired BH-MCO staff has been trained concerning member rights and the procedures for filing a complaint and grievance. Include a copy of the training curriculum.
	Standard 68.1	Interview with Complaint Coordinator demonstrates a clear understanding of the complaint process including how complaint rights procedures are made known to members, BH-MCO staff and the provider network. <ul style="list-style-type: none"> • BBA Fair Hearing • 1st Level • 2nd Level • External
	Standard 68.2	100% of Complaint Acknowledgement and Decision Letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Standard 68.3	Complaint decisions letters are written in clear, simple language that includes each issue identified in the member's complaint and a corresponding explanation and reason for the decision(s).
	Standard 68.4	The Complaint Case File includes documentation of the steps taken by the BH-MCO to investigate a complaint. All contacts and findings related to the involved parties are documented in the case file.
	Standard 68.5	Complaint case files include documentation of any referral of complaint issues, especially valid complaint issues to County/BH-MCO Committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff either by inclusion in the complaint case file or reference in the case file to where the documentation can be obtained for review.
	Standard 71.1	Procedures are made known to members, BH-MCO staff and the provider network. <ul style="list-style-type: none"> • BBA Fair Hearing • 1st Level • 2nd Level • External • Expedited
	Standard 71.2	100% of Grievance Acknowledgement and Decision Letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Standard 71.3	Grievance decision letters must be written in clear, simple language that includes a statement of all services reviewed and a specific explanation and reason for the decision including the medical necessity criteria utilized.
Standard 71.4	Grievance case files must include documentation of any referrals to County/BH-MCO committees for further review and follow up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff either by inclusion in the grievance case file or reference in the case file to where the documentation can be obtained for review.	
Standard 72.1	Denial notices are issued to members in a timely manner using the required template. The content of the notices adhere to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.	



BBA Category	PEPS Reference	PEPS Language
§438.404 Notice of action	Standard 23.1	BH-MCO has assessed if 5% requirement is applicable.
	Standard 23.2	BH-MCO phone answering procedures provides instruction for non-English members if 5% requirement is met.
	Standard 23.3	List of interpreters is available for non-English Speakers.
	Standard 24.1	BH-MCO provides application includes information about handicapped accessibility.
	Standard 24.2	Provider network data base contains required information for ADA compliance.
	Standard 24.3	BH-MCO phone answering uses TTY or PA telecommunication relay services.
	Standard 24.4	BH-MCO is able to access to interpreter services.
	Standard 24.5	BH-MCO has the ability to accommodate people who are hard of hearing.
	Standard 24.6	BH-MCO can make alternate formats available upon request.
	Standard 72.1	Denial notices are issued to members in a timely manner using the required template. The content of the notices adhere to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.
Standard 72.2	Denial case files include complete and appropriate documentation according to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.	
§438.406 Handling of grievances and appeals	Standard 68.1	Interview with Complaint Coordinator demonstrates a clear understanding of the complaint process including how complaint rights procedures are made known to members, BH-MCO staff and the provider network. <ul style="list-style-type: none"> • BBA Fair Hearing • 1st Level • 2nd Level • External
	Standard 68.2	100% of Complaint Acknowledgement and Decision Letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Standard 68.3	Complaint decisions letters are written in clear, simple language that includes each issue identified in the member's complaint and a corresponding explanation and reason for the decision(s).
	Standard 68.4	The Complaint Case File includes documentation of the steps taken by the BH-MCO to investigate a complaint. All contacts and findings related to the involved parties are documented in the case file.
	Standard 68.5	Complaint case files include documentation of any referral of complaint issues, especially valid complaint issues to County/BH-MCO Committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff either by inclusion in the complaint case file or reference in the case file to where the documentation can be obtained for review.
	Standard 71.1	Procedures are made known to members, BH-MCO staff and the provider network. <ul style="list-style-type: none"> • BBA Fair Hearing • 1st Level • 2nd Level • External • Expedited
	Standard 71.2	100% of Grievance Acknowledgement and Decision Letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Standard 71.3	Grievance decision letters must be written in clear, simple language that includes a statement of all services reviewed and a specific explanation and reason for the decision including the medical necessity criteria utilized.
	Standard 71.4	Grievance case files must include documentation of any referrals to County/BH-MCO committees for further review and follow up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the

BBA Category	PEPS Reference	PEPS Language
		C/G staff either by inclusion in the grievance case file or reference in the case file to where the documentation can be obtained for review.
	Standard 72.1	Denial notices are issued to members in a timely manner using the required template. The content of the notices adhere to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.
	Standard 72.2	Denial case files include complete and appropriate documentation according to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.
§438.408 Resolution and notification: Grievances and appeals	Standard 68.1	Interview with Complaint Coordinator demonstrates a clear understanding of the complaint process including how complaint rights procedures are made known to members, BH-MCO staff and the provider network. <ul style="list-style-type: none"> • BBA Fair Hearing • 1st Level • 2nd Level • External
	Standard 68.2	100% of Complaint Acknowledgement and Decision Letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Standard 68.3	Complaint decisions letters are written in clear, simple language that includes each issue identified in the member's complaint and a corresponding explanation and reason for the decision(s).
	Standard 68.4	The Complaint Case File includes documentation of the steps taken by the BH-MCO to investigate a complaint. All contacts and findings related to the involved parties are documented in the case file.
	Standard 68.5	Complaint case files include documentation of any referral of complaint issues, especially valid complaint issues to County/BH-MCO Committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff either by inclusion in the complaint case file or reference in the case file to where the documentation can be obtained for review.
	Standard 71.1	Procedures are made known to members, BH-MCO staff and the provider network. <ul style="list-style-type: none"> • BBA Fair Hearing • 1st Level • 2nd Level • External • Expedited
	Standard 71.2	100% of Grievance Acknowledgement and Decision Letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Standard 71.3	Grievance decision letters must be written in clear, simple language that includes a statement of all services reviewed and a specific explanation and reason for the decision including the medical necessity criteria utilized.
	Standard 71.4	Grievance case files must include documentation of any referrals to County/BH-MCO committees for further review and follow up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff either by inclusion in the grievance case file or reference in the case file to where the documentation can be obtained for review.
	Standard 72.1	Denial notices are issued to members in a timely manner using the required template. The content of the notices adhere to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.
	Standard 72.2	Denial case files include complete and appropriate documentation according to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality



BBA Category	PEPS Reference	PEPS Language
		Management Denial Summary Report for the respective review year.
§438.410 Expedited resolution of appeals	Standard 71.1	Procedures are made known to members, BH-MCO staff and the provider network. <ul style="list-style-type: none"> • BBA Fair Hearing • 1st Level • 2nd Level • External • Expedited
	Standard 71.2	100% of Grievance Acknowledgement and Decision Letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Standard 71.3	Grievance decision letters must be written in clear, simple language that includes a statement of all services reviewed and a specific explanation and reason for the decision including the medical necessity criteria utilized.
	Standard 71.4	Grievance case files must include documentation of any referrals to County/BH-MCO committees for further review and follow up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff either by inclusion in the grievance case file or reference in the case file to where the documentation can be obtained for review.
	Standard 72.1	Denial notices are issued to members in a timely manner using the required template. The content of the notices adhere to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.
	Standard 72.2	Denial case files include complete and appropriate documentation according to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.
§438.414 Information about the grievance system to providers and subcontractors	Standard 68.1	Interview with Complaint Coordinator demonstrates a clear understanding of the complaint process including how complaint rights procedures are made known to members, BH-MCO staff and the provider network. <ul style="list-style-type: none"> • BBA Fair Hearing • 1st Level • 2nd Level • External
	Standard 71.1	Procedures are made known to members, BH-MCO staff and the provider network. <ul style="list-style-type: none"> • BBA Fair Hearing • 1st Level • 2nd Level • External • Expedited
§438.420 Continuation of benefits while the MCO or PIHP appeal and the State fair hearing are pending	Standard 71.1	Procedures are made known to members, BH-MCO staff and the provider network. <ul style="list-style-type: none"> • BBA Fair Hearing • 1st Level • 2nd Level • External • Expedited
	Standard 71.2	100% of Grievance Acknowledgement and Decision Letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Standard 71.3	Grievance decision letters must be written in clear, simple language that includes a statement of all services reviewed and a specific explanation and reason for the decision including the medical necessity criteria utilized.
	Standard 71.4	Grievance case files must include documentation of any referrals to County/BH-MCO committees for further review and follow up. Evidence of subsequent corrective action



BBA Category	PEPS Reference	PEPS Language
		and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff either by inclusion in the grievance case file or reference in the case file to where the documentation can be obtained for review.
	Standard 72.1	Denial notices are issued to members in a timely manner using the required template. The content of the notices adhere to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.
	Standard 72.2	Denial case files include complete and appropriate documentation according to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.
§438.424 Effectuation of reversed appeal resolutions	Standard 71.1	Procedures are made known to members, BH-MCO staff and the provider network. <ul style="list-style-type: none"> • BBA Fair Hearing • 1st Level • 2nd Level • External • Expedited
	Standard 71.2	100% of Grievance Acknowledgement and Decision Letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Standard 71.3	Grievance decision letters must be written in clear, simple language that includes a statement of all services reviewed and a specific explanation and reason for the decision including the medical necessity criteria utilized.
	Standard 71.4	Grievance case files must include documentation of any referrals to County/BH-MCO committees for further review and follow up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff either by inclusion in the grievance case file or reference in the case file to where the documentation can be obtained for review.
	Standard 72.1	Denial notices are issued to members in a timely manner using the required template. The content of the notices adhere to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.
	Standard 72.2	Denial case files include complete and appropriate documentation according to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.

Appendix B: OMHSAS-Specific PEPS Items

Category	PEPS Reference	PEPS Language
Second Level Complaints and Grievances		
Complaints	Standard 68.6	The second level complaint case file includes documentation that the member was contacted about the 2nd level complaint meeting and offered a convenient time and place for the meeting and asked about their ability to get to the meeting and if they need any assistive devices.
	Standard 68.7	Training rosters identify that all 2nd level panel members have been trained. Include a copy of the training curriculum.
	Standard 68.8	A transcript and/or tape recording of the 2nd level committee meeting will be maintained to demonstrate appropriate representation, familiarity with the issues being discussed and that the decision was based on input from all panel members.
	Standard 68.9	Where applicable there is evidence of County oversight and involvement in the 2nd level complaint process.
Grievances and State Fair	Standard 71.5	The second level grievance case file includes documentation that the member was contacted about the 2nd level grievance meeting and offered a convenient time and



Category	PEPS Reference	PEPS Language
Hearings		place for the meeting and asked about their ability to get to the meeting and if they need any assistive devices.
	Standard 71.6	Training rosters identify that all 2nd level panel members have been trained. Include a copy of the training curriculum.
	Standard 71.7	A transcript and/or tape recording of the 2nd level committee meeting will be maintained to demonstrate appropriate representation, familiarity with the issues being discussed and that the decision was based on input from all panel members.
	Standard 71.8	Where applicable there is evidence of County oversight and involvement in the 2nd level grievance process.
Enrollee Satisfaction		
Consumer / Family Satisfaction	Standard 108.3	County/BH MCO role of fiduciary (if applicable) is clearly defined, provides supportive function as defined in C/FST Contract as opposed to directing the program.
	Standard 108.4	The C/FST Director is responsible for setting program direction consistent with County direction, negotiating contract, prioritizing budget expenditures, recommending survey content and priority and directing staff to perform high quality surveys.
	Standard 108.9	Results of surveys by provider and level of care are reflected in BH MCO provider profiling and have resulted in provider action to address issues identified.

REFERENCES

- i World Health Organization. (2008) WHO Global Burden of Disease: 2004 Update. Available from: www.who.int/healthinfo/global_burden_disease/2004_report_update/en/index.html
- ii Dombrovski A, Rosenstock J (2004) Bridging General Medicine and Psychiatry: Providing General Medical and Preventive Care for the Severely Mentally Ill. *Current Opinion in Psychiatry*, 17(6):523-529
- iii Moran M. (2009) Schizophrenia Patients Show High Rates of Comorbid Illness. *Psychiatric News*, 44(18):22.
- iv Gill SS. (2005). Stable Monotherapy with Clozapine or Olanzapine Increases the Incidence of Diabetes Mellitus in People with Schizophrenia. *Evid Based Ment Health*, 8(1):24.
- v Leslie DL, Rosenheck RA. (2004) Incidence of Newly Diagnosed Diabetes Attributable to Atypical Antipsychotic Medications. *Am J Psychiatry*, 161:1709–11.
- vi Druss BG, Rosenheck, RA, Desai MM, &Perlin, J. B. (2002). Quality of Preventive Medical Care for Patients with Mental Disorders. *Medical Care*, 40(2):129–136.
- vii Desai M, Rosenheck RA, Druss BG, Perlin J.B. (2002) Mental Disorders and Quality of Diabetes Care in Veterans Health Administration. *Am J Psychiatry*, 159:1584-1590
- viii Frayne SM., Halanych JH., Miller D.R., et al. (2005) Disparities in Diabetes Care: Impact of Mental Illness. *Arch Intern Med*, 165(22):2631-8.
- ix Druss BG, Bradford DW, Rosenheck RA et al. (2000) Mental Disorders and Use of Cardiovascular Procedures After Myocardial Infarction *JAMA*, 283(4):506-11.
- x Averyt JM, Kuno E, Rothbard AB, Culhane DP. (1997) Impact of Continuity of Care on Recurrence of Homelessness Following an Acute Psychiatric Episode. *Continuum* 4.3
- xi National Institute of Mental Health — Statistics. <http://www.nimh.nih.gov/health/topics/statistics/index.shtml>. updated Mar 31,2009. Accessed May 20, 2009.
- xii Insel TR. (2008) Assessing the Economic Costs of Serious Mental Illness. *Am J Psychiatry*, 165:663-65.
- xiii D’Mello DA, Boltz MK, Msibi B. (1995) Relationship between Concurrent Substance Abuse in Psychiatric Patients and Neuroleptic Dosage. *Am J Drug Alcohol Abuse*, 2:257-65.
- xiv National Committee for Quality Assurance (NCQA, 2007). *The State of Health Care Quality 2007*. Washington, DC: National Committee for Quality Assurance. Available at http://www.ncqa.org/Portals/0/Publications/Resource%20Library/SOHC/SOHC_2007.pdf (Accessed July 12, 2010).
- xv van Walraven C, Mamdani M, Fang J, Austin PC. (2004) Continuity of Care and Patient Outcomes After Discharge. *J Gen Intern Med*, 19:624-31
- xvi Hermann RC. (2000) Quality measures for mental health care: results from a National Inventory. *Medical Care Research and Review*, 57:136-54

xvii Ibid.

xviii Cuffel BJ, Held M, Goldman W. (2002) Predictive Models and the Effectiveness of Strategies for Improving Outpatient Follow-up Under Managed Care. *Psychiatric Services* 53:1438-43.

xix Nelson EA, Maruish ME, Axler JL. (2000) Effects of Discharge Planning and Compliance with Outpatient Appointments on Readmission Rates. *Psychiatric Services*, 51:885-889.

xx Ibid.

xxi Adair CE, McDougall GM, Mitton CR. (2005) Continuity of Care and Health Outcomes Among Persons with Severe Mental Illness. *Psychiatric Services*, 56(9):1061-69.

xxii Mitton CR, Adair CE, McDougall GM, Marcoux G. (2005) Continuity of Care and Health Care Costs Among Persons with Severe Mental Illness. *Psychiatric Services*, 56(9):1070-6.

xxiii Chien C, Steinwachs DM, Lehman AF, et al. (2000) Provider Continuity and Outcomes of Care for Persons with Schizophrenia. *Mental Health Services Research*, 2:201-11.

xxiv Ibid.