December 2015

2014 Year in Review

The Allegheny County HealthChoices Program

Allegheny HealthChoices · Inc

BEHAVIORAL HEALTH INNOVATION

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 itself and Community Care Behavioral Health, a non-profit managed care organization; and between itself and Allegheny HealthChoices, Inc. (AHCI), an independent, non-profit oversight and monitoring agency.

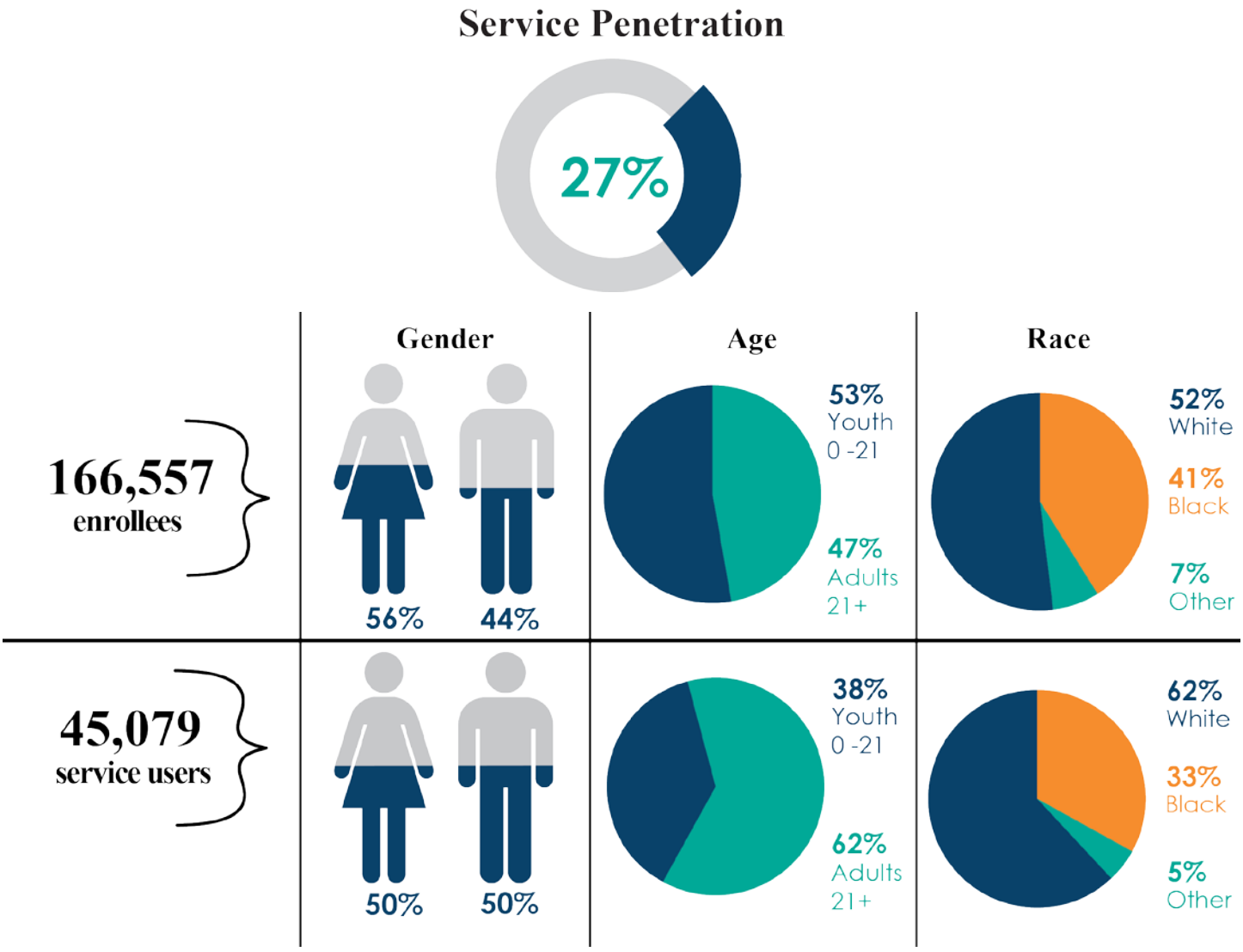
As part of AHCI's role to provide oversight and monitoring, this report details information from 2014 for the HealthChoices behavioral health program, one part of the behavioral health system of care in Allegheny County. Since the HealthChoices program provides a multitude of services that will be referenced throughout this report, please refer to the description of services on page 14.

This report serves as an overview of the HealthChoices program in 2014. Claims, authorizations, and capitation data were used for this report. 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 2013. Data from this report will be used to help define reports, projects, and/or areas for further analysis in 2015 and 2016.

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 2014 was the same as the rate reported in 2013; 27% of those enrolled used at least one mental health or substance use disorder service.



Gender: As observed in 2013, there were slightly more females than males, although an equal proportion of males and females accessed services.

Age: Similar to 2013, 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 services users in 2013.

Enrollment by Category of Aid

Table 1. Number of Service Users Enrolled by Category of Aid, 2013-2014

Category of Aid	2013	2014
SSI Without Medicare	20,195	20,029
THM (TANF + Healthy Beginnings + MAGI[1])	2,075	9,325
Temporary Assistance for Needy Families (TANF)	12,188	8,146
SSI With Medicare	6,881	6,854
Categorically Needy	4,333	4,589
Healthy Beginnings	3,543	801
Other	166	149
TOTAL	**44,726**	**45,079**

The largest number of members were enrolled in 2014 through SSI Without Medicare, followed by THM. The number of members enrolled from the Healthy Beginnings (HB) and TANF aid categories decreased, while those associated with the THM category increased substantially. It should be noted that during the 2013-2014 time period, the Pennsylvania Department of Human Services (DHS) made changes to the eligibility categories, which explains some of the changes seen in the HB, TANF and THM categories. This includes the integration of Health Beginnings with the THM category. The first change took place mid-year 2013.

As Medicaid expansion takes effect in 2015, it will be important to monitor changes in member enrollment and service penetration by aid category. From January to July 2015, Pennsylvania has reported enrolling approximately 439,000 residents in HealthChoices - nearly 37,000 of these are from Allegheny County.

[1] MAGI = Modified Adjusted Gross Income

Overall Costs of Behavioral Health Services

Total claims paid (in millions) in 2014 by age (0-20 and 21+) and service type (mental health and substance use disorders) are presented below. These results are similar to those in 2013.

Total Costs

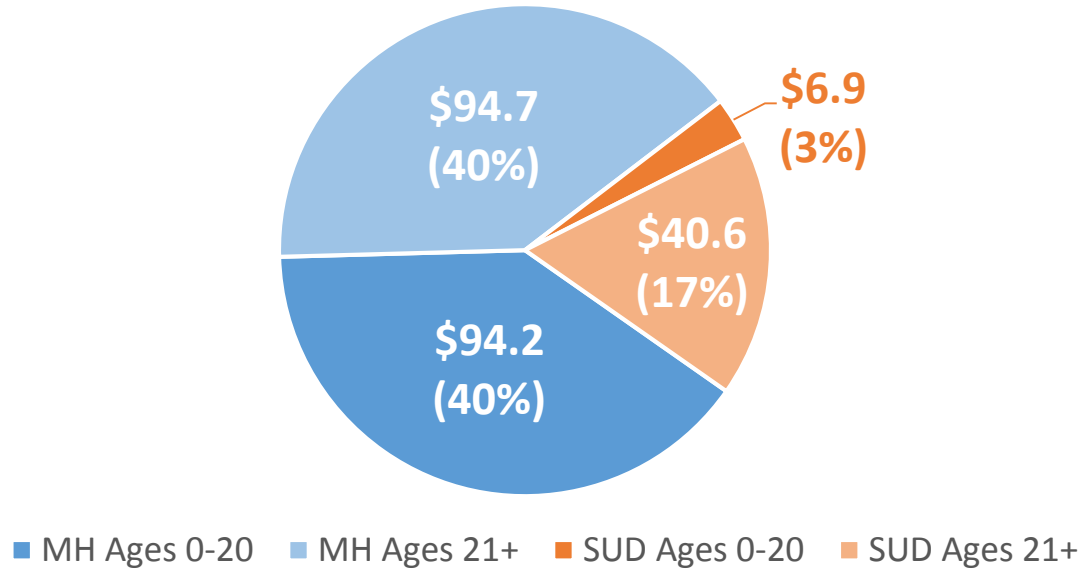
$236.4 Million (100%)

Mental Health Services

$188.8 Million (80%)

Substance Use Services

$47.6 Million (20%)



Mental health services accounted for a majority (80%) of the paid claims in 2014.

Substance use disorder (SUD) services paid claims were over five times higher for adults (17%) than youth (3%).

The proportion of mental health services paid claims were similar for youth (40%) when compared to adults (40%).

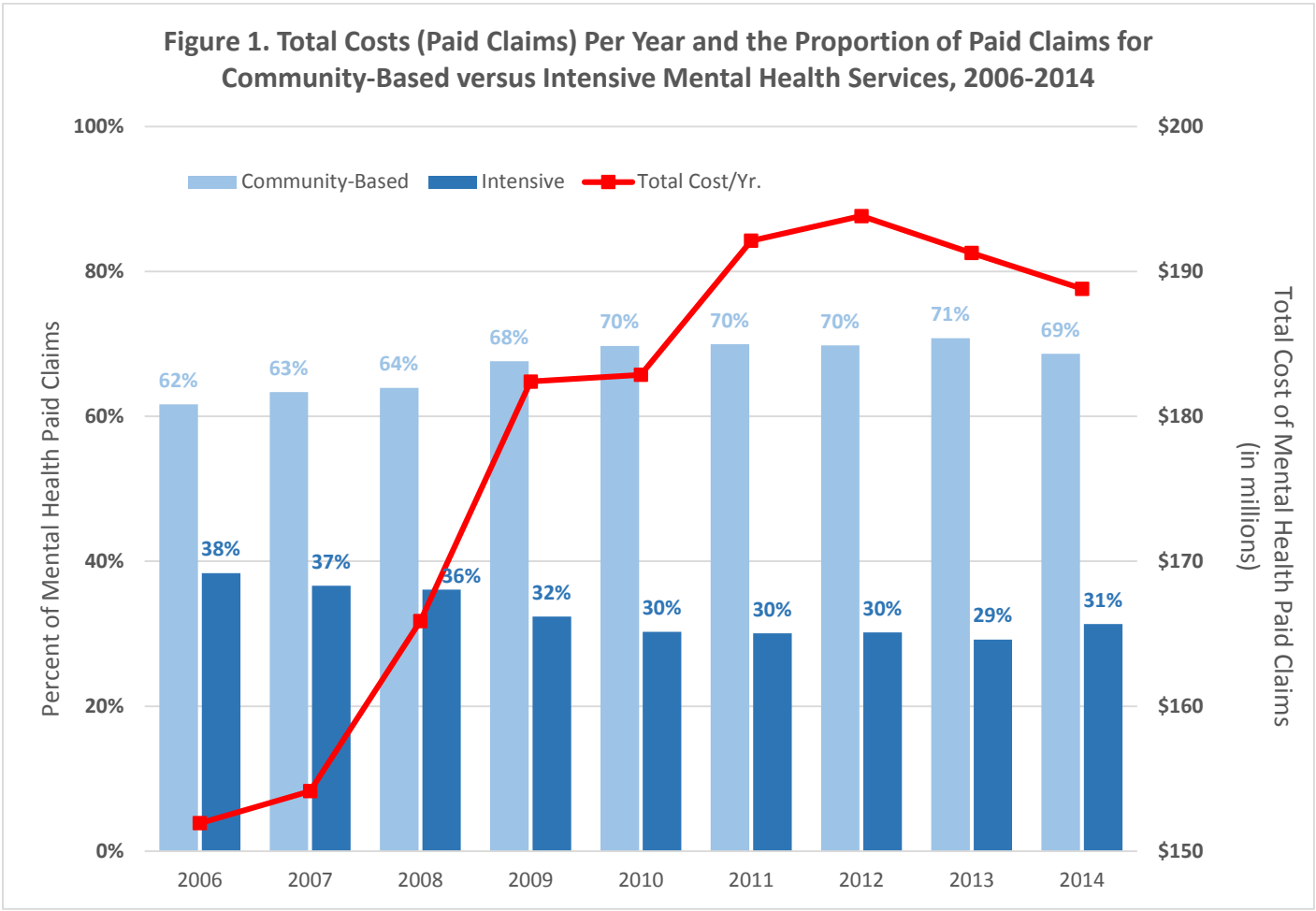
Community-Based Versus Intensive Mental Health Services

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 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 2006-2014.

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, 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 14 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 starting in 2013.

Figure 1. Total Costs (Paid Claims) Per Year and the Proportion of Paid Claims for Community-Based versus Intensive Mental Health Services, 2006-2014



Over 99% of youth utilized community-based services, which accounted for over 76% of the total cost for youth mental health services. This is similar to 2013. Over 99% of adults also utilized community-based mental health services, which accounted for 62% of the total cost for adult mental health services. 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. Note that total annual mental health service costs increased by 10% from 2008 to 2009 due to a 16% increase in paid claims for community-based services ($16.9 million). This was driven by an 8.2% increase in members served as well as service development initiatives to support people's mental health service needs in the community following the closure of the Mayview State Hospital.

Service Utilization for Youth (0-20 Years)

Table 2 summarizes services used and associated costs for youth in 2014. 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 2. Total Paid Claims (in Millions), Number of Service Users, and Average Cost per Service User for Youth, 2014

	$ (Millions)	% of Total	% Change from 2013	Number of Service Users*		Average Cost per Service User
Community-Based Mental Health Services	$69.4	(69%)	-6.2%	16,542	(96%)	$4,192
Residential Treatment Services	$11.2	(11%)	+4.6%	217	(1%)	$51,411
Psychiatric Inpatient and Related Intensive Services	$10.9	(11%)	+15.4%	858	(5%)	$12,740
Substance Use Disorder Services	$6.9	(7%)	+5.3%	1,087	(6%)	$6,374
Crisis Services	$2.0	(2%)	-18.7%	1,704	(10%)	$1,188
TOTAL	$100.4	(100%)	-2.7%	17,273	(100%)	$5,812

**People may have used more than one service in 2014. As a result, the number of service users will be more than 17,273 and the percentage of service users will equal more than 100%.*

Overall, there were few notable changes in service use from 2013 to 2014. Some service categories are comprised of a single service and others have multiple services. For categories with multiple services, Table 3 presents additional information about utilization.

Table 3. Utilization information for categories with multiple services – Youth, 2014

Community-Based Mental Health Services	• Despite a $4.9 million decrease from 2013, behavioral health rehabilitation services (BHRS) still accounted for the largest portion (49%) of paid claims in this category. • Outpatient mental health services accounted for the largest percentage of members (69%) in this category. • Mental health supplemental services had the highest amount ($18,199) paid per member (PPM). The high PPM for mental health supplemental services may be driven by the 18.7% increase in billed units from 2013 to 2014 and increased paid claims. Mental health supplemental services included community residential respite services, forensic support specialists and multi-systemic therapy.
Psychiatric Inpatient and Related Intensive Services	• Inpatient hospitalizations accounted for the largest proportion of paid claims (96%) and service users (99.4%) in this category. • Alternative outpatient program (AOP) services had the highest amount ($62,010) paid per member, although there were very few youth (3 people ages 18 to 20) that used this service in 2014. These are clinical services associated with residential programs.
Substance Use Disorder Services	• Non-hospital rehabilitation accounted for the largest portion of paid claims (76%) and the highest amount ($17,499) paid per member in this category. • Outpatient services accounted for the largest number of members (82%).
Crisis Services	• The total amount paid was slightly higher for the crisis subcategory than for diversion acute stabilization (DAS) services ($1.0M or 51%). • The cost per member was higher for DAS ($5,460 per member). • The percentage of members using crisis services (1,599 or 93.8%) was higher than the percentage of members using DAS services (180 or 10.6%).

Joe's Story

Living with a co-occurring mental illness and a substance use disorder can be challenging. As an adult with lived experience, Joe knows this well after his past struggles with relapse and rough living on the streets, a time which he describes as "living like a rat." After his last relapse, he was referred to a new program for HealthChoices members that uses a Brief Critical Time Intervention (BCTI) approach to meet consumers where they are with essential services. BCTI interventions have been associated with a decrease in early readmission rates (less than 30 days)[2], suggesting that this model may be an effective approach to improve continuity of care. This program helps to stabilize people and engage them with community-based recovery supports.

Although he no longer keeps in touch with his family, Joe has started to build a new support system for himself. Joe considers his individual therapy sessions to be "the most relaxing two hours that I can spend with anyone… it's my natural self." Joe has also built a trusting relationship with his service coordinator, who has helped him get a copy of his birth certificate, insurance cards and other documentation needed to access benefits. He knows that his service coordinator provides an important safety net, especially during early recovery. Joe observes that "he makes sure my back is covered. He can sense it when I'm getting ready to wander off. [When that happens], he pops up!"

After being involved with the program for about three months, Joe has started to set goals for himself like finding his own apartment and getting a job at an antique store. He also has a desire to give back to the community by volunteering as a prevention mentor for youth. He wants to prevent them from developing problems associated with substance abuse.

Now, Joe considers himself to be in recovery. He regularly attends 12 Step meetings, including "Talking Circles" that are specifically designed for people like him who identify as Native American. He notes that his program staff are "helping the inner child in me to become an adult." He would like to stay involved in the program as long as he can, but knows that he will always be able to reach out to his support system if he needs help in the future.

[2] http://www.researchgate.net/publication/280630364_Brief_Critical_Time_Intervention_to_Reduce_Psychiatric_Rehospitalization

Top Diagnoses for Youth (0-20 Years)

In 2014, 17,146 youth received a behavioral health diagnosis (15,302 mental health only, 59 substance abuse only, and 1,785 co-occurring disorder). From 2013 to 2014 there was an increase in paid claims for youth with depressive disorders and for youth with cannabis-related diagnoses. Other costs, number of service users, and units of service remained similar to 2013 for all other diagnoses. 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 5,893 service users had paid claims for the treatment of **ADHD**
$3,200 cost / user

25%

or 4,192 service users had paid claims for the treatment of **adjustment disorders**
$2,026 cost / user

19%

or 3,170 service users had paid claims for the treatment of **major depression/ depressive disorders**
$6,035 cost / user

17%

or 2,922 service users had paid claims for the treatment of **autism spectrum disorders**
$7,458 cost / user

Substance Use

76%

or 802 service users had paid claims for treatment related to **cannabis use**
$6,596 cost / user

14%

or 151 service users had paid claims for treatment related to **opiate use**
$5,005 cost / user

9%

or 92 service users had paid claims for treatment related to **alcohol use** **$3,697** cost / user

8%

or 82 service users had paid claims for treatment related to the **use of multiple substances**
$4,315 cost / user

Top Diagnoses for Adults (21+ Years)

In 2014, 27,558 adults received a behavioral health diagnosis (11,238 mental health only, 631 substance abuse only, and 15,689 co-occurring disorder). From 2013 to 2014 there was an increase in paid claims for adults with cannabis-related diagnoses and adults with opiate-related diagnoses. Other costs, number of service users, and units of service remained similar to 2013 for all other diagnoses. Adults may be included in more than one diagnostic group. As a result, the percentage of service users will not equal 100%.

Mental Health

45%

or 10,582 service users had paid claims for the treatment of **major depression/ depressive disorders**
$2,419 cost / user

21%

or 4,902 service users had paid claims for the treatment of **bipolar disorder**
$2,732 cost / user

17%

or 4,089 service users had paid claims for the treatment of **schizophrenia**
$9,229 cost / user

17%

or 3,938 service users had paid claims for the treatment of **anxiety disorders**
$907 cost / user

Substance Use

60%

or 5,293 service users had paid claims for treatment related to **opiate use**
$4,786 cost / user

23%

or 1,982 service users had paid claims for treatment related to **alcohol use**
$3,160 cost / user

21%

or 1,805 service users had paid claims for treatment related to the **use of multiple substances**
$3,063 cost / user

10%

or 837 service users had paid claims for treatment related to **cocaine use**
$3,500 cost / user

Service Utilization for Adults (21+ Years)

Table 4 summarizes the services used and the associated costs for adults in 2014. Services are categorized into four groups: community-based mental health, psychiatric inpatient and related intensive services, substance use disorder services, and crisis services.

Table 4. Total Paid Claims (in Millions), Number of Service Users, and Average Cost per Service User for Adults, 2014

	$ (Millions)	% of Total	% Change from 2013	Number of Service Users*		Average Cost per Service User
Community-Based Mental Health Services	**$52.8**	**(39%)**	**+1.1%**	**24,204**	**(86%)**	**$2,182**
Substance Use Disorder Services	**$39.7**	**(30%)**	**+5.5%**	**8,208**	**(29%)**	**$4,840**
Psychiatric Inpatient and Related Intensive Services	**$36.4**	**(27%)**	**+2.7%**	**2,648**	**(9%)**	**$13,755**
Crisis Services	**$5.4**	**(4%)**	**-19.8%**	**3,341**	**(12%)**	**$1,627**
TOTAL	**$134.4**	**(100%)**	**+1.7%**	**28,010**	**(100%)**	**$4,798**

**People may have used more than one service in 2014. As a result, the number of service users will be more than 28,010 and the percentage of service users will equal more than 100%.*

The most notable change in service use was the decrease in paid claims for crisis services from 2013 to 2014. Some service categories are comprised of a single service and others have multiple services. For categories with multiple services, Table 5 presents additional information about utilization.

Table 5. Utilization information for categories with multiple services – Adults, 2014

Community-Based Mental Health Services	• Together outpatient mental health and medication checks accounted for the largest proportion of paid claims (33%) and service users (92%) in this category. • Community treatment teams (CTT) had the highest average cost per service user ($21,281).
Substance Use Disorder Services	• Paid claims were highest for non-hospital rehabilitation services (46%) in this category. • Outpatient treatment services continued to account for the largest number of service users (72%). • Halfway house services had the highest average service cost per user ($7,920).
Psychiatric Inpatient and Related Intensive Services	• Inpatient hospitalizations continued to account for the largest portion of paid claims (65%) as well as the largest proportion of service users (97%) in this category. • Inpatient extended acute services had the highest amount paid per member ($62,367).
Crisis Services	• Total paid claims were slightly higher for crisis services (55%) than for diversion acute stabilization (DAS) in this category. • The majority of service users (95%) used crisis services, while 12% used DAS. • The cost per member was higher for DAS than other crisis services at $6,122 per member.

Daniel's Story

With the assistance of the Integrated Dual Disorder Treatment (IDDT) Team, Daniel has come a long way over the past two years of his adult life. When speaking about his past, Daniel says, "I was homeless, I was down on my luck and I needed structure in my life." Since that time, his IDDT Team has helped him to find independent housing, stabilize his medications, and provide other supportive services. The IDDT model is an evidence-based practice that improves the quality of life for people with co-occurring mental illness and substance use disorders by combining substance abuse services with mental health services.

To stay actively engaged in his recovery journey, Daniel participates in group counseling sessions up to four times a week, including a Dual Recovery Anonymous group for people recovering from both mental health and substance use disorders. Daniel also meets with his team staff regularly to discuss his progress towards achieving his goals and to set new goals as needed.

One of Daniel's long-term goals is to run his own cleaning company. In order to work towards that goal, the IDDT Team was able to connect him to the Office of Vocational Rehabilitation – a link which enabled him to enroll in community college. Daniel is now studying building maintenance; he plans to start an internship soon and will be graduating in a few months. He is optimistic that his college's job placement program will be able to help him find employment when he graduates.

A lifelong resident of Pittsburgh, Daniel stays connected to the community by volunteering. He now makes a point to integrate healthy activities into his life, such as going to the gym, cleaning his apartment, and spending time with his two children. Although he was previously involved with the criminal justice system, he has now completed probation and looks forward to getting his driver's license back this year.

Daniel's advice to others is to, "Give yourself a chance. Be patient. Don't expect results overnight." Daniel notes, "I'm always going to have challenges… as long as I continue to make new friends and continue [using] my support network, I'll be alright."

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 6 and 7, 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 (0-20 Years)

Table 6. Admissions, 30-Day Readmissions, ALOS, and 7-day Follow-Up for Youth, 2014

	# of Admissions (Unduplicated Consumers)		# of 30-day Readmissions	% of Readmissions	ALOS (Days)	7-day Follow-Up Rate
Mental Health* and RTF						
Inpatient Mental Health**	**1,125**	(842)	**103**	**11.0%**	**12**	**63%**
Residential Treatment Facilities	**368**	(326)	**15**	**4.1%**	**109**	**69%**
DAS	**123**	(117)	**1**	**0.8%**	**19**	**96%**
Standard RTF	**146**	(138)	**11**	**7.5%**	**233**	**46%**
Short-Term RTF	**99**	(95)	**3**	**3.0%**	**22**	**73%**
Substance Use Services						
Non-Hospital Rehabilitation	**389**	(271)	**29**	**7.4%**	**49**	**21%**
Short-Term (3B)	**111**	(91)	**12**	**10.8%**	**14**	**31%**
Long-Term (3C)	**278**	(189)	**17**	**6.1%**	**62**	**17%**

**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.*

***Inpatient Mental Health follow-up rates are calculated based on the Island Peer Review Organization (IPRO) specifications for each year. Readmission rates are calculated using the HealthChoices Performance Standard Methodology.*

Highlights from Table 6:

- Admissions for youth decreased from 2013 for inpatient mental health (IPMH), DAS and standard RTF. Admissions increased from 2013 for non-hospital rehabilitation and short-term RTF. Short-term RTF programs are temporary therapeutic residential treatment facilities that serve as a diversion/stepdown from IPMH and standard RTFs for 60-120 days. The increase in admissions for short-term RTF was due to the addition of a new provider joining the network.
- The number of readmissions within 30 days of discharge decreased in 2014 for all services except for non-hospital rehabilitation and short-term RTF. For inpatient mental health, the OMHSAS standard for readmissions within 30 days (less than or equal to 10%) was not achieved in 2014.
- Average length of stay (ALOS) remained similar from 2013 to 2014 for DAS and inpatient mental health. Standard RTF ALOS increased by 23 days (from 210 days to 233 days). Overall non-hospital rehabilitation ALOS increased by four days – this was driven by a six day increase in ALOS for the 3C (long-term rehab) subcategory. Short-term RTF ALOS decreased by two days (from 24 days to 22 days).
- In 2014, 7-day follow-up rates increased for all services except for inpatient mental health and standard RTF. For inpatient mental health, the OMHSAS standard for 7-day follow-up is 90%, which was not met. However, the 2014 Healthcare Effectiveness Data and Information Set (HEDIS) 75th percentile benchmark of 58% was achieved.

Table 7. Admissions, 30-Day Readmissions, ALOS, and 7-day Follow-Up for Adults, 2014

	# of Admissions (Unduplicated Consumers)		# of 30-day Readmissions	% of Readmissions	ALOS (Days)	7-day Follow-Up Rate
Mental Health and RTF						
Inpatient Mental Health*	**3,838**	(2,531)	**493**	**15.9%**	**11**	**63%**
Inpatient Extended Acute	**210**	(116)	**15**	**7.4%**	**48**	**83%**
RTF - Adult	**70**	(62)	**4**	**5.9%**	**55**	**86%**
Substance Use Services						
Non-Hospital Rehabilitation	**3,589**	(2,542)	**284**	**8.3%**	**25**	**44%**
Short-Term (3B)	**2,229**	(1,763)	**171**	**8.0%**	**13**	**42%**
Long-Term (3C)	**1,360**	(1,109)	**113**	**8.8%**	**45**	**46%**
Non-Hospital Detoxification	**2,098**	(1,480)	**128**	**6.3%**	**3**	**72%**
Inpatient Detoxification	**441**	(341)	**34**	**7.7%**	**4**	**60%**
Halfway House	**443**	(384)	**12**	**3.0%**	**72**	**28%**
Inpatient Rehabilitation	**29**	(26)	**0**	**0.0%**	**7**	**100%**

**Inpatient Mental Health follow-up rates are calculated based on the IPRO specifications for each year. Readmission rates are calculated using the HealthChoices Performance Standard Methodology.*

Highlights from Table 7:

- Admissions for adults increased from 2013 for all levels of care except for halfway house, inpatient detoxification, inpatient mental health, and inpatient rehabilitation.
- The number of readmissions within 30 days of discharge decreased or stayed the same in 2014 for all levels of care except halfway house, inpatient extended acute and non-hospital rehabilitation (3B and 3C). For inpatient mental health, the OMHSAS standard for readmissions (less than or equal to 10%) was not achieved in 2014.
- Average length of stay (ALOS) remained the same for inpatient detoxification, non-hospital detoxification and non-hospital rehabilitation (3B). ALOS increased for non-hospital rehabilitation (3C), halfway house and RTF-A. ALOS decreased for inpatient extended acute and inpatient rehabilitation.
- In 2014, 7-day follow-up rates remained the same or increased for all services except for halfway house, inpatient extended acute and RTF-Adult. For inpatient mental health, the OMHSAS standard for 7-day follow-up is 90%, which was not met. However, the 2014 HEDIS 75th percentile benchmark of 58% was met.

Summary

This report provides an overview of the HealthChoices program in 2014, noting changes from 2013. 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. However, there were a few areas of note in which additional monitoring and analysis may be indicated:

UTILIZATION CHANGES

- **Increased Utilization of Inpatient Extended Acute and RTF-A:** In 2014, there was a noticeable increase in paid claims for inpatient extended acute and residential treatment facilities for adults (RTF-A) services. This may have been driven in part by providers that used RTF-A as a diversion resource instead of inpatient mental health (IPMH) services. There was an increase in admissions to both services. While the average length of stay (ALOS) for inpatient extended acute decreased by four days, the ALOS for RTF-A services increased by seven days during this period. Additionally, there was a rate increase for RTF-A which also took effect during this time.
- **Decreased Utilization of BHRS among Youth:** Community Care has been focused on educating providers on the medical appropriateness of BHRS services as well as other levels of care for youth. These coordinated care management efforts brought about a $4.9 million decrease (-12.7%) in BHRS utilization from 2013.
- **Decreased Utilization of Crisis Services among Adults:** From 2013 to 2014, there was a 19.8% decrease in paid claims for adult crisis services and 6.3% fewer adult members using these services. This was driven by a decrease in the number of members utilizing walk-in crisis services and individually-delivered mobile crisis services.

PROGRAM CHANGES

- **CTT Pay-for-Performance:** Community Care Behavioral Health instituted an incentive payment structure for Community Treatment Team (CTT) services. For 2014, two CTT providers had 20% of their rate withheld, with the opportunity to earn that 20% and a possible 10% bonus payment if certain outcomes were met (i.e. reduced average cost per person for inpatient mental health services). Both of the eligible CTT providers met these performance goals by demonstrating a decreased average inpatient cost per member per year ranging from 28% to 64% from the baseline year (2012). This payment structure continues to evolve for CTT and other services to assure continuous quality improvement.
- **Addition of Short-Term RTF Program:** One of the network providers converted their adolescent diversion acute stabilization (DAS) to a short-term residential treatment facility (RTF) in the fall of 2014. This may also have impacted the decreased number of admissions to regular RTF and DAS programs. This resulted in an increased number of admissions for short-term RTF. Short-term RTF programs are temporary therapeutic residential treatment facilities that serve as a diversion/stepdown from IPMH and standard RTFs for 60-120 days.

SYSTEM CHANGES

- **Improving Readmission and Follow-Up Rates:** Community Care has initiated a Health Care Performance Improvement Project aimed at the “Successful Transition from Inpatient to Ambulatory Care”. This initiative has included interventions such as High Risk Care Management interviews, Drug and Alcohol Case Management, Brief Critical Time Intervention Expansion, Enhanced Discharge Planning, and Medication Reconciliation Education. These interventions are designed to address various barriers to treatment engagement and retention.
- **Medicaid Expansion:** The Pennsylvania Department of Human Services (DHS) has transitioned from the *Healthy PA* program instituted by Governor Corbett effective January 1, 2015 to a traditional Medicaid expansion model starting April 2015 under Governor Wolf. The impact of these program changes (particularly the increase in Medicaid eligibility) will become more evident upon the analysis of 2015 HealthChoices data.

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

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 Behavioral 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 Allegheny County Department of Human Services' Office of Behavioral Health.