Behavioral Health Rehabilitation Services: Brief Treatment Model

Presented by

Allegheny HealthChoices, Inc.
444 Liberty Avenue, Pittsburgh, PA 15222
Phone: 412/325-1100 Fax 412/325-1111

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AHCI is a contract agency for the Allegheny County Department of Human Services' HealthChoices Program.

About HealthChoices and AHCI

HealthChoices, Pennsylvania's managed care program for Medicaid, provides physical health care and behavioral health care services to both children and adults. The goals of Pennsylvania's HealthChoices program are to improve:

- Access to services;
- Quality of care;
- Continuity of the care provided in a multi-system environment; and
- Coordination and distribution of finite Medical Assistance resources.

Under HealthChoices, Allegheny County contracts with the Commonwealth of Pennsylvania to implement the behavioral health services portion of the program. Allegheny County has delegated responsibilities for managing the behavioral health program to two other organizations:

- The County contracts with Community Care Behavioral Health Organization (Community Care) to manage behavioral health services for the HealthChoices program.
- Allegheny County also contracts with Allegheny HealthChoices, Inc. (AHCI) to carry out the County's oversight and monitoring responsibilities required under the HealthChoices program.

This report is one of a series published by AHCI as part of its oversight and monitoring responsibilities. All AHCI reports can be downloaded from our Web site at www.ahci.org. For more information or additional copies of this report, please visit our Web site, or contact us by phone at 412-325-1100. We can also be reached via email at mutz@ahci.org or eheberlein@ahci.org.

EXECUTIVE SUMMARY

Behavioral Health Rehabilitation Services (BHRS) provide comprehensive treatment to children and adolescents[1] diagnosed with a serious emotional or behavioral disorder. Also known as wraparound services, BHRS are prescribed for children who require interventions at the place where problematic behaviors occur, such as in their home, school, and/or community. This service is an intensive, community-based service, usually delivered by several professionals working together as: Behavioral Specialist Consultants (BSC), Mobile Therapists (MT), and Therapeutic Staff Support (TSS). BHRS are covered services under HealthChoices, the Pennsylvania Medicaid managed care program.

Over time, Allegheny County BHRS providers and Community Care noted that a sub-population of children would benefit from a less intensive form of BHRS treatment. To address these needs, Allegheny County BHRS providers and Community Care began developing a BHRS "brief" treatment model. According to this model, children receiving Brief Treatment can receive either MT or BSC services for a maximum of 36 weeks, with between one and six hours of service per week. Children also can receive three two-week "booster" sessions in the year after their discharge from Brief Treatment, to allow for continuity of care during times of transition or crisis. The goals of the "BHRS Brief Treatment" model are:

- To meet the service needs of children who would benefit from time-limited periods of MT-only or BSC-only service;
- To provide an opportunity for clinicians to work with children in their homes and community to develop a more complete understanding of their treatment needs;
- To ease the transition and provide greater continuity of care for children who need a step-down in service from traditional BHRS; and
- To provide a form of service that is quicker and easier to access for children in need of immediate BHRS treatment, especially for children leaving inpatient or residential treatment facilities (RTFs).

The BHRS Brief Treatment model was approved by the Office of Mental Health and Substance Abuse Services (OMHSAS) and implemented January 1, 2004. From January 1, 2004 to June 30, 2005:

- 448 children received BHRS Brief Treatment services. Paid claims for BHRS Brief Treatment during this 18-month period totaled $1.36 million, with an average of $3,033 paid per child.
- Children were much more likely to use MT than BSC services; MT accounted for 83% of paid claims for Brief Treatment. Very few children used the booster sessions.
- The mean length of service for children receiving BHRS Brief Treatment was 20 weeks. During the period of treatment, children received an average of 2.7 hours of treatment per week.

[1] For ease of reading, "children" will refer to both children and adolescents (under age 21) in this report.

- Most children who used BHRS Brief Treatment were between the ages of 6 and 17 years old. The most common diagnoses were Attention Deficit Hyperactivity Disorder (ADHD), Child/Adolescent Emotional Disorder (a category that includes primarily Oppositional Defiant Disorder), Conduct Disorder, and Adjustment Disorder.

Providers have not experienced any implementation difficulties with the model and believe it is a very valuable addition to the service system. In particular, they believe that the streamlined authorization process works very well and accessing the service is very "user-friendly."

Many children have used this service as a "step-up" from outpatient services. Children have also accessed this service as a "step-down" from traditional BHRS and family-based mental health services.

For the most part, utilization of other behavioral health services during Brief Treatment appears to be appropriate, with before and aftercare services overlapping with Brief Treatment and case management services coinciding with Brief Treatment.

A small number of children used more intensive services like RTF, respite, and/or inpatient mental health services before, during and after Brief Treatment. These low patterns of utilization indicate Brief Treatment is often not the most appropriate service for children leaving these intensive levels of treatment.

A large number of children used traditional BHRS services after Brief Treatment (45%). However, most of these children switched to an authorization for traditional BHRS at the same treatment prescription (e.g. BSC for three hours per week) they had under BHRS Brief Treatment rather than requiring more intensive BHRS services that included TSS. This indicates that the 36 week time limit for BHRS Brief Treatment is not sufficient for all children.

Many children transitioned to outpatient services (23%) or medication checks (30%) after Brief Treatment. About 20% of children did not use follow-up services in the three months after Brief Treatment services ended, which includes children who did not receive recommended follow-up services and children who no longer needed formal behavioral health services in addition to their community supports.

Brief Treatment appears to be meeting its intended goals. Monitoring of the service should continue through claims analysis using longer follow-up periods, through ongoing discussions with Community Care and providers, and through gathering input from children and families who have used Brief Treatment services.

INTRODUCTION

Behavioral health rehabilitation services (BHRS) are mental health services prescribed to children and adolescents by a psychiatrist or psychologist after completing a face-to-face clinical evaluation. BHRS, also referred to as wraparound services, are designed to provide comprehensive treatment to children[2] diagnosed with a serious emotional or behavioral disorder who require interventions at the place where problematic behaviors occur, such as in their home, school, and/or community.

Through BHRS, clinicians promote developmentally appropriate behavior, activities, skills, and social skills by providing treatment based on each child's unique strengths and needs. Additionally, BHRS are intended to promote family independence by lessening the need for professional treatment and therapeutic supports. BHRS clinicians therefore work with families on skills development and assistance in the development of community support networks.[3]

Behavioral health rehabilitation services consist of three specialized forms of treatment:

- **Behavioral Specialist Consultant (BSC) services**: Master's or PhD level BSCs work with children, family members, and members of the treatment team to address behavioral problems through the development and implementation of non-aversive behavior management plans. In the traditional BHRS model, BSCs typically provide guidance to other members of the BHRS treatment team, rather than working one-on-one with children or adolescents. However, BSCs often serve as the primary clinician for children in BHRS with Autism Spectrum Disorders.
- **Mobile Therapy (MT) services**: Master's or PhD level mobile therapists provide child-centered, family-focused, individual and family-level psychotherapy.
- **Therapeutic Staff Support (TSS) services**: TSS staff work one-on-one with children on therapeutic activities to address treatment plan goals. TSS staff also work with the family to stabilize the child and promote age-appropriate behavior. BSCs and/or MTs supervise TSS services.

BHRS are covered services under Medicaid. In Allegheny County, Community Care manages BHRS referrals, authorizations, and payment to providers for children enrolled in the HealthChoices program. BHRS are some of the most highly utilized services in the Allegheny County HealthChoices program. Paid claims for BHRS service typically make up close to 25% of total paid claims and almost 50% of the paid claims for services provided to children and adolescents.

BHRS are relatively intensive services and are therefore not appropriate for many children who would otherwise benefit from home- or community-based services. In particular, a number of children need only BSC or MT services and do not need more intensive combinations of BSC, MT, and TSS services. In 2002, BHRS providers and

[2] For ease of reading, "children" will refer to both children and adolescents (under age 21) in this report.
[3] Information on BHRS taken from Commonwealth of Pennsylvania's HealthChoices Behavioral Health Program Standards and Requirements Appendix T (Part B(2)).

Community Care began working on the development of a BHRS Brief Treatment model that would suit the needs of these children. The goals of the BHRS Brief Treatment model are:

- To meet the service needs of children who would benefit from time-limited periods of MT-only or BSC-only service;
- To provide an opportunity for clinicians to work with children in their homes and community to develop a more complete understanding of their treatment needs;
- To ease the transition and provide greater continuity of care for children who need a step-down in service from traditional BHRS; and
- To provide a form of service that is quicker and easier to access, especially for children leaving inpatient or residential treatment facilities (RTFs) in need of immediate services.

The model was first approved by OMHSAS and piloted during the last quarter of 2003 with several providers. In January 2004, Community Care made BHRS Brief Treatment a HealthChoices service, making Allegheny County the first county in Pennsylvania to offer the service to HealthChoices members.

This report provides an overview of BHRS brief treatment in Allegheny County. The report includes:

- A description of the treatment model;
- BHRS Brief Treatment service utilization data;
- Race, gender, and age characteristics and diagnoses of children who use BHRS Brief Treatment; and
- Children's use of other behavioral health services, such as inpatient and outpatient services, before, during and after they used Brief Treatment.

The report draws on HealthChoices claims data from January 1, 2004 to June 30, 2005, the first 18 months using this model. Additionally, the report features information gathered from BHRS Brief Treatment providers in Allegheny County and Community Care staff.

BHRS BRIEF TREATMENT SERVICE MODEL

BHRS Brief Treatment is designed to serve children (20 years or younger) with the following treatment needs:

- **Children in need of a "step-down" to less intense services** than full BHRS, family based mental health services (FBMHS), residential treatment facility (RTF), or inpatient services
- **Children in need of a "step-up" to more intensive services** from outpatient services. For example, this would include children who have trouble generalizing what they have learned in clinic-based treatment to real-life situations.

- **Children who would benefit from further assessment** by a master's level clinician in the home or community in order to determine which type and intensity of treatment would be most appropriate
- **Children who would benefit from maintaining the therapeutic alliance established with a clinician currently providing MT or BSC services**, thereby permitting greater continuity of care
- Children in need of **supplemental treatment, or "booster" sessions** after completing BHRS Brief Treatment

There are five key differences between traditional BHRS and the BHRS Brief Treatment model. The following table and list summarizes these differences.

Table 1: BHRS Brief Treatment and Traditional BHRS

	BHRS Brief Treatment	Traditional BHRS
1. Service mix	MT-only or BSC-only	MT, BSC, TSS
2. Establishing medical necessity criteria	Evaluation from a behavioral health provider and a letter of recommendation from a psychiatrist or licensed psychologist	Best practice evaluation
3. Service duration	Maximum of 36 weeks	No maximum
4. Service intensity	Maximum of 6 hours per week	No maximum
5. Availability of "booster" treatment	Yes (only after discharge from BHRS Brief Treatment)	No

1. Through BHRS Brief Treatment, children may receive Mobile Therapy (MT) or Behavioral Specialist Consultation (BSC) services. This model differs from more intensive, traditional BHRS treatment, since children using traditional BHRS may receive MT and BSC service concurrently, and may also receive Therapeutic Staff Support (TSS) services, if medically necessary.
2. The BHRS Brief Treatment authorization process was designed to minimize the length of time between a request for service and the date at which service begins. To establish medical necessity criteria for BHRS Brief Treatment, an evaluation from a behavioral health provider and a letter of recommendation from a psychiatrist or licensed psychologist are sufficient. Establishing medical necessity criteria for traditional BHRS pre-authorizations requires a more intensive Best Practice Evaluation process. Both require an Interagency Service Planning Team Meeting.
3. In the Brief Treatment model, children may receive a *maximum* of 36 weeks of BHRS Brief Treatment services. In traditional BHRS, there are no specific

restrictions on the period of time children may be authorized to receive services. Typically, children are authorized for traditional BHRS in four-month increments, although some children with Autism Spectrum Disorders may be authorized for one year at a time.

4. During the course of treatment, children in BHRS Brief Treatment may receive between 1 hour and 6 hours of service per week. There is no restriction on the number of hours of service per week in traditional BHRS.

5. Booster treatments may be authorized, as necessary, in the year following the initial period of BHRS Brief Treatment. A maximum of three non-consecutive booster sessions may be authorized, each for a maximum of two weeks. In the simplified authorization process for booster sessions, providers submit a plan of care and details about the level of service to be provided. Booster sessions also involve MT-only or BSC-only treatment. These sessions allow families to maintain continuity of care by accessing familiar clinicians during periods of change or crisis. Booster treatment is not available in traditional BHRS.

According to providers, treatment activities provided during BHRS Brief Treatment are quite similar to those provided during traditional BHRS. Additionally, family members and treatment teams identify similar treatment goals for children who use BHRS Brief Treatment or traditional BHRS. Children who receive Brief Treatment or traditional BHRS often need help with managing their behaviors, dealing with anxiety and/or depression, and handling trauma and transitions. The intensity of the child's treatment needs, acuity of the child's symptoms, and the family's resources/supports are primary issues when considering the appropriateness of Brief Treatment. Based on these factors, providers consider the length of time they believe will be necessary to meet the child's treatment goals and make decisions about seeking authorization for Brief Treatment or traditional BHRS accordingly.

Providers have not experienced any implementation difficulties with the model and believe it is a very valuable addition to the services they can offer. In particular, they believe that the streamlined authorization process works well and accessing the service is very "user-friendly." They also think the time-limited nature of the service (which is similar to the family-based mental health services model) is important as it provides greater treatment focus for the clinician, child, and family.

BHRS BRIEF TREATMENT DEMOGRAPHICS

From January 1, 2004 to June 30, 2005, 448 children received BHRS Brief Treatment services. Table 2 shows the race, gender, and age characteristics for children who used BHRS Brief Treatment during the period.

Table 2: Race, Gender, and Age of Children in BHRS Brief Treatment

	Number and percent of children who used BHRS Brief Treatment	Total paid claims	Average paid claims per child
African American females	61 (14%)	$187,814	$3,079
African American males	109 (24%)	$296,042	$2,716
Other[4] females	7 (2%)	$23,711	$3,387
Other males	8 (2%)	$15,473	$1,934
Caucasian females	92 (21%)	$261,767	$2,845
Caucasian males	171 (38%)	$573,817	$3,356
Ages 0 – 5	21 (5%)	$63,446	$3,021
Ages 6 – 12	205 (46%)	$600,805	$2,931
Ages 13 – 17	195 (44%)	$579,701	$2,973
Ages 18 – 20	27 (6%)	$114,672	$4,247
All members	**448**	**$1,358,624**	**$3,033**

Race and gender characteristics

- Caucasian males represented the largest group (38%) of children receiving BHRS Brief Treatment and also had more paid claims for service, on average. This differs from traditional BHRS, where a larger proportion of children using traditional BHRS during this same period were Caucasian male (51%).
- African American males comprised the second largest group of children receiving BHRS Brief Treatment but had a smaller amount of paid claims for service, on average, than most other race and gender groups.
- Race and gender patterns by *type* of BHRS brief treatment (MT-only, BSC-only, Booster) were similar to the overall distribution shown in Table 2, except that African Americans represented a smaller proportion of children who used BSC-only Brief Treatment (6%) and Caucasian males constituted a larger proportion of children who used BSC-only Brief Treatment (45%).

[4] The category "other" includes Asian, Native American, Hispanic, Pacific Islander, and all other races.

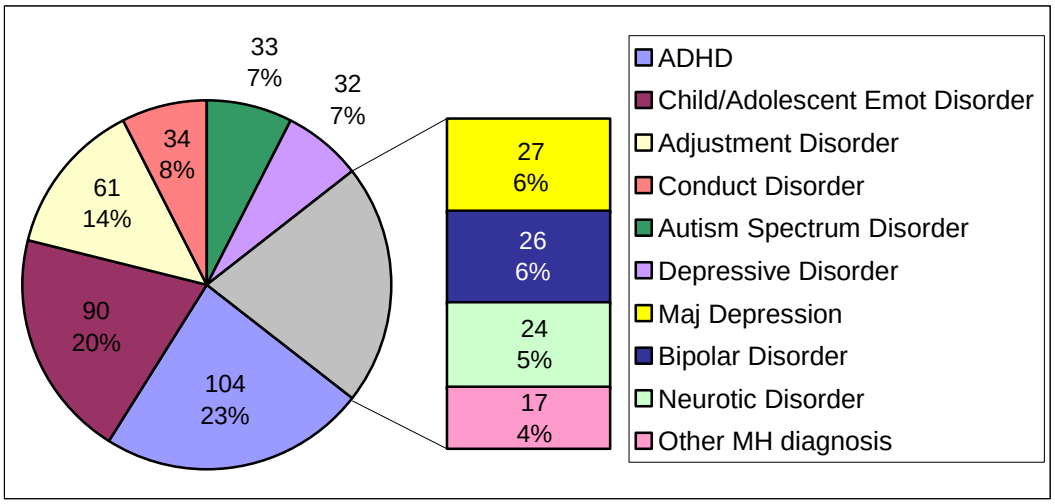
Age characteristics

- Most children using BHRS Brief Treatment were between the ages of 6 and 17 years old. The number of children, total paid claims, and average claims per child were very similar for the 6-12 and 13-17 year age groups.
- Children in the 0-5 age range were more likely to use BSC-only services than MT-only services. In contrast, children in the 18-20 age range were more likely to use MT-only services than BSC-only services.
- Compared to children receiving traditional BHRS, a much higher proportion (50%) of children who used BHRS Brief Treatment were 13 years or older. Only 31% of children receiving traditional BHRS were 13 years or older.

DIAGNOSES FOR CHILDREN IN BHRS BRIEF TREATMENT

In order to be eligible for BHRS Brief Treatment, a child or adolescent must have a diagnosis of a mental illness or a serious emotional disorder. Figure 1 illustrates the primary diagnoses[5] of children receiving BHRS Brief Treatment.

Figure 1: Primary Diagnosis of Children in BHRS Brief Treatment



Overall, Attention Deficit Hyperactivity Disorder (ADHD) was the primary diagnosis for the largest number of children who used BHRS Brief Treatment. Child and Adolescent Emotional Disorder (Child/Adolescent Emot Disorder) was another common primary diagnosis category. This category includes several separate diagnoses, with the most frequent being Oppositional Defiant Disorder.

However, it is important to note that the distribution of diagnoses varied significantly by type of BHRS Brief Treatment service. In particular, children with Autism Spectrum

[5] For purposes of this report, a child's primary diagnosis was the diagnosis that appeared most frequently on claims for BHRS Brief Treatment services.

Disorders constituted a much higher percent of children who used BSC-only Brief Treatment (25%) than MT-only Brief Treatment (4%). Similarly, children with ADHD and Adjustment Disorder diagnoses represented larger proportions of children who used MT-only Brief Treatment than BSC-only Brief Treatment.

The contrast in diagnosis distribution reflects differences between BSC and MT services. BSC duties primarily focus on behavior management plans and interventions, types of treatment frequently used for children with Autism Spectrum Disorder diagnoses. MTs, on the other hand, focus on psychotherapy activities, which are less frequently used when treating children with Autism Spectrum Disorder.

Overall, a smaller proportion of children receiving BHRS Brief Treatment had Autism Spectrum Disorder diagnoses compared to children receiving traditional BHRS. Almost 40% of the children receiving traditional BHRS had a primary diagnosis of Autism Spectrum Disorder compared to only 7% of children receiving BHRS Brief Treatment. The differences are greater when looking at claims: 54% of paid claims for traditional BHRS were for children with Autism Spectrum Disorder diagnoses, while only 6% of Brief Treatment paid claims were for children with Autism Spectrum Disorder diagnoses.

These differences between diagnoses are not surprising when the two treatment models are compared. Traditional BHRS offers a more intense form of treatment, a longer potential period of treatment, and the availability of TSS services – all of which are often necessary in treating children with Autism Spectrum Disorder diagnoses. Traditional BHRS are therefore used more frequently than BHRS Brief Treatment for treating children with Autism Spectrum Disorder diagnoses.

BHRS Brief Treatment Service Utilization

From January 1, 2004 to June 30, 2005, paid claims for BHRS Brief Treatment totaled $1.36 million with an average of $3,033 paid per child (a total of 448 children). Almost 3,000 children received MT, BSC, or TSS through traditional BHRS treatment during the same time period. Paid claims for traditional BHRS totaled approximately $49 million, with average paid claims per child of $15,992. Comparing BHRS Brief Treatment to traditional BHRS, the amount of claims paid per Brief Treatment member was almost $13,000 less than traditional BHRS.

Table 3 illustrates the number of members, total paid claims, and paid claims per child by MT-only, BSC-only, and Booster Brief Treatment service.

Table 3: Claims and Number of Children by BHRS Brief Treatment Service Type

	Total paid claims	Number of children	Average paid claims per child
MT-only	$1,137,273	370	$3,074
BSC-only	$212,369	77	$2,758
Booster	$8,983	17	$528
TOTAL	**$1,358,624**	**448**	**$3,033**

MT-only services comprised the largest portion of paid claims for BHRS Brief Treatment services. As shown in Table 3, more children received MT-only services than BSC-only or Booster services. Additionally, MT-only BHRS Brief Treatment had the highest level of paid claims per member ($3,074).

Paid claims for each type of service differed dramatically between BHRS Brief Treatment and traditional BHRS. Almost 60% of the total paid claims for traditional BHRS were for TSS services, with MT and BSC only comprising 13% and 27%, respectively. Since Brief Treatment does not involve TSS, MT and BSC are the only billable services for BHRS Brief Treatment.

The mean length of service for children receiving MT-only and BSC-only BHRS Brief Treatment was 20 weeks. During the period of treatment, children using MT-only and BSC-only services received an average of 2.7 hours of treatment per week. More intensive Booster sessions lasted approximately 1 week with children receiving an average of 5.4 hours of service. The average length of service and number of hours of service per week fell well within the BHRS Brief Treatment model guidelines.

During the period, 24 facilities or practitioners provided BHRS Brief Treatment for 448 children. The number of children who used Brief Treatment varied greatly from provider to provider. On average, providers served 19 children in BHRS Brief Treatment. All 24 providers also delivered traditional BHRS services during this time period.

Booster treatment

While relatively few children received Booster sessions after BHRS Brief Treatment, providers felt it was an important part of the treatment model. According to providers, parents were more likely to consider Brief Treatment as a viable option, knowing Booster sessions were available after the initial period of Brief Treatment.

Additionally, Brief Treatment clinicians work with children and family members to develop crisis plans. Providers thought that children and family members may utilize Crisis Services like ACES, often listed in crisis plans, after the initial period of Brief Treatment rather than Booster sessions.

USE OF OTHER HEALTHCHOICES SERVICES BEFORE, DURING, AND AFTER BRIEF TREATMENT

An examination of service utilization by children in BHRS Brief Treatment is useful for several reasons. First, utilization of BHRS Brief Treatment as a step-down or step-up service may be evident from differences in service use before and during the period a child receives BHRS Brief Treatment. Additionally, service use during and after BHRS Brief Treatment provides an indication of the degree to which the service meets the needs of children and the types of treatment children continue to utilize after receiving BHRS Brief Treatment.

Table 4 illustrates how many children used other behavioral health services and the average cost of these services prior to BHRS Brief Treatment. For each child, service data was collected for the 90 day period prior to the date of his or her first BHRS Brief Treatment service.

Table 4: Service Utilization Before BHRS Brief Treatment[6]

	Number of children who used the service 90 days prior to Brief Treatment[7]	Percent of children	Average paid claims per child
BHRS[8]	142	34%	$2,276
OP-MH	135	32%	$359
Med Check	135	32%	$63
Case Mgmt	131	31%	$903
PHP-MH	51	12%	$2,206
FBMHS	50	12%	$6,415
IP-MH	25	6%	$5,548
Crisis	16	4%	$444
Respite/DAS	6	1%	$3,977
RTF	3	1%	$23,332
No services	71	17%	N/A
Total number of children: 422			

[6] 422 of the 448 children who used BHRS Brief Treatment were eligible for HealthChoices services in the 90-day period before the date of their first BHRS Brief Treatment session.
[7] Children may have received more than one type of service in the 90 days prior to Brief Treatment.
[8] MT, BSC, TSS services. Other services billable as BHRS (evaluations, summer camp, etc.) are not included in these totals, in order to measure how many children were referred to Brief Treatment from traditional BHRS.

The service utilization data indicates that in the period 90 days before BHRS Brief Treatment began:

- 34% of children received traditional BHRS
- 32% received outpatient services
- 12% received family-based mental health services (FBMHS)
- 17% of children did not use any HealthChoices-funded behavioral health services in the three months before starting Brief Treatment (even though they were enrolled in HealthChoices)

The data therefore indicates BHRS Brief Treatment was often prescribed as a step-down service from traditional BHRS and FBMHS, and was also prescribed as a step-up from outpatient services. For some children, this was the first behavioral health service they received, or had at least a three month gap since receiving another service. Providers have often educated other programs in their agencies on Brief Treatment and who may be an appropriate referral. Many receive referrals from other levels of care within their agency, including in-school mental health programs and family-based programs. Case managers also may recommend the service.

Few children used RTF or inpatient services before Brief Treatment, indicating the service was rarely prescribed as a step-down from these intensive levels of service. According to BHRS providers, many children discharged from RTF or inpatient services require a higher level of service intensity than that available in BHRS Brief Treatment. Additionally, providers indicated that family members often preferred TSS to be included in treatment plans for children being discharged from relatively restrictive levels of treatment. However, it is also important to note that compared to BHRS and outpatient services, fewer children use RTF or inpatient mental health services in general, so the pool of possible referrals is smaller.

Table 5 illustrates how many children used other behavioral health services and the average cost of these services during the time they were receiving BHRS Brief Treatment. Paid claims for non-BHRS Brief Treatment services totaled $710,733 or approximately $1,582 per child during the period of BHRS Brief Treatment.

Table 5: Service Utilization During BHRS Brief Treatment

	Number of children using each service during Brief Treatment[9]	Percent of children	Average paid claims per child
Case Mgmt	154	34%	$1,399
Med Check	149	33%	$92
OP-MH	121	27%	$259
PHP-MH	44	10%	$3,239
FBMHS	33	7%	$887
IP-MH	24	5%	$5,733
Crisis	18	4%	$655
Respite/DAS	4	1%	$4,668
RTF	2	1%	$5,131
Total number of children: 448			

According to the treatment model, while receiving BHRS Brief Treatment, children should not participate in long periods of therapy at any other level of care such as outpatient therapy or FBMHS, since receiving these forms of treatment would be a duplication of services. However, a short period of overlap of services is not only acceptable but encouraged. For instance, during the first few weeks of BHRS Brief Treatment, a child may keep his or her FBMHS team to ensure a successful transition between the two services. Similarly, a child may receive outpatient services during the final weeks of BHRS Brief Treatment, to provide time for clinicians to communicate about future treatment needs and service approaches.

The service utilization data shows that many children used outpatient and/or FBMHS services during the period they received BHRS Brief Treatment. The relatively low paid claims per child indicate that these services were appropriately overlapping with Brief Treatment for a small number of total hours, on average.

While only 10% of children also used partial hospitalization services during Brief Treatment, the average cost per child indicates that partial hospitalization and Brief Treatment have been used concurrently by some children. Providers mentioned that a small number of children in school-based partial programs need the extra one-on-one therapy provided in Brief Treatment so they do receive both services at the same time.

A very small percent of children used intensive services like RTF, inpatient, and respite in addition to Brief Treatment. This would indicate that most of the children receiving Brief Treatment are not requiring more intensive services than Brief Treatment can provide.

[9] Children may have accessed more than one additional type of service during Brief Treatment.

Paid claims for case management services during BHRS Brief Treatment increased from the time period before Brief Treatment. The increase in the number of children receiving case management services once they started Brief Treatment is likely the result of BHRS Brief Treatment providers making referrals for case management services. Providers stated they occasionally will make referrals for case management.

Table 6 shows post-Brief Treatment service utilization. For each child, service data was collected for the 90-day period following the last date he or she received BHRS Brief Treatment.

Table 6: Service Utilization After BHRS Brief Treatment[10]

	Number of children using the service 90 days after Brief Treatment[11]	Percent of children	Average paid claims per child
BHRS[12]	192	45%	$1,890
Case Mgmt	145	34%	$891
Med Check	130	30%	$64
OP-MH	99	23%	$309
PHP-MH	39	9%	$1,910
IP-MH	16	4%	$8,186
Crisis	10	2%	$299
Respite/DAS	9	2%	$3,588
RTF	9	2%	$16,082
FBMHS	6	1%	$3,910
No services	85	20%	N/A
Total number of children: 428			

The amount of paid claims for all HealthChoices services 90 days after BHRS Brief Treatment was $327,000 less than the amount of paid claims for services 90 days prior to Brief Treatment services. For many services, both the number of children and the average paid claims per child dropped from pre-Brief Treatment levels. This suggests

[10] 428 of the 448 children who used BHRS Brief Treatment were eligible for HealthChoices services in the 90 day period after the date of their last BHRS Brief Treatment session.
[11] Children may have received more than one form of service in the 90 days after Brief Treatment.
[12] MT, BSC, TSS services. Other services billable as BHRS (evaluations, summer camp, etc.) are not included in these totals, in order to measure how many children went on to receive traditional BHRS after Brief Treatment.

that fewer children are using these services and that services are being used, on average, at less intense levels after Brief Treatment.

Few children used the more intensive services like inpatient and crisis in the three month period after Brief Treatment. While 50 children used FBMHS prior to starting BHRS Brief Treatment, only 6 children "stepped up" to this service after Brief Treatment. This would seem to indicate that the majority of children do not need highly intensive services in the 90 day period following Brief Treatment. Many more children receive step-down services like outpatient (23%) and medication checks (30%) after Brief Treatment, and continue to receive the support of a case manager (34%).

A large proportion (43%) of children went on to receive traditional BHRS services after Brief Treatment. According to providers, this means one of two things:

- During the course of Brief Treatment, treatment needs emerge that require a Best Practice Evaluation and a traditional BHRS prescription.
- While the intensity of Brief Treatment is appropriate (1-6 hours per week), the child would benefit from continuing in treatment longer than the 36 weeks allowed by the Brief Treatment model.

Claims data indicates that children who receive traditional BHRS after Brief Treatment were treated at a similar level as with BHRS Brief Treatment. Over 75% of these children received only MT or BSC services in quantities similar to those received during Brief Treatment. This supports providers' impressions that many children may not need more intensive BHRS, but rather, need additional time[13] at the BHRS Brief Treatment level before being discharged.

About 20% of children did not receive any other services after Brief Treatment. This includes children who did not receive recommended follow-up services and children who no longer needed formal behavioral health services in addition to their community supports.

[13] Under the BHRS Brief Treatment model, children may receive a maximum of 36 weeks of BHRS Brief Treatment.

CONCLUSION

BHRS Brief Treatment has been available to children in Allegheny County since the beginning of 2004. In the first 18 months of the program, almost 450 children received Brief Treatment services. Brief Treatment represented almost 12% of all children using BHRS during that period. The average length of service and number of hours of service per week fell well within the BHRS Brief Treatment model guidelines.

Claims data shows that BHRS Brief Treatment is used mostly as a means of providing time-limited Mobile Therapy services. Brief Treatment is primarily provided to children with diagnoses of ADHD, Oppositional/Defiant Disorder, and Adjustment Disorders.

While children continue to access a range of HealthChoices services after being discharged from BHRS Brief Treatment, many children have used a lower level of service than they used before Brief Treatment.

Providers and Community Care indicate the model has met its intended goals by providing services to children who do not require the level of intensity offered through traditional BHRS but could benefit from wraparound services provided in the community. BHRS Brief Treatment has filled a gap in the service continuum by providing the opportunity for children to access Brief Treatment as a step-down or step-up level of service. Additionally, the Brief Treatment option has provided clinicians with the opportunity to more fully evaluate children and make more informed treatment recommendations based on observations in the home and community.

Initial data suggests BHRS Brief Treatment in Allegheny County has closely followed the goals and guidelines of the treatment model. Claims-based monitoring and discussions with providers should continue as a means of monitoring this service. Future analyses might examine levels of satisfaction for children and family members as well as long-term service utilization patterns of children served by BHRS Brief Treatment.

GLOSSARY OF SERVICES

BHRS (Behavioral health rehabilitation services): 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 include Therapeutic Support Staff (TSS), Behavioral Specialist Consultants (BSC), Mobile Therapy (MT) and specialized services, as approved.*

Case Mgmt (Case management services): 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. Intensive case management services are available 24 hours a day, 7 days per week.*

Crisis (Crisis services): These services are available 24 hours a day. Members experiencing crises call a toll-free number, and receive telephone counseling. When indicated, professional behavioral health counselors will provide mobile crisis services at the member's home or in the community.

FBMHS (Family-based mental health services): Evaluation and treatment services provided to a specific child in a family, but focuses 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.*

IP-MH (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.*

Med Check (Medication check): 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.

OP-MH (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, individual or group therapy. Services are provided by licensed facilities under the supervision of a psychiatrist or by private credentialed practitioners.*

PHP-MH (Partial hospitalization mental health program): 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.*

Respite/DAS (Respite and Diversion/Acute stabilization services): 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.

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* Service descriptions are quoted from The Office of Mental Health and Substance Abuse Services (OMHSAS), available at http://www.dpw.state.pa.us/omhsas/omhchoices.asp.

RTF (Residential treatment facility): Comprehensive mental health treatment services for children with severe emotional disturbances or mental illness. These services are provided in facilities which must be licensed by OCY&F under Chapter 3800. The facility must have a service description approved by OMHSAS, be certified by OMHSAS through annual on-site review, have a utilization review plan in effect and be enrolled in the MA program.*