August 2014

2013 Year in Review

The Allegheny County HealthChoices Program

Allegheny HealthChoices, Inc.

Contents at a Glance

Introduction

Medicaid is the primary publicly financed health care coverage program in the United States, covering millions of individuals with low-income and/or a disability. HealthChoices, implemented in Allegheny County in 1999, is Pennsylvania's mandatory managed care program for Medicaid recipients. HealthChoices provides services to address physical and behavioral (mental health and substance use disorder) health needs. This report focuses on the mental health and substance use disorder services of the HealthChoices program.

In order to manage the behavioral health portion of the HealthChoices program, Allegheny County established contractual relationships between the Allegheny County Office of Behavioral Health and Community Care Behavioral Health, a non-profit managed care organization; and between the Allegheny County Office of Behavioral Health and Allegheny HealthChoices, Inc. (AHCI), an independent, non-profit oversight and monitoring agency.

As part of AHCI's role to provide oversight and monitoring, this report details information from 2013 for the HealthChoices Behavioral Health program, one part of the behavioral health system of care in Allegheny County. Since the HealthChoices program provides a multitude of services that will be referenced throughout this report, please refer to the description of services on page 16.

Claims, authorizations, and capitation data were used to obtain information for this report. Statistical testing was performed to determine if there were significant changes from 2012 to 2013.[i]

This report serves as an overview of the HealthChoices program in 2013. Generally speaking, the HealthChoices data related to population (enrollees and service users), service utilization and cost, diagnoses, readmissions, average length of stay, and follow-up rates for youth and adults was similar to 2012. Data from this report will be used to help define special topic reports, projects, and/or areas for further analysis in 2014 and 2015.

[i] The differences of proportions test was used to assess statistical significance.[1,2] Given a large sample size, very small differences can be found to be significant, so ad-hoc effect size testing (Cohen's H) was used to determine the magnitude (i.e. small=0.2, medium=0.5, or large=0.8) of the differences.[1,3] If there was a significant difference and an effect size equal to or greater than the value representative of a small magnitude, the change is noted as "a significant change, difference, an increase, or a decrease." Insignificant differences or differences with effect sizes deemed negligible (less than the value for a small effect size) are stated as "no difference or similar to 2012."

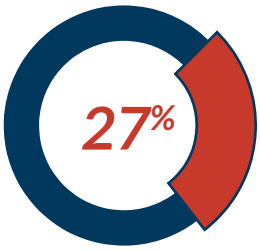
Example: In 2013, out of 8,672 adults, 897 (10.3%) had cocaine listed as their primary substance use disorder diagnosis. In 2012, out of 8,749 adults, 1,025 (11.7%) had cocaine listed as their primary substance use disorder diagnosis. Using the difference of proportions test this difference was statistically significant at the p=.01 level. However, performing the ad hoc Cohen's H effect size testing, the magnitude of the difference was 0.0, which is less than 0.2, the value for a small effect size. As a result, the number of adults with a primary substance use disorder diagnosis of cocaine from 2012 to 2013 is considered to be similar.

The HealthChoices Population

This section provides detailed information regarding (1) the number of people enrolled compared to the number of people that accessed services (penetration rate), and (2) the demographics (i.e. age, race, and gender) of enrollees compared to service users.

Service Penetration

The penetration rate observed in 2013 was the same as the rate reported in 2012; 27% of those enrolled used at least one mental health or substance use disorder service.

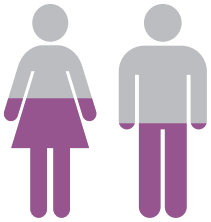


166,699
Enrollees

44,681
Service Users

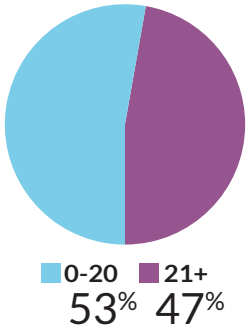
Gender

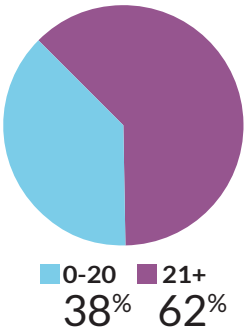
As observed in 2012, there were slightly more females enrolled than males, although an equal proportion of males and females accessed services.



Age

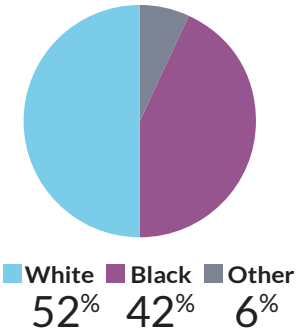
Similar to 2012, there were slightly more youth enrolled than adults, while more adults were service users.

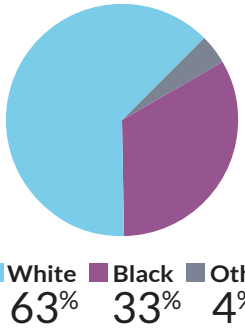




Race

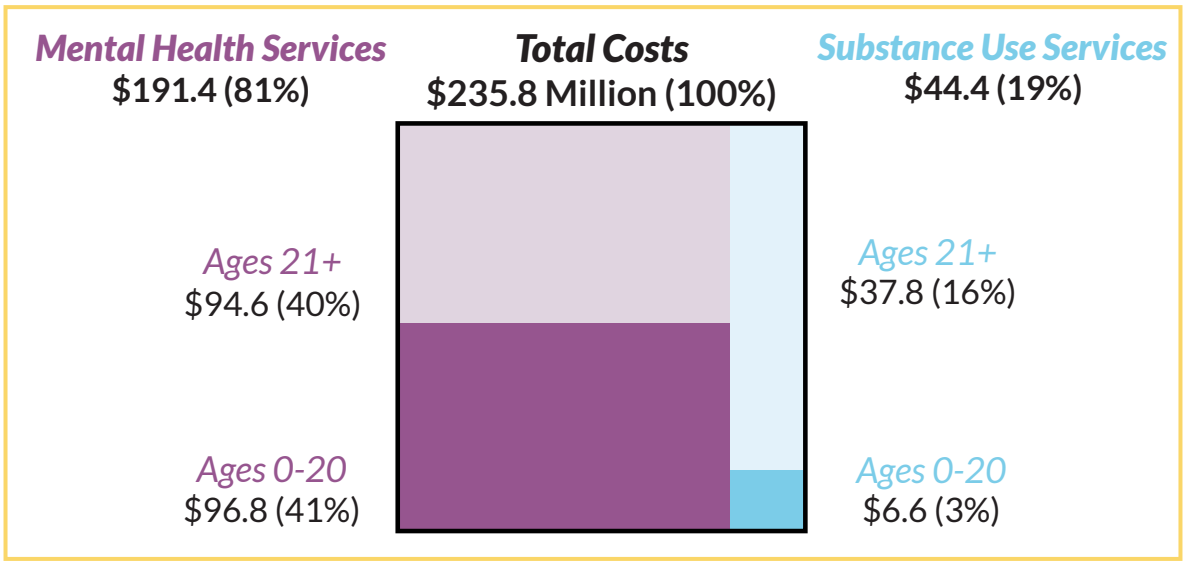
There were slightly more whites than blacks and other races enrolled, but service users include disproportionately more whites. This is consistent with the percentage of enrollees and service users in 2012.





Overall Costs of Behavioral Health Services

Total claims paid (in millions) in 2013 by age (0-20 and 21+) and service type (mental health and substance use disorders) are presented below. Mental health services accounted for a majority (81%) of the paid claims. Mental health services paid claims were similar for youth (41%) compared to adults (40%), while substance use disorder services paid claims were over five times higher for adults (16%) than youth (3%). These results are similar to those in 2012.



The school-based partial hospital program (SBPHP) provides licensed mental/behavioral health services integrated within a school/classroom setting. SBPHP classrooms include both education specialists and mental health treatment specialists. Below is a mother's story of her son's experience with a SBPHP.

Lauren's Story

While attending daycare, Lauren noticed there were differences between her son and other kids. He was diagnosed with Autism by the early intervention staff, at which time they began working with him. He attended a public school but his behavioral issues progressed, even though he was in an autism support classroom. By the second grade he faced being expelled due to behavioral outbursts. To avoid expulsion, he left public school and was enrolled in a school-based partial hospital program (SBPHP).

"It literally saved us. He has done a complete 360°. He has just transformed. His attitude and his ability to carry himself and have pride in himself, they instilled some of that. Without him being in Partial, he wouldn't be where he is," Lauren says. He can now calm himself. He has learned how to control his outbursts and remove himself from an uncomfortable situation. One particularly useful skill has been using a fight or flight approach. "To this day [he] uses that. [He will say] this is a fight situation and I have to stand up for myself or I'm walking away because this is a flight [situation]."

He likes to play deck hockey and video games. He's a huge movie buff, and he likes to watch the military and history channels. Lauren says, "He wants to go into the military, but if the military won't take him because of his diagnosis, he said he's going to try to be a police officer. This is after he goes to sleep away college." He also wants to be a husband and a father. As his parent, Lauren hopes to see that he can function on his own and that he will be able to make wise decisions.

Lauren's advice to other parents is, "Get help! Don't try to do it on your own. Go look for the services that are out there."

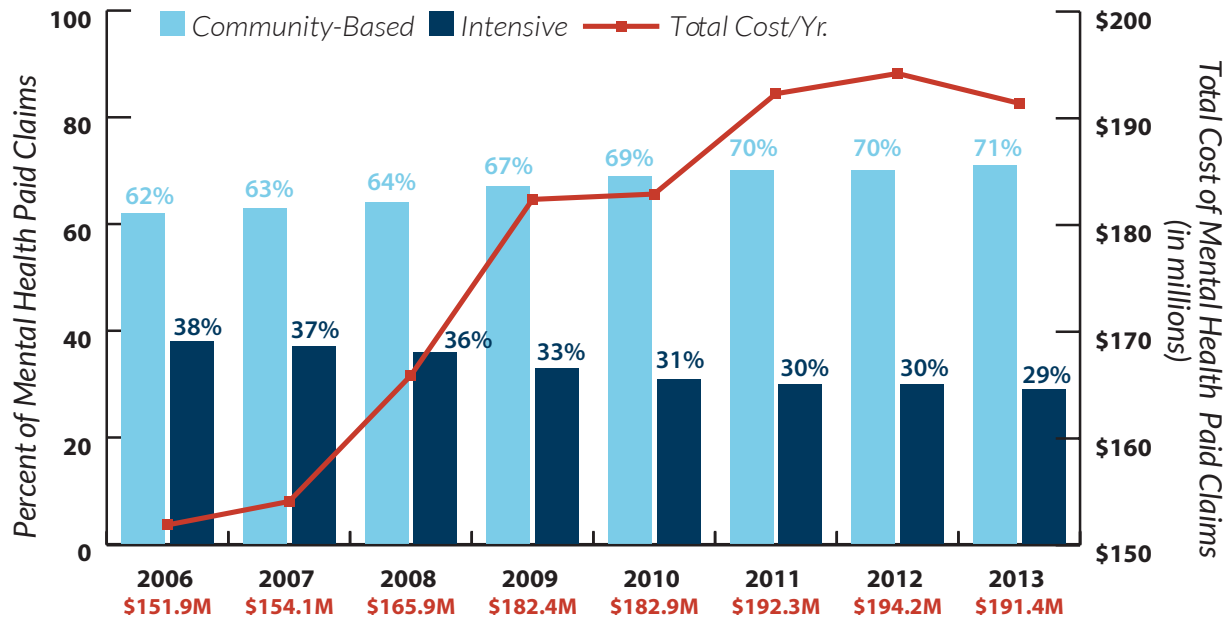
Community-Based Versus Intensive Mental Health Services

Allegheny County has a continuing commitment to a recovery-oriented system of care. Given this, there is an expectation that, on average, more spending (total paid claims) and more people will be treated via community-based services than using more intensive services. Figure 1 provides total costs for mental health services by year and compares spending for community-based versus intensive mental health services from 2006-2013.

Community-based services are services provided within the community and/or home setting to meet the needs of the person (i.e. behavioral health rehabilitation services, community treatment teams, crisis services, outpatient mental health, respite, etc.). Intensive services provide care in an inpatient or more restrictive setting (i.e. extended acute care, residential treatment facilities, and inpatient hospitalizations). Please refer to page 16 for a more detailed list and description of services.

Figure 1 shows that total costs for mental health services has gradually increased over the years, with the exception of a slight decline in 2013. For youth, community-based services accounted for 99% of the service users and 79% of the total cost for mental health services. This is similar to 2012. For adults, community-based services accounted for 99% of the service users and 63% of the total cost for mental health services (an increase in total cost of 4% from 2012). Given the nature of the services, average cost per service user remains higher for intensive mental health services compared to community-based mental health services.

Figure 1. Total Costs (Paid Claims) Per Year and the Proportion of Paid Claims for Community-Based versus Intensive Mental Health Services, 2006-2013



Service Utilization for Youth (0 - 20 Years)

Table 1 summarizes services used and associated costs for youth in 2013. Services are categorized into five groups: community-based mental health, residential treatment facilities (RTFs), psychiatric inpatient and related intensive services, substance use disorder services, and crisis services.

Table 1. Total Paid Claims (in Millions), Number of Service Users, and Average Cost Per Service User for Youth, 2014

	$ (Millions)		% Change from 2012	Number of Service Users*		Average Cost per Service User
1 Community-Based Mental Health	**$74.0**	**(72%)**	**-6.1%**	**16,415**	**(96%)**	**$4,508**
Behavioral Health Rehabilitation Services	*$39.1*	*(38%)*	*-13.8%*	*6,048*	*(35%)*	*$6,471*
2 Residential Treatment Facilities	**$11.3**	**(11%)**	**-1.5%**	**273**	**(2%)**	**$41,356**
3 Psychiatric Inpatient and Related Intensive Services	**$9.4**	**(9%)**	**-0.7%**	**876**	**(5%)**	**$10,743**
4 Substance Use Disorder Services	**$6.6**	**(6%)**	**-3.5%**	**1,528**	**(9%)**	**$4,311**
5 Crisis Services	**$2.1**	**(2%)**	**+8.4%**	**1,698**	**(10%)**	**$1,262**
TOTAL	**$103.4**	**(100%)**	**-4.7%**	**17,155**	**(100%)**	**$6,029**

**People may have used more than one service in 2013. As a result the number of service users will be more than 17,155 and the percentage of service users will equal more than 100%.*

Overall, there were no significant changes in any service category for the total cost of services or the average costs per service user from 2012 to 2013. Service utilization highlights include the following:

For community-based mental health services, behavioral health rehabilitation services (BHRS) continues to account for the largest proportion (53%) of paid claims in this category, while outpatient mental health services accounted for the largest proportion of service users (66%). Community treatment teams continue to have the highest average cost per service user ($14,999) in this category. The decrease in paid claims for BHRS resulted from shorter duration (i.e. fewer units) of clinical care provided by mobile therapists, behavioral specialist consultants, and therapeutic support staff.

When looking at psychiatric inpatient and related intensive services, inpatient hospitalizations accounted for the largest proportion of paid claims (93%) and service users (99.7%). Inpatient extended acute care services had the highest average cost per service user ($74,098), although there were very few youth (7 people) that used this service in 2013.

For substance use disorder services, short- and long-term nonhospital rehabilitation accounted for the largest proportion of paid claims (73%) and the highest average cost per service user ($16,479). Outpatient substance use disorder services accounted for the largest number of service users (86%) in this service group.

For the crisis services category, the total amount paid was similar between crisis and respite/diversion acute stabilization (DAS) services, although more people used crisis services (94%) and respite/DAS had a higher average cost per services user ($5,769). The 8.4% increase in paid claims from 2012 in this category is attributable to slightly more youth (+41) using respite/DAS in 2013.

Enhanced clinical service coordination (ECSC) services assist people 21 years of age or older with serious mental illness or co-occurring serious mental illness and substance use disorders. ECSC provides mobile clinical treatment and support services mostly within the community. ECSC teams include a master's level clinician/team leader, registered nurse, service coordinators, peer support specialists, and a part-time psychiatrist. Part-time therapists may also be included in the team.

Heather's Story

After high school, Heather relocated from Pittsburgh to Texas on a basketball scholarship. While away at school her mother was diagnosed with cancer. During a Christmas break visit, she saw how sick her mother was and she decided to stay. She became the primary caregiver for her mom and maintained the household. When her mom passed in 2008, her brother was awarded the apartment and told Heather she could no longer stay there.

She initially stayed with neighbors but decided to go to a shelter until she could get a place of her own. A contingency for staying at the shelter was that she had to get an evaluation. She agreed and was subsequently admitted to an inpatient psychiatric hospital for the first time. Being homeless, working, and going to school had become too overwhelming.

Heather was assigned an ECSC team after her discharge and was doing well. She eventually decided to leave Pittsburgh, losing contact with her team. When she returned, she reconnected with the ECSC team, and was admitted to a psychiatric hospital for the second time in February 2014.

After being discharged she has remained connected with the therapist on her team. Heather says, "Without the ECSC team, especially [my therapist], it's just like I would be lost... it's like having an extra family member... she's always checking on my mental health ... she went to court with me ... she's getting me acclimated back to the community so I can be on my own again... She does everything."

Of her team in general she says, "They give moral support ...They give me wisdom about how to go about things in a professional manner and [they] give me resources. They are teaching me how to be responsible and let me know that if I need help to go and seek it."

Her team also helps her work on, maintain, and achieve her goals. Though she says she is taking baby steps; some of her goals are to keep up with her doctors' appointments, taking her medications, exercising, and going out in to the community more. She is also making use of her wellness recovery action plan (WRAP)* and becoming better at recognizing her triggers.

She is thinking about going back to school and wants to be employed. She is considering working with people in programs similar to the ECSC. She wants to let people know that they don't have to feel ashamed about what they go through, "... You can't do everything on your own when you are fresh out [of] the hospital. They [ECSC] help the recovery process move a lot smoother."

* Wrap is a self-designed, self-management and recovery plan for helping an individual stay well and to increase personal empowerment and an improved quality of life. The six sections of the plan are: Daily Maintenance Plan, Triggers, Early Warning Signs, When Things are Breaking Down, Crisis Plan or Advance Directive, and Post Crisis Plan.

Top Diagnoses for Youth (0 - 20 Years)

From 2012 to 2013 there was a decrease in the total amount paid, the number of service users, and the number of units for youth with a diagnosis of multiple substances. There was, however, an increase in the number of units used for youth with an opiate diagnosis. Other costs, number of service users, and units of service remained similar to 2012 for all other diagnoses.

In 2013, 17,018 youth received a behavioral health diagnosis (15,073 mental health only, 86 substance abuse disorder only, and 1,859 co-occurring disorder). These youth may be included in more than one diagnostic group. As a result, the percentage of service users will not equal 100%.

Mental Health

35%
or 5,859 service users had paid claims for the treatment of **ADHD**
$3,575 cost /user

25%
or 4,157 service users had paid claims for the treatment of **adjustment disorders**
$1,932 cost /user

18%
or 3,091 service users had paid claims for the treatment of **major depression or other depressive disorders**
$5,195 cost /user

16%
or 2,945 service users had paid claims for the treatment of **autism spectrum disorders**
$8,057 cost /user

Substance Use

45%
or 790 service users had paid claims for treatment related to **cannabis use**
$6,159 cost /user

7%
or 143 service users had paid claims for treatment related to **opiate use**
$5,179 cost /user

6%
or 117 service users had paid claims for treatment related to **alcohol use**
$4,380 cost /user

4%
or 76 service users had paid claims for treatment related to the **use of multiple substances**
$4,737 cost /user

Top Diagnoses for Adults (21+ Years)

There were no major changes in the amount paid per diagnoses, the number of people with each diagnoses, or the amount paid per person by diagnoses from 2012 to 2013 for adults.

In 2013, 27,291 adults received a behavioral health diagnosis (11,351 mental health only, 710 substance abuse disorder only, and 15,230 co-occurring disorder).These adults may be included in more than one diagnostic group. As a result, the percentage of service users will not equal 100%.

Mental Health

40%
or 10,599 service users had paid claims for the treatment of **major depression or other depressive disorders**
$2,389 cost /user

19%
or 4,983 service users had paid claims for the treatment of **bipolar disorder**
$2,695 cost /user

16%
or 4,157 service users had paid claims for the treatment of **schizophrenia**
$8,741 cost /user

14%
or 3,811 service users had paid claims for the treatment of **anxiety disorders**
$901 cost /user

Substance Use

32%
or 5,123 service users had paid claims for treatment related to **opiate use**
$4,408 cost /user

12%
or 1,981 service users had paid claims for treatment related to **alcohol use**
$2,990 cost /user

12%
or 1,954 service users had paid claims for treatment related to the **use of multiple substances**
$3,252 cost /user

6%
or 897 service users had paid claims for treatment related to **cocaine use**
$3,668 cost /user

Service Utilization for Adults (21+ Years)

Table 2 summarizes the services used and the associated costs for adults in 2013. Services are categorized into four groups: community-based mental health, psychiatric inpatient and related intensive services, substance use disorder services, and crisis services. The highest cost services are highlighted in each category.

Table 2. Total Paid Claims (in Millions), Number of Service Users, and Average Cost Per Service User for Adults, 2014 (with the highest cost services highlighted)

	$ (Millions)		% Change from 2012	Number of Service Users*		Average Cost per Service User
1 Community-Based Mental Health	**$53.0**	**(40%)**	**+11.2%**	**24,255**	**(88%)**	**$2,185**
Outpatient MH and Med Checks	*$17.7*	*(13%)*	*+14.0%*	*22,485*	*(81%)*	*$786*
Community Treatment Teams	*$16.6*	*(13%)*	*+20.7%*	*712*	*(3%)*	*$23,294*
Service Coordination	*$13.0*	*(10%)*	*+2.0%*	*4,431*	*(16%)*	*$2,941*
2 Substance Use Disorder Services	**$37.8**	**(29%)**	**+3.2%**	**8,584**	**(31%)**	**$4,405**
Long and Short Term Non- Hospital Rehabilitation	*$16.4*	*(12%)*	*+9.6%*	*2,469*	*(9%)*	*$6,656*
Methadone Maintenance	*$7.3*	*(6%)*	*-2.6%*	*2,314*	*(8%)*	*$3,155*
Outpatient Substance Use	*$4.7*	*(4%)*	*+3.9%*	*6,419*	*(23%)*	*$737*
3 Psychiatric Inpatient and Related Intensive Services	**$34.8**	**(26%)**	**-9.1%**	**2,787**	**(10%)**	**$12,479**
Psychiatric Inpatient	*$24.7*	*(19%)*	*-8.5%*	*2,698*	*(10%)*	*$9,150*
Extended Acute Care	*$9.1*	*(77%)*	*-6.7%*	*181*	*(0.7%)*	*$50,035*
Residential Treatment Facility - Adults	*$1.2*	*(1%)*	*-26.2%*	*61*	*(0.002%)*	*$19,019*
4 Crisis Services	**$6.8**	**(5%)**	**+3.8%**	**3,564**	**(13%)**	**$1,903**
Crisis Services	*$3.8*	*(3%)*	*+0.4%*	*3,403*	*(12%)*	*$1,118*
Respite/DAS	*$3.0*	*(2%)*	*+8.5%*	*420*	*(1%)*	*$7,087*
TOTAL	**$132.4**	**(100%)**	**+2.5%**	**27,732**	**(100%)**	**$4,773**

**People may have used more than one service in 2013. As a result the number of service users will be more than 27,732 and the percentage of service users will equal more than 100%.*

Overall, there were no major changes in any service category for the total cost of services or the average costs per service user from 2012 to 2013. Service utilization highlights for adults include the following:

Together, outpatient mental health and medication checks accounted for the largest proportion of paid claims (33%) and service users (93%) under community-based mental health services. Community treatment teams have the highest average cost per service user ($23,294).

For the psychiatric inpatient and related intensive services group, inpatient hospitalizations continue to account for the largest proportion of paid claims (71%) as well as the highest proportion of service users (97%). Extended acute care services continue to have the highest average cost per service user ($50,035).

For substance use disorder services, paid claims were highest for short- and long-term nonhospital rehabilitation (43%). Outpatient substance use disorder services accounted for the largest number of service users (78%), while halfway house services have the highest average cost per service user ($7,106).

In 2013, there were no major changes overall for the crisis services category. The total amount paid was similar between crisis and respite/diversion acute stabilization (DAS) services, though more people used crisis services and respite/DAS had a higher average cost per service user.

Elaine's Story

Elaine became very ill in 2009. Her weight dropped to the lowest it had ever been and she started using inhalants. She was eventually admitted to a hospital for treatment related to an eating disorder and a series of readmissions followed. Her most recent admission was in January 2014.

Elaine receives support from an ECSC team and states, "They've been supportive. I haven't been an easy consumer... I am very reluctant to change. Although the desire to change is there and they recognize that ... I think that's why they stick by because there is still the potential for change and recovery. You can tell they care too."

She talks with the nurse on her team about what's going on in her life and the frequency of behaviors. In particular, one of her ongoing goals is to work on binge-purge behaviors, which have decreased, but she is striving for more episode free days.

Another goal she is working on is to get out in the community more often. However, going out makes her anxious. "It [has to] be me to make the effort," she realizes, so when it's nice out she'll walk to the park or take a bus ride to various places. She also sees her dad twice a week and has a few friends with whom she keeps in touch.

Elaine has made some great accomplishments on her recovery journey. Prior to becoming ill she attended college for three years. Since 2010, she has continued her educational efforts by obtaining an Associates' degree in biotechnology, completing an internship in a genomic sciences research lab, as well as working as a lab assistant. Currently she is pursuing a Bachelors' degree in Biology. In the future she would like to obtain a Ph.D. Her ECSC team has also been helping her with job applications, helping her with going back to school, and also enrolling in classes.

When thinking about recovery Elaine says, "[To me] recovery means being at a healthy weight and eating portioned meals at regular times without purging. Building some friendships and finishing school and finding work ... Maybe even meeting somebody."

Readmissions, Follow-Up After Discharge, and Average Length of Stay (ALOS)

This section reports on 30-day readmission rates, 7-day follow-up rates and average length of stay (ALOS) for youth and adults (Tables 3 and 4 respectively). These continue to be important indicators related to inpatient treatment, engagement, continuity of care, and for determining how long it takes to get individuals stabilized and ready to move back in to the community.

Youth (0-21 Years)

Table 3. Admissions, 30-day Readmissions, ALOS, and 7-day Follow-up for Youth, 2013

	# of Admissions (Unduplicated Consumers)		# of 30-day Readmissions (Unduplicated Consumers)		% of Readmissions	ALOS (Days)	7-day Follow-Up Rate
Mental Health* and RTF							
Inpatient Mental Health	**1,300**	(930)	**176**	(121)	**13.5%**	**12.2**	**72%**
Residential Treatment Facilities	**206**	(187)	**3**	(3)	**1.4%**	**199.2**	**66%**
Standard RTF	**167**	(156)	**2**	(2)	**1.2%**	**226.0**	**65%**
Short-Term RTF	**43**	(41)	**1**	(1)	**1.9%**	**70.3**	**73%**
Substance Use Services*							
Non-Hospital Rehabilitation	**298**	(251)	**18**	(17)	**5.7%**	**64.3**	**29%**
Short-Term (3B)	**111**	(92)	**7**	(7)	**6.3%**	**14.3**	**38%**
Long-Term (3C)	**187**	(168)	**11**	(10)	**5.3%**	**91.5**	**24%**

**The use of substance use disorder and mental health services is low for children and adolescents for the most intensive level of care services (i.e. halfway house, inpatient and non-hospital detoxification, inpatient extended acute care, and RTF-Adult), therefore they are not included in this table.*

- Admissions for youth decreased from 2012 for non-hospital rehabilitation (overall and for both subcategories) and for RTF (overall and short-term). Admissions increased from 2012 for standard RTF and inpatient mental health.
- The number of readmissions within 30-days of discharge decreased in 2013 for all levels of care except inpatient mental health. For inpatient mental health, the OMHSAS standard for readmissons within 30 days (less than or equal to 10%) was not achieved in 2013.[4]
- Average length of stay (ALOS) remained similar from 2012 to 2013 for non-hospital rehabilitation (overall and for both subcategories) and inpatient mental health. For RTF overall, the ALOS increased by 28 days. This is attributable to an increase in the ALOS for short-term RTF (45.9 days in 2012 to 70.3 days in 2013). For standard RTF, there was a decrease of 33.7 days (259.7 days in 2012 to 226.0 days in 2013). Short-term RTFs provide treatment over a more condensed length of time than standard RTFs, with length of stays ranging from 60 to 120 days.
- In 2013, 7-day follow-up rates decreased for all services except standard RTF and inpatient mental health. For inpatient mental health, the OMHSAS standard for 7-day follow-up is 90%, which was not met, however, the Healthcare Effectiveness Data and Information Set (HEDIS) 50th percentile benchmark of 46% was achieved.[4-5]

Table 4. Admissions, 30-day Readmissions, ALOS, and 7-day Follow-up for Adults, 2013

	# of Admissions (Unduplicated Consumers)	# of 30-day Readmissions (Unduplicated Consumers)	% of Readmissions	ALOS (Days)	7-day Follow-Up Rate
Mental Health* and RTF					
Inpatient Mental Health	**4,806** (2,965)	**954** (558)	**19.8%**	**12.9**	**72%**
Inpatient Extended Acute	**90** (87)	**9** (9)	**8.7%**	**98.9**	**92%**
RTF - Adults	**53** (53)	**0** (0)	**0%**	**63.2**	**94%**
Substance Use Services*					
Non-Hospital Rehabilitation	**3,218** (2,366)	**244** (199)	**7.6%**	**26.2**	**50%**
Short-Term (3B)	**2,037** (1,637)	**156** (137)	**7.7%**	**13.3**	**47%**
Long-Term (3C)	**1,187** (1,043)	**89** (82)	**7.6%**	**48.5**	**56%**
Non-Hospital Detoxification	**1,769** (1,285)	**136** (118)	**7.7%**	**3.6**	**73%**
Inpatient Detoxification	**583** (399)	**68** (52)	**11.6%**	**4.0**	**55%**
Halfway House	**376** (347)	**10** (10)	**2.5%**	**75.0**	**33%**
Inpatient Rehabilitation	**54** (47)	**4** (4)	**7.3%**	**8.3**	**84%**

- Admissions for adults decreased from 2012 for all levels of care except short-term non-hospital rehabilitation and non-hospital detoxification.
- The number of readmissions within 30-days of discharge decreased or remained the same in 2013 for all levels of care except inpatient mental health, inpatient rehabilitation, non-hospital detoxification, and short-term non-hospital rehabilitation. For inpatient mental health, the OMHSAS standard for readmissons within 30 days (less than or equal to 10%) was not achieved in 2013.[4]
- ALOS remained similar from 2012 to 2013 for all levels of care.
- In 2013, 7-day follow-up rates remained the same or increased for all services except inpatient rehabilitation, non-hospital detoxification, non-hospital rehabilitation (overall and for both subcategories), and inpatient extended acute. For inpatient mental health, the OMHSAS standard for 7-day follow-up is 90%, which was not met, however, the HEDIS 50th percentile benchmark of 46% was achieved.[4-5]

Summary

This report provides an overview of the HealthChoices program in 2013, noting any significant changes from 2012. Overall for the HealthChoices population (enrollees and service users), service utilization and costs, diagnoses, readmissions, average length of stay, and follow-up rates for youth and adults were similar in both years.

While monitoring these indicators often focuses on changes over time, sometimes the lack of change is the "story" the data tells. This is the case with the comparison of 2013 data to 2012 data. There are several possible reasons for this:

- The one year timeframe may not be enough time to show changes in a large behavioral healthcare system. A more longitudinal look would likely show more variation.
- The Commonwealth of Pennsylvania continues to work with the Centers for Medicare & Medicaid Services (CMS) to define the parameters of their participation in the Affordable Care Act (ACA). As such, changes that impact Medicaid and the HealthChoices program have not been realized yet.
- There have not been any significant service system or statewide policy changes that could affect the HealthChoices program. It is changes such as service development or new policies that often drive utilization and cost changes in the program.

AHCI will continue to monitor utilization and costs for the HealthChoices program quarterly and annually.

Citations

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3 Ferguson, C. J. (2009). An Effect Size Primer: A Guide for Clinicians and Researchers. *Professional Psychology: Research and Practice*, 40(5), 532-538.

4 Commonwealth of Pennsylvania Department of Public Welfare (DPW) Office of Mental Health and Substance Abuse Service (OMHSAS). (March 28, 2014). *2013 External Quality Review Report: Community Care Behavioral Health.* Lake Success: n.a.

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Description of Services

Community-Based Services

Behavioral Health Rehabilitation Services (BHRS): Treatment and therapeutic interventions prescribed by a psychologist or psychiatrist provided on an individual basis in the person's own environment such as the home, school and community. These services may include Behavioral Specialist Consultants (BSC), Mobile Therapy (MT), Therapeutic Support Staff (TSS), and specialized services, as approved.

Community Treatment Team (CTT): Also known as Assertive Community Treatment (an evidence-based practice), CTT is a team-delivered service with extensive success in helping people with serious mental illness live in the community. While staffing patterns may vary from rural to urban areas, CTTs typically include a Team Leader, a Psychiatrist, Nurses, Mental Health Professionals, Drug and Alcohol Specialists, Peer Support Counselors, and Vocational Specialists. The hours are flexible, services are provided in the community, and CTT handles after-hours emergencies. The teams provide a wide array of services, including psychiatric evaluations, mental health and drug and alcohol therapy, medication management, case management, peer support, assistance with housing, crisis and hospital diversion services, vocational assessments and supported employment, and assistance in managing personal finances. The staff to consumer ratio is low (10 consumers per staff).

Crisis Services: These services are available through the re:solve Crisis Network 24 hours a day. People experiencing crises call a toll-free number, and receive telephone counseling. When indicated, professional behavioral health counselors will provide mobile crisis services at the person's home or in the community. Walk-in and overnight crisis services are also available.

Enhanced Clinical Service Coordination (ECSC): ECSC is a team-delivered mental health service. The team includes a clinical therapist, nurse, case manager, and peer specialist.

Family-Based Mental Health Services: Evaluation and treatment services provided to a specific child in a family, but focusing on strengthening the whole family system to increase their ability to successfully manage their child's behavioral and emotional issues. Services are provided by licensed agencies employing a mental health professional and a mental health worker as a team to provide treatment and case management interventions. Services are provided in the home of the family.

Family-Focused, Solution-Based Services (FFSBS): FFSBS are for families involved in the Children, Youth and Families (CYF) or Juvenile Probation systems who have mental health service needs. Services are provided by a master's level therapist and bachelor's level family support staff person. Services provided include individual and family therapy, family support, crisis intervention and stabilization, and case management.

Outpatient Mental Health Services: Evaluation and treatment services provided to persons who may benefit from periodic visits that may include psychiatric and psychological evaluation, medication management, and individual or group therapy. Services are provided by licensed facilities under the supervision of a psychiatrist or by private credentialed practitioners.

Medication Checks: A service provided for consumers taking medication to treat their mental illnesses or substance abuse disorders. Medication levels are checked, side effects discussed, and adjustments to prescriptions are made as necessary.

Mobile Medications: Mobile medication teams include three nurses and a peer specialist, with the consultation of a pharmacist. The teams focus on both providing medications and teaching people how to manage their own medications.

Mobile Mental Health Treatment (MMHT): A full range of outpatient therapy services for individuals who have encountered barriers to, or have been unsuccessful in receiving services in an outpatient clinic. Services are provided within the consumers' place of residence or other appropriate community setting. The purpose is to provide therapeutic treatment to reduce the need for more intensive levels of service, including crisis intervention or inpatient hospitalization.

Partial Hospitalization Mental Health Services: Treatment services provided from 3 to 6 hours per day up to 5 days per week in a licensed facility. Evaluation, treatment and medication are provided under the supervision of a psychiatrist for persons who need more intensive treatment than psychiatric outpatient. Services are provided for a short duration of time for persons acutely ill and for longer periods for persons experiencing long-term serious mental illness. Services are typically provided in a therapeutic group setting. School-based partial programs are also available for children and adolescents.

Peer Specialists: Peer specialists are current or former consumers of behavioral health services who are trained to offer support and assistance in helping others in their recovery and community integration process. Peer specialists provide mentoring and service coordination supports that allow individuals with serious mental illness to achieve personal wellness and cope with the stressors in their lives. Efforts to provide certification for peer specialists are occurring in Pennsylvania.

Psychiatric Rehabilitation (also called Psychosocial Rehabilitation or Psych Rehab): Psychiatric rehabilitation services assist consumers in their recovery from mental illness, with the goal of improving functioning so consumers are satisfied with the roles they choose in their communities. While mental health treatment focuses on the reduction of symptoms, psych rehab focuses on community participation, through consumer-driven goals including housing, employment, education, relationships, and engaging in community and social activities.

Respite and Diversion/Acute Stabilization Services (DAS): Short term, community- based residential programs intended to divert consumers who would otherwise be admitted to the hospital. These services can also be used as step-down services after an inpatient stay.

Service Coordination (previously called Case Management): Services provided to assist children, adolescents and adults with serious mental illness or emotional disturbance to obtain treatment and supports necessary to maintain a healthy and stable life in the community. Caseload sizes are limited to ensure adequate attention to the person's needs as they change. Emphasis is given to housing, food, treatment services, use of time, employment and education. Service coordination services are available 24 hours a day, 7 days per week.

Intensive Services

Adult Outpatient Program (AOP): This service provides 24/7 care for individuals who need longer term, intensive mental health treatment in a structured, supervised setting. It is used primarily as a step down from acute inpatient or as a diversion from admissions to an acute inpatient facility or long term hospitalization.

Extended Acute Care (EAC): These programs offer diversionary and acute stabilization services in either a hospital or community setting. EAC provides a longer period of stabilization in a recovery-oriented environment that permits the individual to return to the community and avoid state hospitalization.

Inpatient Mental Health Services: Evaluation and treatment services provided in a licensed psychiatric unit of a community hospital or a community psychiatric hospital that is not part of a medical hospital. Services are provided to persons with acute illness where safety for self or others is an issue. Services are provided by psychiatrists, nurses and social services staff. Persons may be involuntarily committed for evaluation and treatment.

Residential Treatment Facility (Standard RTF): Comprehensive mental health treatment services for children and adolescents with severe emotional disturbances or mental illness. These services are provided in facilities which must be licensed by the Department of Public Welfare and be enrolled in the Medicaid program.

Residential Treatment Facility (Short Term RTF): This service is used as a diversion/step down from inpatient mental health admissions, crisis services (as part of a crisis plan for other community services such as Family Based Mental Health or Behaviorial Health Rehabilitation Services), and/or standard RTF. Provides comprehensive mental health treatment services for children and adolescents with severe emotional disturbances or mental illness, similar to standard RTF, but for a duration of 60 to 120 days.

Residential Treatment Facility for Adults (RTF-A): RTF-A programs provide highly structured residential mental health treatment services for individuals 18 years or older. They offer stabilization services and serve as an alternative to either state or community hospitalization.

Substance Use Services

Halfway House: A residential program to assist people in their recovery from drug and alcohol addictions. Halfway Houses are transitional programs to support people in their re-integration in the community.

Inpatient Detoxification Services: Treatment includes 24-hour medically directed evaluation and detoxification of consumers with substance use disorders in an acute care setting. The individuals who use this type of care have acute withdrawal problems which are severe enough to require primary medical and nursing care facilities; 24-hour medical service is provided, and the full resources of the hospital facility are available.

Inpatient Rehabilitation Services: Treatment which includes 24-hour medically directed evaluation, care and treatment for addicted consumers with coexisting biomedical, psychiatric, and/or behavioral conditions which need frequent care. Facilities must have, at a minimum, 24-hour nursing care, 24-hour access to specialized medical care and intensive medical care, and 24-hour access to physician care.

Intensive Outpatient Drug and Alcohol Services: Intensive outpatient services for people with substance use disorders include assessments, specialized medical consultation, individualized treatment planning, individual, group, and family therapy, and aftercare planning. Typically, intensive outpatient services are provided for five to ten hours per week.

Methadone Maintenance: Medication used to achieve stabilization or prevent withdrawal symptoms. Slow withdrawal or outpatient detoxification of the person from the maintenance medication is part of this treatment process.

Non-Hospital Detoxification Services: Treatment service conducted in a residential facility that provides a 24-hour professionally directed evaluation and detoxification of addicted consumers. Detoxification is the process of assisting a drug or alcohol-intoxicated or dependent consumer through the period of time required to eliminate the intoxicating substance and with any other dependency factors. This process also includes motivating and supporting the consumer to seek additional treatment after detoxification. The full resources of an acute care facility are not necessary.

Non-Hospital Rehabilitation Services: Treatment services provided in a licensed community residential program where a full range of treatment and supportive services are provided for people with substance use disorders in acute distress. Interventions include social, psychological and medical services to assist the person whose addiction symptomatology is demonstrated by moderate impairment of social, occupational, and/ or school functioning. Rehabilitation is a treatment goal. Services include both short-term and long-term programs.

Outpatient Drug and Alcohol Services: Evaluation and treatment services provided at a licensed facility to persons who can benefit from psychotherapy and substance use/abuse education. Services are provided in regularly scheduled treatment sessions for a maximum of 5 hours per week by qualified D&A treatment staff.

Partial Hospitalization Drug and Alcohol Services: For individuals who do not need residential addictions treatment but do need more intensive services than outpatient provides, partial programs provide assessments, medical consultation, treatment planning, group and family therapy, discharge planning, referral to services, access to vocational, educational, legal, health, housing, social activities, and other services. Services are provided at least three days per week for more than 10 hours per week.

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AHCI's mission is to assure equitable access to quality, cost-effective behavioral health care that promotes positive clinical outcomes, recovery, and resiliency.

AHCI is a contract agency for the Allegheny County Department of Human Services' Office of Behavioral Health