pennsylvania
DEPARTMENT OF HUMAN SERVICES

CENTERS OF EXCELLENCE

Goals and Benchmarks

2018

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COE GOALS AND BENCHMARKS

A. Introduction

This document provides detailed guidance on the goals and benchmarks that were originally described in the Request for Applications (RFA) that the Center of Excellence (COE) designee signed and submitted. The document should be used to guide COE programs toward the COE vision (see below). The document contains several glossaries within the Appendices. The primary glossary (Appendix A) can be found on page 9, which defines many of the terms used in this document in **bold**. Another glossary (Appendix E) defines the data components in the two primary tracking sheets required by the COE. Lastly, additional resources are available in Appendices B and C.

B. COE Vision

The Pennsylvania Department of Human Services (DHS) defines the vision of the COE as: "ensuring effective care coordination, integrating physical and behavioral health needs for every patient with an Opioid Use Disorder (OUD), and increasing access to Medication-Assisted Treatment (MAT)."

C. COE Goals and Benchmarks

1. Deploy a community-based care management team to support care management of individuals with OUD.

The COE must deploy a **community-based care management (CBCM) team** that 1) consists of licensed and unlicensed professionals that provide a suitable range of behavioral health and primary care expertise and role functions, 2) have shared operations and workflows, and 3) have formal or on-the-job training (1). The **CBCM** team's activities must not overlap or be redundant of already existing reimbursed care management services.

The COE will:

1. Establish one or more **CBCM team** tailored to the needs of each client and situation.
2. Employ methods to identify clients within the COE designated area who may need or may benefit from the COE. Develop and maintain a capacity to make **initial contact** with individual where they are physically located (see Appendix B for recommended community stakeholders) in a safe, public location within 30 miles of the COE or within the COE itself.
3. Ensure that all uninsured **COE-engaged clients,** who are eligible for Medicaid, are appropriately enrolled within 60 days of becoming **engaged** with the COE.
   - ◊ If an uninsured **COE-engaged client** is not eligible for Medicaid, the COE will conduct a **referral** to the appropriate Single County Authority (SCA).
4. **Engage** clients in identifying their treatment and **non-treatment** needs for care and the particular clinicians or other individuals to address those needs.

5. Involve both the client and **CBCM** to create an explicit, unified, and coordinated **care plan** that addresses each **COE-engaged client's** treatment and **non-treatment needs**, with systematic follow-up and adjustment of the **care plan** if the client is not improving as expected.
6. The **CBCM COE-engaged client's care plan** should be supported by 1) the client expecting that his/her behavioral and physical health care needs will be coordinated as a standard of care, 2) COE office practice, leadership alignment, and business model, and 3) a continuous quality improvement and measurement of effectiveness that routinely collects and uses data and periodically examines and reports outcomes.
7. Ensure every **COE-engaged client** receives a **Level of Care Assessment** by a licensed professional within 7 days of **initial contact,** if the client consents to receive OUD treatment services and the **Level of Care Assessment** has not already been completed with the client within the past 6 months.
   - ◊ If the **COE-engaged client** consents to receive OUD treatment services, the COE will identify and **engage** with an appropriate **OUD treatment provider** per **Level of Care Assessment** and client choice, and ensure client admission to OUD treatment within 14 calendar days of **initial contact** with the **CBCM** team.
   - ◊ If the **COE-engaged client** does not consent to receive OUD treatment services, the **CBCM** team will still prepare individualized **care plans** that (see Appendix C for example plan) provide **positive support services**, utilizing **motivational interviewing** to progress the client toward addressing treatment needs.
8. Utilize the Prescription Drug Monitoring Program (PDMP) and urine drug screen testing as allowed, required by law, and appropriate to identify individuals at increased risk for inappropriate medication usage per Pennsylvania Prescribing Guidelines for opioids and benzodiazepines (2).
9. Administer the Outcomes Tool face-to-face within 30 days of the initial COE treatment admission date, then re-administer it face-to-face every six-months thereafter.

The COE may place an individual in an inactive status from COE services if:

1. He or she voluntarily elects to discontinue participation in the program; or
2. He or she consistently participates in SUD treatment and establishes community supports that perpetuate the **recovery** process.

2. Integrate physical and behavioral health.

The COE will:

1. Utilize **motivational interviewing** principles (3) to motivate and encourage clients with OUD during continued **engagement** to follow the **care plan** that addresses both treatment (in both **physical** and **behavioral health)**and **non-treatment needs**.
2. **Assess** the **COE-engaged client's physical** and **behavioral health** needs and **non-treatment needs** against the client's **care plans** every 30 days, and update the **care plans** to reflect progress every 6 months (4).

3. Ensure every **COE-engaged client** is **engaged** in primary care that is provided either on-site or elsewhere, as demonstrated by a signed consent form between the primary care physician and the COE **CBCM** team, and at least one follow-up primary care visit as defined by the client's **care plan** within 6 months of COE client **engagement**.
4. Ensure every **COE-engaged client** identified as a pregnant female is **engaged** with an OB/GYN, either on-site or elsewhere, as demonstrated by a signed consent form between the OB/GYN provider and COE **CBCM** team, and at least one follow-up OB/GYN visit as defined by the client's **care plan** within 6 months of COE client **engagement.**
5. Ensure every **COE-engaged client** has a defined licensed **behavioral health** provider, either on-site or elsewhere, as demonstrated by a signed consent form between the **behavioral health** provider and the COE **CBCM** team, and at least one follow-up visit as defined by the client's **care plan** within 6 months of COE client **engagement**.
    - ◊ As appropriate, work with telemedicine psychiatry providers in rural area to increase the referral for appropriate treatment of behavioral health.
6. Ensure all patients receiving medication for the treatment for OUD has an established and implemented pathway to **psychosocial interventions** for every **COE-engaged client** receiving MAT, per the client's **care plan**(6).

3. Increase access to Medication-Assisted Treatment (MAT).

The U.S. Department of Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA) defines MAT as the use of medications, in combination with counseling and behavioral therapies, to provide a whole-patient approach to the treatment of Substance Use Disorders (SUD)(5). MAT is clinically driven with a focus on individualized patient care. Research continues to demonstrate medication, along with behavioral therapies, results in successful outcomes (6).

The COE will:

1. Provide access on-site that is available within 24 hours to at least one medication for the treatment of OUD (e.g. buprenorphine, methadone, naltrexone), as determined by both client choice and treatment needs **assessed** during **initial contact** or ongoing **engagement**.
2. Establish and implement a **referral** pathway so that every **COE-engaged client** has access within 24 hours for any medication not available on site, as determined by client choice and treatment needs assessed during **initial contact** or ongoing **engagement.**

D. Additional COE Goals and Benchmarks

1. Organizational Health

The COE will:

1. Create and adopt a **vision statement** to guide the work of the COE that aligns with the DHS vision.
2. Collect **performance measurements** that allow the COE to assess its performance against it's vision and specified goals and objectives stated in C. and D. of this document. Example **performance measurements** may include results of Urine Drug Screens, or verified face-to-face contact every 30 days.
3. Specify and document COE staff organization, roles, and responsibilities, including leadership.
4. Develop a training matrix for all COE staff to follow, based upon each staff's development against his/her roles and responsibilities, and identified knowledge gaps per the **performance measurements**.

2. Community Partnership Building

In order to effectively **engage** individuals with OUD in the services that they need, the COE must establish and maintain partnerships with a variety of agencies that can address a **COE-engaged client's** needs.

The COE will:

1. Initiate contact and meet at least one time with all community stakeholders defined in Appendix B to discuss the **vision** of the COE, services offered by the COE, and potential referral mechanisms from the community partner to the COE. All meetings should be documented with agenda, attendees present and meeting minutes. If a community partner either does not exist in the area served by the COE, or is unwilling to meet after two attempts, this should be documented and submitted to DHS.
2. Convene and facilitate recurring quarterly meetings with **key partners**. The COE will maintain records of the agendas, attendees, and meeting minutes. The goals of these meetings are to:
    - ◊ Review and report existing services to address treatment needs in the community;
    - ◊ Identify and report opportunities to collaborate and bridge treatment and recovery support gaps; and
    - ◊ Develop strategies to achieve effective **coordinated care** between **key partners.**

Note: Counties with more than one COE will work cooperatively with the other COE(s) to convene the key partners.

3. Participation in Technical Assistance and Learning Network

DHS engaged the University of Pittsburgh's School of Pharmacy Program Evaluation & Research Unit (PERU) to develop the Learning Network. Full participation by each COE is expected in the Learning Network and with Technical Assistance. Each COE will be expected to use $5,000 of the FY17-18 grant funding to participate in a learning network that supports professional development activities that supplement Learning Network events.

COE GOALS AND BENCHMARKS

The COE will:

1. Participate fully in PERU's Technical Assistance Program, including attending Need's Assessment Report site visits, data and Technical Assistance phone calls and webinars, and timely execution of an agreed upon individualized Technical Assistance plan specified by goals and timelines.
2. Provide quarterly updates to PERU regarding execution of the COE Requirements specified in Goals 1-3.
3. Participate fully in all in-person and regional Learning Network events and online Learning Community, including attending all events, completing action items, and logging into the Learning Community at least every 30 days.

4. Tracking and Reporting Access to Care and Quality Outcomes

To track and report metrics at an individual and aggregate level, the COE will maintain the DHS-provided Care Management Report and Quality Data Report tracking spreadsheets that record quality, care management, and outcomes for each individual receiving COE services and supports as specified in Appendix D. In addition, the COE will maintain the Provider Profile, COE Medicaid Cross Reference Spreadsheet, and COE Outcomes Survey. Data is required to be submitted monthly on the last day of the month for the preceding month through an established DocuShare site. The COE is expected to report data elements for all **COE-engaged clients** seen, regardless of their Medicaid enrollment status beginning in July 2018.

5. Budgetary Requirements

A FY 17-18 budget should be submitted by each COE. The majority of the OUD-COE money must be used for care management of individuals with OUD. The following are allowable COE expenses:

1. Salary and benefits of the care management staff;
2. Salary and benefits, or a pro-rated portion of salary and benefits, of a manager or supervisor of the care management team, as well as other employees involved in the administration and oversight of the COE (e.g., data entry, reporting) commensurate with the amount of time devoted to the COE;
3. Up to $25,000 (5%) per fiscal year for minor computer equipment and software purchases, which may include computer equipment (e.g., personal computer, tablet, laptop) and mobile devices (or reimbursement for use of personal devices);
4. Travel-related costs (e.g., reimbursement for mileage for the **CBCM** team);
5. Up to $15,000 (3%) in FY 16-17, and $5,000 (1%) in FY 17-18 for expenses related to participation in the Learning Network; and
6. Up to $15,000 (3%) per fiscal year for operating expenses, which may include expenses for rent, utilities, taxes, insurance, supplies, printing/copying and telephone.

COE GOALS AND BENCHMARKS

The following are not allowable COE expenses:

1. Treatment services and other client-related support services that are covered under the Medical Assistance program (i.e., services included on the Medical Assistance program Fee Schedule or covered under a contract or an agreement between the provider and a physical or behavioral health managed care organization, as well as services that are covered under the individual's private insurance), given that the **CBCM** team's activities must not overlap or be redundant of already existing reimbursed care management services;
2. Neither the COE nor any provider with which it collaborates to provide services to COE clients may charge COE clients cash for any OUD related services;
3. Vehicles;
4. Computer system, including electronic health record software; and
5. Brick and mortar or other capital costs or fixed assets (e.g. new building, renovations).

6. Other Goals and Benchmarks

1. The COE will initiate treatment for and engage at least 300 new clients in its first year of operation. A new client is an individual who has not had services within the past 60 days. The COE is not required to engage 300 new clients in FY17-18, but rather to continue to serve those already engaged and continue to engage new clients at least until 300 clients are engaged.
2. The COE will follow the **Public Health Services Act** and **Federal Confidentiality Regulations**, and **State Confidentiality Regulations**. DHS reserves right to audit pursuant to its regulations if it is suspected that confidentiality requirements are not being followed appropriately.

APPENDIX A: GLOSSARY

Assessment: An on-going process by which the Community Based Care Management team is able to determine the client's physical, behavioral, and social needs, as well as client's strengths, weaknesses, and goals (4).

Behavioral Health: An umbrella term for care that addresses the impact of behavioral problems on health. Encompasses mental health care and substance use disorder (SUD) treatment, as well as health-related behaviors and the effect of stress on physical symptoms (1).

Care Management: Development and management of a client's individual care plan that addresses the physical and behavioral health needs of the client along with the positive support services, by working directly with individuals and service agencies to coordinate and facilitate services to address the issues and needs that often occur concurrently with an Opioid Use Disorder. Care management will provide services guided by a recovery-based philosophy of care, supporting the client's continuing stability and wellness as the client moves through the recovery continuum.

Care Plan: A explicit, unified, and integrated plan that contains assessments and plans for biological/physical, psychological, cultural, social, and organization of care aspects of the patient's health and health care. Scope includes prevention, acute, and chronic/complex care.

COE-Engaged Client: Clients that have completed initial contact with a Community Based Care Management member, Level of Care Assessment, and confirmed Treatment Admission. Following these items, face-to-face meetings should occur, at a minimum, every 30 days with demonstrated success toward care plan goals.

Community-Based Care Management (CBCM) Teams: Multi-disciplinary teams, including licensed and un-licensed professionals, that are responsible for coordinating both clinical and non-clinical services for individuals with complex illnesses (7). Community Based Care Management teams are responsible for connecting individuals to community resources and navigating transitions of care. These teams engage with individuals to promote whole-person care across the spectrum of providers, settings, and care systems (8). Community Based Care Management teams develop sustained relationships with clients through face-to-face contact.

Coordinated Care: The organization of patient care activities between two or more participants involved in care, to facilitate appropriate delivery of healthcare services. Organizing care involves the marshaling of personnel and other resources needed to carry out required care activities, and often managed by the exchange of information among participants responsible for different aspects of care (1).

Engage/Engaged/Engagement: Documented client or client provider contact in accordance with care plan goals, at a minimum of every 30 days. If it is a client provider, consent must be documented to share appropriate information regarding the client's care that can be reported to Pennsylvania Department of Human Services.

Federal Confidentiality Regulations (42 CFR Part 2 and 45 CFR Part 96): 42 CFR Part 2 applies to any individual or entity that is federally assisted and holds itself out as providing, and provides alcohol or drug abuse diagnosis, treatment, or referral to treatment. The regulations restrict the disclosure and use of alcohol and drug patient records which are maintained in connection with the performance of any federal assisted alcohol and drug abuse program (9). 45 CFR Part 96 applies to the Substance Abuse Prevention and Treatment Block Grant, which is administered by the Substance Abuse and Mental Health Services Administration. More information can be found at https://www.law.cornell.edu/cfr/text/45/part-96/subpart-L.

APPENDIX A: GLOSSARY

Initial Contact: Face-to-face meeting with a client, that includes a strategy for enhancing client engagement and an assessment of the client's treatment and non-treatment needs.

Key Partners: Single County Authority, Hospital and Hospital Systems, Managed Care Organizations, Primary Care Physicians, and Opioid Use Disorder Treatment Providers for COE-engaged clients.

Level of Care Assessment: Face-to-face interview with the individual to ascertain treatment needs based on the degree and severity of alcohol and other drug use through the development of a comprehensive confidential personal history, including significant medical, social, occupational, educational, and family information (examples are Pennsylvania Client Placement Criteria and American Society of Addiction Medicine Criteria).

Motivational Interviewing (MI): A directive, client-centered counseling style for eliciting behavior change by helping clients to explore and resolve ambivalence. The spirit of motivational interviewing can be described as collaborative, evocative, and honoring patient autonomy (3).

Non-Treatment Needs: Include services such as housing, food, transportation, voter registration, employment, education, job training, and interpreter.

Opioid Use Disorder Treatment Provider: Opioid Use Disorder treatment providers are licensed by the Pennsylvania Department of Drug and Alcohol Programs to provide drug and alcohol services to clients with an Opioid Use Disorder.

Performance Measurement: Regular measurement of processes and outcomes, which generates reliable data that can be used to continuously improve the effectiveness and efficiency of programs.

Physical Health: Management of acute and/or chronic physiological health conditions or co-morbidities. Also includes maintenance health appointments including, but not limited to: yearly physicals vaccinations, reproductive health screenings, Sexually Transmitted Infection screenings (including Hepatitis C and Human Immunodeficiency Virus), and dental care.

Positive Support Services: Culturally and linguistically appropriate services that facilitate recovery, wellness, and linkage to and coordination among services providers, and other supports shown to improve quality of life.

Psychosocial Interventions: Interpersonal or informational activities, techniques, or strategies that target biological, behavioral, cognitive, emotional, interpersonal, social, or environmental factors (10).

Public Health Services Act (42 U.S.C §§ 290ee-3, 290dd-2): Requires that the identity, diagnosis, prognosis, or treatment of any patient which are maintained in connection with the performance of any program or activity relating to substance abuse education, prevention, training, treatment, rehabilitation, or research, which is conducted, regulated, or directly or indirectly assisted by any department or agency of the United States shall, except as provided to the Uniformed Services, be confidential and be disclosed only for the purposes and under the consent of the patient. More information can be found at https://www.gpo.gov/fdsys/pkg/USCODE-2010-title42/pdf/USCODE-2010-title42-chap6A-subchapIII-A-partD-sec290dd-2.pdf (11).

APPENDIX A: GLOSSARY

Recovery: Process of change through which an individual ultimately achieves abstinence from illicit substances and improves health, wellness, and quality of life, as reported by National Council on Alcoholism and Drug Dependence.

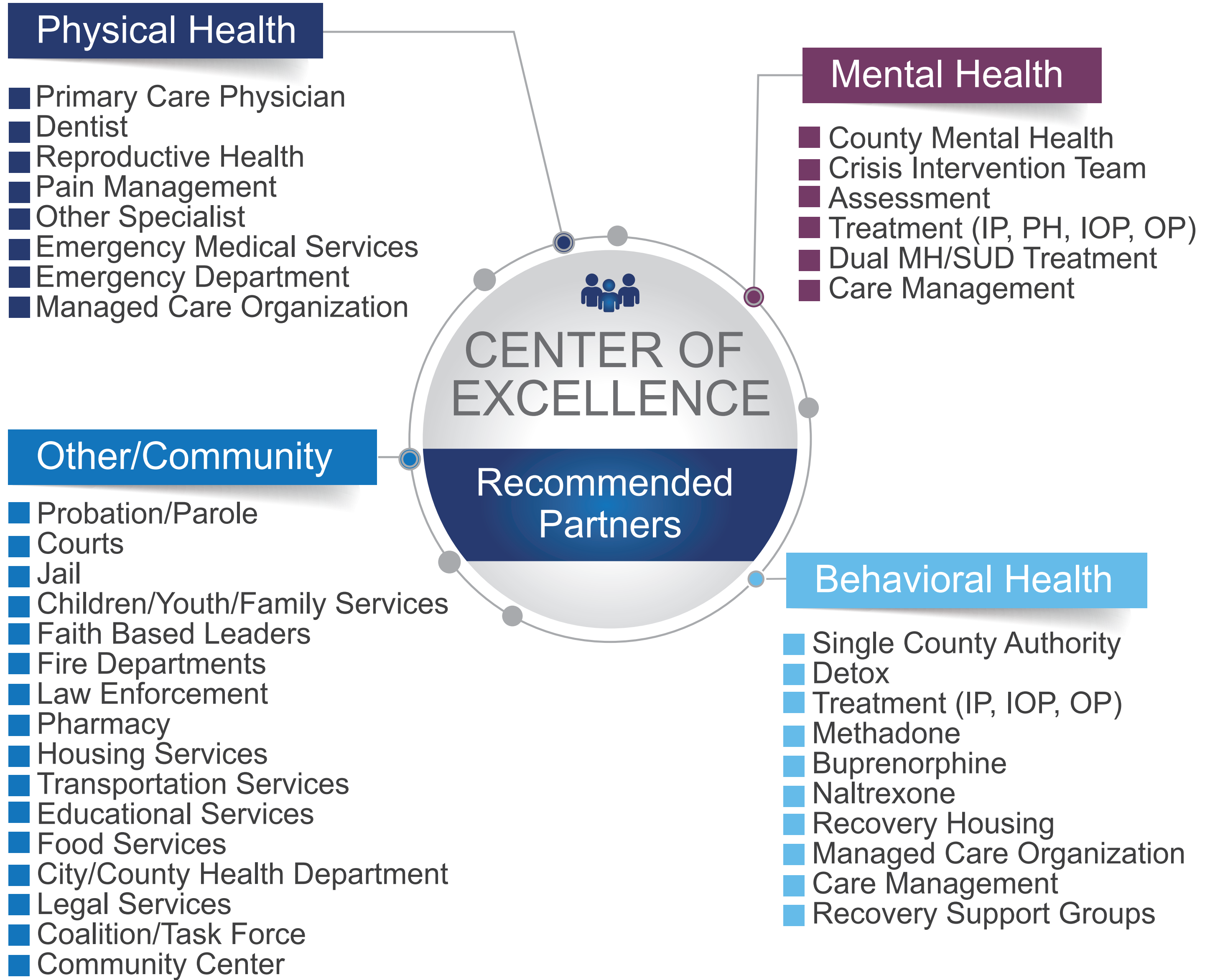
Referral: Two way connection of the Community Based Care Management team to a recipient agency that will provide services for the COE-engaged client. To be an adequate referral, there must be notification back to the Community Based Care Management team that the information was received and the client accessed services.

State Confidentiality Regulations (4 Pa. Code §§ 255.5 and 257.4): 4 Pa. Code §§ 255.5 states that information and reporting systems shall not disclose or be used to disclose client oriented data which reasonably may be utilized to identify the client to any person, agency, institution, governmental unit, or law enforcement personnel. More information can be found at https://www.pacode.com/secure/data/004/chapter255/s255.5.html (12). 4 Pa. Code §§ 257.4 requires, as a component of the Comprehensive Drug and Alcohol Treatment and Prevention Plan, that each SCA shall, in cooperation with service providers, develop a plan for the provision of a case management system for all individuals entering or currently a client of drug or alcohol treatment services provided by the Single County Authority Confidentiality information is detailed and can be found at https://www.pacode.com/secure/data/004/chapter257/s257.4.html (13).

Vision: A vision statement should clearly and specifically outline the ideal conditions the COE hopes to attain. This vision should serve as a guide for decision-making in the COE and should be understood by all staff. The COE vision must encompass effective care coordination, integrated physical and behavioral health, and client access to Medication-Assisted Treatment.

*Most definitions above were adapted from the Lexicon for Behavioral Health and Primary Care Integration: Concepts and Definitions Developed by Expert Consensus (1).

APPENDIX B: COMMUNITY STAKEHOLDERS



APPENDIX C: SAMPLE RECOVERY PLAN

Goals and Aspirations What do I want? What do I currently have?	**Resources, Strengths and Skills** What do I have access to? What have I used in the past?	**Barriers and Problems** What barriers or issues do I need to remove or overcome to achieve my goals?
Recovery from Opioid Misuse		
Mental and/or Emotional Health		
Medical and/or Physical Health		
Living Situation and/or Environment		
Employment and Financial Independence		
Independence from Legal Issues		
Relationships and Social Support		
Education and/or Intellectual Health		
Spirituality		
Leisure and Recreation		

APPENDIX D: DATA TRACKING DICTIONARY

Care Management Reporting Tracking Sheet

COE Care Management Reporting	Provide all information on COE Medical Assistance (MA) Members and COE Members that do not have MA with a diagnosis of Substance Use Disorder. One line of Unique summarized data is being requested per MA recipient ID.	Format	Length	Valid Values
Name of COE	Entered on the summary page-will automatically populate.	N/A	N/A	N/A
COE Care Manager	First initial and last name (Example: Arleen Smith is A. Smith). If multiple care managers provide support services to a member on one date of service, enter the first initial and last name of each care manager separated by a comma on the same line.	Character	Unknown	Unknown
Licensed Care Manager	Enter 'Y' or 'N', to indicate if the Care Management Team member providing the Care Management service is a Licensed professional.	Character	Unknown	Unknown
Unlicensed Care Manager	This field will automatically populate with 'Y' or 'N' based on the answer entered in column C-- "Licensed Professional".	Character	1	Unknown
Date of Service	Enter the date (MM/DD/YYYY) the service was performed.	Date	10	MM/DD/YYYY
MA Recipient ID or Other ID	Enter a valid, unique Medical Assistance Recipient ID (MA ID) on each line. This is the 10-digit number assigned to the Member by the Pennsylvania Department of Human Services. One line per MA Recipient ID. If an individual does not have a MA ID, like the COE code and assign a numeric value (Example: Tadiso, Inc., Patient #1 without a MA ID is listed as 01-001). When the patient has been enrolled in HealthChoices, enter the MA ID on the corresponding line. Also, enter on the COE cross reference tab.	Character	≤10	Unknown
Date of Initial Contact	Enter the date (MM/DD/YYYY) of the COE initial face-to-face contact with the care manager by individual requesting service, who has NOT had services within 60 days of contact.	Date	10	MM/DD/YYYY
Service Provider 1	Enter the name of service provider that the care manager has engaged. List full name of the service provider once and then designate the abbreviation used for the same provider in records following. However, if the service occurs at the COE, enter the 2-digit COE code.	Character	Unknown	Unknown
Activity Location Code 1	Enter Location of Service: 01=Onsite-COE; 02=Transportation; 03= Home Visit; 04= PH Provider Offic;, 05= MH Provider's Office; 06= Emergency Department; 07= D&A Inpatient Non-Hospital/Hospital Residential Detox; 08= D&A Inpatient Non-Hospital/Hospital Residential Rehab; 09= Acute Mental Health Admission; 10= Inpatient Acute Physical Health Admission; 11= Medication Assisted Treatment (MAT) Provider; 12= Licensed D&A Provider; 13= Corrections (Local Jail/State Prison); and/or 14= Other.	Numeric	2	2

Care Management Reporting Tracking Sheet, cont'd.

COE Care Management Reporting	Provide all information on COE Medical Assistance (MA) Members and COE Members that do not have MA with a diagnosis of Substance Use Disorder. One line of Unique summarized data is being requested per MA recipient ID.	Format	Length	Valid Values
Activity Code 1	Enter the Activity Codes: 01= Evaluation of Needs; 02= Care Manger Warm Hand-off; 03= Care Manger Follow-up (Call/Letter); 04= Care Manager Re-engagement Contact (Call/Letter); 05= Referral for Housing; 06= Referral for Job Training; 07= Referral for Transportation Services; 08= Referral for Educational Services; 09= Referral for Vocational Services; 10= Referral for Food; 11= Referral for Healthcare Services; 12= Referral for Mental Health Services; 13= Referral for Pain Management Services; 14= Referral for SUD LOC Evaluation; 15= Referral for SUD Treatment; 16= Referral for Interpreter Services; 17= Referral for Voter Registration; 18= Referral for Self-Help Meetings; 19= Advocacy, please specify (CYS, JPO, AP, PD, CrimJ); 20= Face-to-Face Monitoring; 21= Urine of Blood Screen; and/or 22= Other.	Numeric	2	2
Service Provider 2	Same as Service Provider 1 or if "N/A" leave blank.	Numeric	2	2
Activity Location Code 2	Same as Activity Location 1 or if "N/A" leave blank.	Numeric	2	2
Activity Code 2	Same as Activity Code 1 or if "N/A" leave blank.	Numeric	2	2
Activity Service Provider 3	Same as Service Provider 1 or if "N/A" leave blank.	Numeric	2	2
Activity Location Code 3	Same as Activity Location 1 or if "N/A" leave blank.	Numeric	2	2
Activity Code 3	Same as Activity Code 1 or if "N/A" leave blank.	Numeric	2	2
Inactive Status Date	Enter the date (MM/DD/YYYY) of Inactive status decision of if "N/A" leave blank.	Numeric	8	MM/DD/YYYY
Reason for Inactive Status	Enter Reason for Inactive Code: 01= Voluntarily Inactive or 02= Care Management Services No Longer Needed If "N/A" leave blank.	Numeric	2	2
Note: OMHSAS will only accept one COE Care Management Report. Please record all care manager activities on this sheet.				

APPENDIX D: DATA TRACKING DICTIONARY

COE Quality Data Reporting Tracking Sheet

COE Quality Data Reporting	Provided all information on COE Medical Assistance (MA) members and COE members that do not have MA with a diagnosis of Substance Use Disorder (SUD). One line of unique summarized data is being requested per MA Recipient ID.	Format	Length	Valid Values
MA Reciepient/ or Other ID	Enter a valid, unique Medical Assistance Recipient ID (MA ID) on each line. This is the 10-digit number assigned to the Member by the Pennsylvania Department of Human Services. One line per MA Recipient ID. If an individual does not have a MA ID, like the COE code and assisgn a numeric value (Example: Tadiso, Inc., Patient #1 without a MA ID is listed as 01-001). When the patient has been enrolled in HealthChoices, enter the MA ID on the corresponding line. Also, enter on the COE cross reference tab.	Character	≤10	Unknown
MPI Code	Enter the MPI Code where the service was provided.	Numeric	13	13
Pregnancy	Select 'Y' from the dropdown if recipient is currently pregnant. Select 'N' if recipient is not pregnant or if the question is not applicable (Example: recipient is male.).	Character	1	Y or N
Live Birth	Select 'Y' from the dropdown if recipient has had a "live birth" in the past 28 days. Select 'N' from the dropdown if the recipient has not had a "live birth" or if the question is not applicable (Example: Recipient is male.).	Character	1	Y or N
Referral Source	Enter the name of the person and organization that referred the member to the COE.	Character	Unknown	Unknown
Date of Referral to the COE	Enter the date (MM/DD/YYYY) of the contact by individual requesting services, who has NOT had services from the COE within 60 days of the start of the program.	Date	10	MM/DD/ YYYY
Date of Referral to the COE is a Friday	This field will automatically by calculated based on the date entered in Referral to the COE.	N/A	-	-
Date of Initial Contact	Enter the date (MM/DD/YYYY) of the COE initial face-to-face contact with the care manager by individual requesting service, who has NOT had services within 60 days of contact. Note: this data should not be altered once it has been submitted to DHS. If the data must be changed, please provide an explanation in the comment section on this line.	Date	10	MM/DD/ YYYY
Date of Level of Care Evaluation (Initiation)	Enter the data (MM/DD/YYYY) of when the inidividual received a Level of Care evaluation. Note: this date should not be altered once it has been submitted to DHS. If the data must be changed, please provide an explanation in the comment section on this line.	Date	10	MM/DD/ YYYY
Date of Treatment Admission for SUD (Engagement)	Enter the date of the face-to-face SUD Treatment Admission (MM/DD/ YYYY) with a licensed professional/facility. Note: this date should not be altered once it has been submitted to DHS . If this data smust be changed, please provide an explanation in the comment section of this line.	Date	10	MM/DD/ YYYY
Days Between LOC Evaluation and Date of Treatment Admission	This field will be automatically population utilizing the Date of the Level of Care Evaluation from the Date of Treatment Admission.	Date	10	MM/DD/ YYYY

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COE Quality Data Reporting Tracking Sheet, cont'd.

COE Quality Data Reporting	Provided all information on COE Medical Assistance (MA) members and COE members that do not have MA with a diagnosis of Substance Use Disorder (SUD). One line of unique summarized data is being requested per MA Recipient ID.	Format	Length	Valid Values
Engaged Date: 1st Month	Enter one date (MM/DD/YYYY) of face-to-face SUD treatment with a licensed professional/facility within 1-30 days after the treatment admission date. If 'N/A' leave blank.	Date	10	MM/DD/ YYYY
Engaged Date: 2nd Month	Enter one date (MM/DD/YYYY) of face-to-face SUD treatment with a licensed professional/facility within 31-60 days after the treatment admission date. If 'N/A' leave blank.	Date	10	MM/DD/ YYYY
Engaged Date: 3rd Month	Enter one date (MM/DD/YYYY) of face-to-face SUD treatment with a licensed professional/facility within 61-90 days after the treatment admission date. If 'N/A' leave blank.	Date	10	MM/DD/ YYYY
Engaged Date: 4th Month	Enter one date (MM/DD/YYYY) of face-to-face SUD treatment with a licensed professional/facility within 91-120 days after the treatment admission date. If 'N/A' leave blank.	Date	10	MM/DD/ YYYY
Engaged Date: 5th Month	Enter one date (MM/DD/YYYY) of face-to-face SUD treatment with a licensed professional/facility within 121-150 days after the treatment admission date. If 'N/A' leave blank.	Date	10	MM/DD/ YYYY
Engaged Date: 6th Month	Enter one date (MM/DD/YYYY) of face-to-face SUD treatment with a licensed professional/facility within 151-180 days after the treatment admission date. If 'N/A' leave blank.	Date	10	MM/DD/ YYYY
Engaged Date: 7th Month	Enter one date (MM/DD/YYYY) of face-to-face SUD treatment with a licensed professional/facility within 181-210 days after the treatment admission date. If 'N/A' leave blank.	Date	10	MM/DD/ YYYY
Engaged Date: 8th Month	Enter one date (MM/DD/YYYY) of face-to-face SUD treatment with a licensed professional/facility within 211-240 days after the treatment admission date. If 'N/A' leave blank.	Date	10	MM/DD/ YYYY
Engaged Date: 9th Month	Enter one date (MM/DD/YYYY) of face-to-face SUD treatment with a licensed professional/facility within 241-270 days after the treatment admission date. If 'N/A' leave blank.	Date	10	MM/DD/ YYYY
Engaged Date: 10th Month	Enter one date (MM/DD/YYYY) of face-to-face SUD treatment with a licensed professional/facility within 271-300 days after the treatment admission date. If 'N/A' leave blank.	Date	10	MM/DD/ YYYY
Engaged Date: 11th Month	Enter one date (MM/DD/YYYY) of face-to-face SUD treatment with a licensed professional/facility within 301-330 days after the treatment admission date. If 'N/A' leave blank.	Date	10	MM/DD/ YYYY
Engaged Date: 12th Month	Enter one date (MM/DD/YYYY) of face-to-face SUD treatment with a licensed professional/facility within 331-365 days after the treatment admission date. If 'N/A' leave blank.	Date	10	MM/DD/ YYYY
Number of Engaged Months	This field will be automatically calculated utilizing the data entered for each engaged month.	N/A	-	-
Date of Referral Made for MH Treatment	Enter the date (MM/DD/YYYY) of referral for MH treatment. If 'N/A' leave blank. Note: this date should not be altered once it has been submitted to DHS. If the data must be changed, please provide an explanation in the comment section on this line.	Date	10	MM/DD/ YYYY

COE Quality Data Reporting Tracking Sheet, cont'd.

COE Quality Data Reporting	Provided all information on COE Medical Assistance (MA) members and COE members that do not have MA with a diagnosis of Substance Use Disorder (SUD). One line of unique summarized data is being requested per MA Recipient ID.	Format	Length	Valid Values
Date of MH Treatment	Enter the date (MM/DD/YYYY) of MH treatment for the month. if 'N/A' leave blank. Note: this date should not be altered once it has been submitted to DHS. If the data must be changed, please provide an explanation on the comment section on this line.	Date	10	MM/DD/ YYYY
Date of Referral for D&A Counseling	Enter the data (MM/DD/YYYY) of referral to D&A counseling with a licensed professional/facility. if 'N/A' leave blank. Note: this date should not be altered once it has been submitted to DHS. If the data must be changed, please provide an explanation in the comment section on this line.	Date	10	MM/DD/ YYYY
Date of D&A Counseling	Enter the date (MM/DD/YYYY) of D&A counseling with a licensed professional/facility. If 'N/A' leave blank. Note: this date should not be altered once it has been submitted to DHS. If the data must be changed, please provide an explanation in the comment section on this line.	Date	10	MM/DD/ YYYY
Date of Referral for Pain Management Treatment	Enter the date (MM/DD/YYYY) of the referral. If 'N/A' leave blank. Note: this date should not be altered once it has been submitted to DHS. If the data must be changed, please provide an explanation in the comment section on the line.	Date	10	MM/DD/ YYYY
Date of Pain Management Treatment	Enter the date (MM/DD/YYYY) of D&A counseling with a licensed professional/facility. If 'N/A' leave blank. Note: this date should not be altered once it has been submitted to DHS. If the data must be changed, please provide an explanation in the comment section on this line.	Date	10	MM/DD/ YYYY
Date(s) PDMP was Checked	Enter the date(s) (MM/DD/YYYY) with the Prescription Drug Monitoring Program (PDMP) was checked for that individual. Multiple dates within the reporting month will be separated by commas. At the start of each month following, clear previous month's dates, adding new dates that the PDMP was checked for that individual. If 'N/A' leave blank.	Date	10	MM/DD/ YYYY
Date(s) of Urine Drug Screening	Enter the date(s) (MM/DD/YYYY) when Urine Drug Screening (UDS) was completed for that individual. Multiple dates within the reporting month will be separated by commas. At the start of each month following, clear previous month's dates, adding new dates when UDS was completed for that individual. If 'N/A' leave blank.	Date	10	MM/DD/ YYYY
Comment	If an individual's previously submitted data has changed, please indicate why in the comment section. If the individual's data is unchanged, leave blanl.	Character	Unknown	Unknown