The Allegheny County HealthChoices Program

2012 Year in Review

Allegheny HealthChoices, Inc.

September 2013

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) health needs. This report focuses on the mental health and substance use 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 in providing oversight and monitoring, this report details information from 2012 for the HealthChoices Behavioral Health program, one part of the behavioral health system of care in Allegheny County. Since the Behavioral Health program provides a multitude of services that will be referenced throughout this report, please refer to Appendix 1 for a description of services.

Claims, admissions, and capitation data were used to obtain information for this report. Statistical testing was performed to determine if there were significant changes from 2011 to 2012.[i]

While there were not many changes from 2011 to 2012, the results outlined in this report can be used to identify gaps in services, areas for enhancement, and/or the need for more data or further analysis. AHCI also will use this report to help define special topic reports and projects in 2013 and 2014.

[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 2011."

Example: In 2011, out of 16,347 children and adolescents, 5,586 (34.17%) were diagnosed with ADHD. In 2012, out of 16,542 children and adolescents, 5,838 (35.29%) were diagnosed with ADHD. Using the difference of proportions test this difference was statistically significant at the p=.05 level. However, performing the ad hoc Cohen's H effect size testing, the magnitude of the difference was only 0.02, which is less than 0.2 , the value for a small effect size. As a result, the number of children diagnosed with ADHD from 2011 to 2012 is considered to be similar.

The HealthChoices Population

This section provides detailed information for two questions related to access to services: (1) Of those enrolled how many people are currently accessing services (penetration rate)? and (2) Do enrollees differ from service users (i.e. by age, race, and/or gender)? This helps identify where gaps may exist.

Penetration

Figure 1

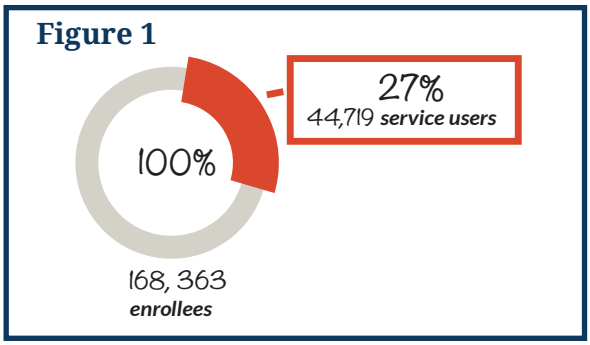
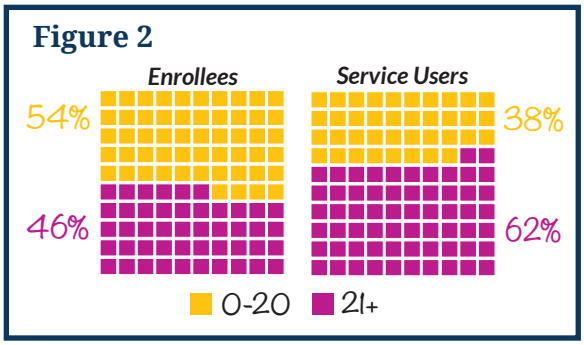


Figure 1 shows that 27% of those enrolled used at least one mental health or substance use service. This penetration rate is similar to the rate observed in 2011. Service penetration rates continue to be higher than the estimated 7%-13% indicated by previous research (from 1999-2003) on behavioral health service use by Medicaid beneficiaries.[4]

Age

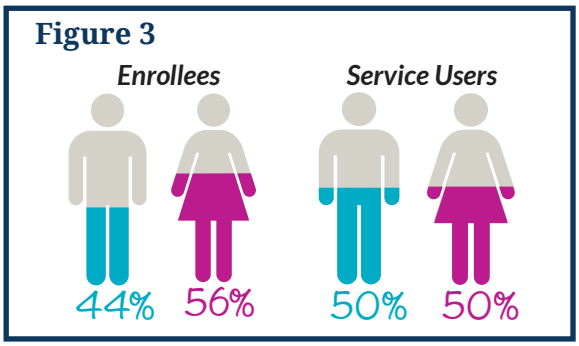
Figure 2



There were slightly more children/adolescents enrolled than adults, while more adults were service users (Figure 2). This is similar to 2011. The higher percentage of adult users may be attributed to the fact that behavioral health issues may not be diagnosed until later in life. There can also be long delays (from 4 to 23 years) between the first onset of symptoms and when people seek and/or receive treatment.[5-7]

Gender

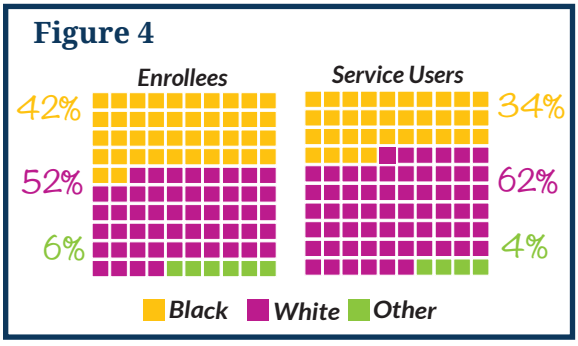
Figure 3



Similar to 2011, there were slightly more females enrolled than males, which may be attributed to eligibility (how people qualify) for Medicaid, although an equal proportion of males and females accessed services (Figure 3).

Race

Figure 4

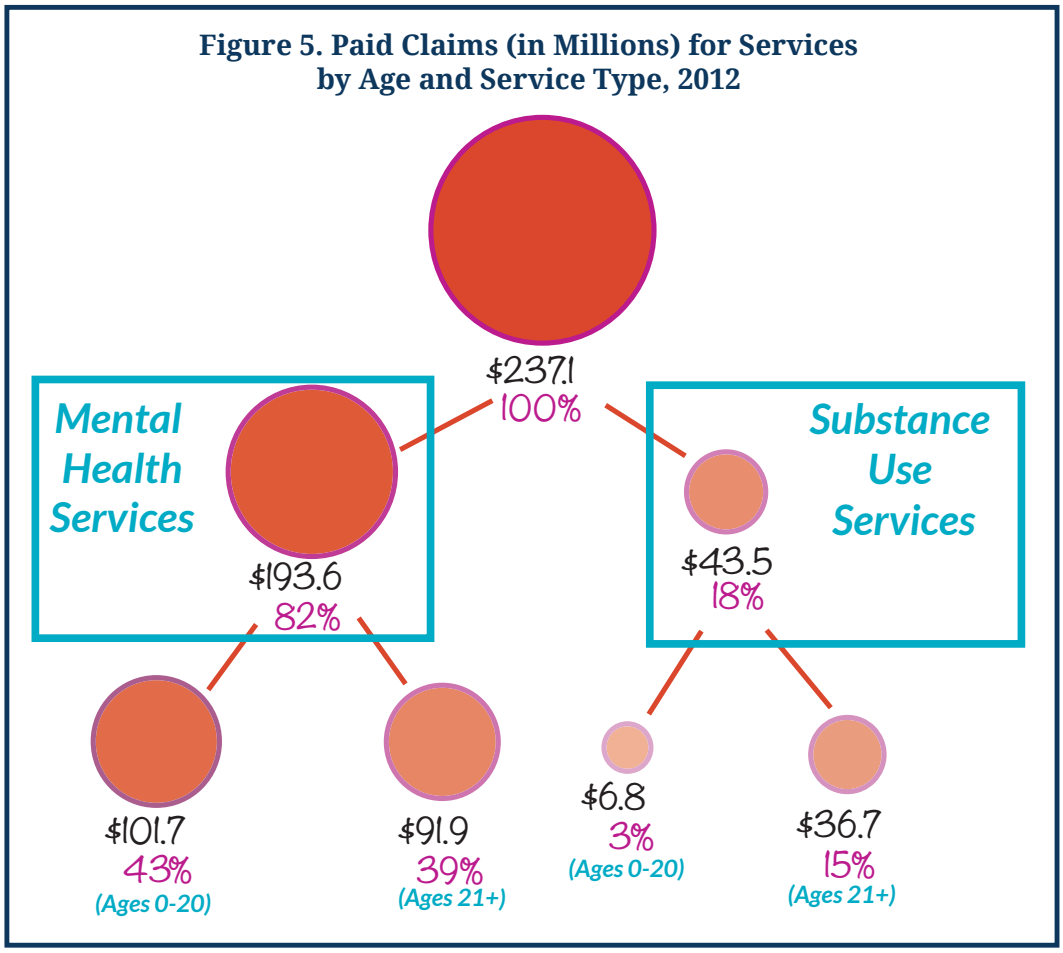


Similar to 2011, there were slightly more whites than blacks and other races enrolled, but consistent with prior research, service users include disproportionately more whites (Figure 4). Other races were a very small proportion of the enrollees and service users. Of note however, is that blacks are more likely to receive mental health treatment in primary care settings versus formal behavioral health services,[8-9] which may lead to the utilization pattern that is being observed for blacks. Nonetheless, it is estimated that only about half of those that need treatment actually receive it.[10]

Overall Costs of Behavioral Health Services

Figure 5 presents the total claims paid (in millions) in 2012 by age (0-20 and 21+) and service type (mental health and substance use). Mental health services accounted for a majority (82%) of the paid claims. Mental health services paid claims were slightly higher for children and adolescents (43%) compared to adults (39%), while substance use services paid claims were five times higher for adults (15%) than children and adolescents (3%). These results are similar to those in 2011.

Figure 5. Paid Claims (in Millions) for Services by Age and Service Type, 2012



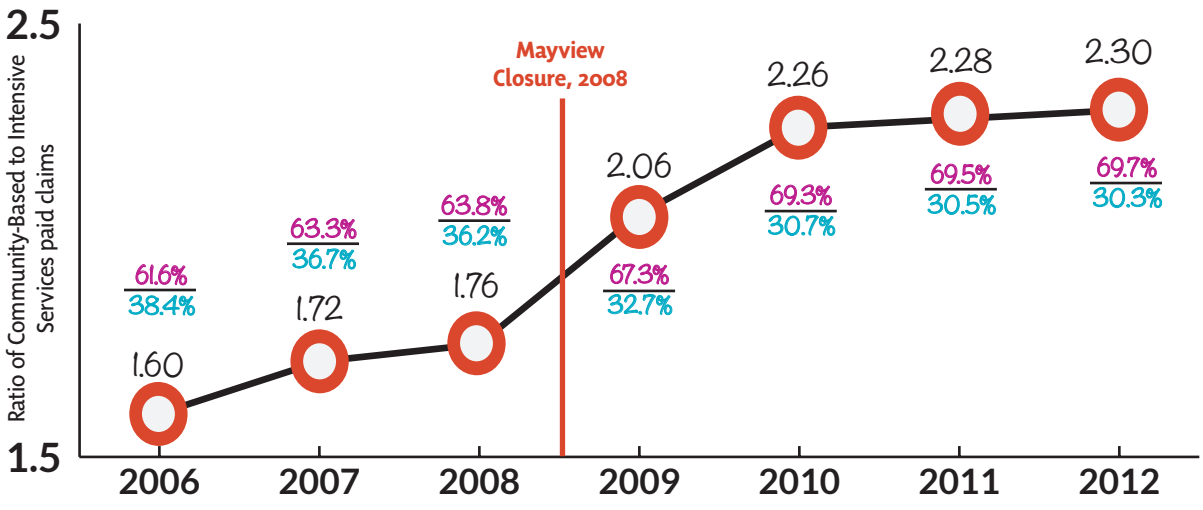
Community-Based Versus Intensive Mental Health Services

Allegheny County is committed 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 6 compares spending for community-based versus intensive mental health services,[ii] from 2006-2012. Spending on community-based services was over 1.5 times greater than intensive services in 2006. The difference in spending gradually increased over the years, and by 2012, the total amount paid for community-based services was over twice as much as intensive services. In 2012, community-based services accounted for 79% of the total cost for mental health services for children and adolescents. For adults, community-based services accounted for 59% of the cost for mental health services in 2012. However, the average cost per service user remains higher for intensive mental health services compared to community-based mental health services.

It is also worth noting that Mayview State Hospital closed at the end of 2008. This closure has contributed to the increased use of community-based services in an effort to meet the needs of the individuals that transitioned back to the community and those who would have been admitted to the state hospital if it were still open.

Figure 6. Ratio of Paid Claims for Community-Based versus Intensive Mental Health Services, 2006-2012



[ii] Community-based services are services provided within the community and/or home setting to meet the needs of the consumer (i.e. behavioral health rehabilitation services, community treatment teams, crisis services, non-hospital long term residential care, outpatient mental health, respite, etc.). Intensive services provide care in an inpatient setting (i.e. extended acute care, residential treatment facilities, and inpatient hospitalizations). Please refer to appendix 1 for a more detailed list and description of services.

Service Utilization for Children (0-20 Years)

Table 1 summarizes services used and associated costs for children and adolescents in 2012. Services are categorized into five groups: community-based mental health, residential treatment facilities (RTFs), psychiatric inpatient and related intensive services, substance use services, and crisis services.

Table 1. Total Paid Claims (in Millions), Number of Service Users, and Average Cost Per Service User for Children and Adolescents, 2012

	$ (millions)	% Change from 2011	Number of Service Users*	Average Cost per Service User
1 Community-Based MH Services	**$78.79 (73%)**	**▲ 0.3%**	**16,341 (95%)**	**$4,822**
Behavioral Health Rehabilitation Services	$45.4 (42%)	▲ 0.8%	5,954 (35%)	$7,621
2 Residential Treatment Facilities	**$11.44 (10%)**	**▼ 8.2%**	**313 (2%)**	**$36,575**
3 Psychiatric Inpatient and Related Intensive Services	**$9.47 (9%)**	**▼ 9.6%**	**817 (5%)**	**$11,603**
4 Substance Use Services	**$6.84 (6%)**	**▲ 8.4%**	**1,272 (7%)**	**$5,379**
5 Crisis Services	**$1.98 (2%)**	**▲ 8.5%**	**1,603 (9%)**	**$1,233**
TOTAL	**$108.5 (100%)**	**▼ 1.1%**	**17,109 (100%)**	**$6,343**

** People may have used more than one service in 2012. As a result the number of service users will be more than 17,109 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 number of people that used services from 2011 to 2012. Significant changes were seen in some average costs per user :

1. For community-based MH services, behavioral health rehabilitation services (BHRS) continued to account for the largest proportion (58%) of paid claims for community-based mental health services, while outpatient mental health services accounted for the largest proportion of service users (66%).

2. Although the number of service users remains steady for youth in residential treatment facilities, the average cost per service user significantly decreased from 2011 to 2012 as did average length of stay (200.8 days in 2011 to 171 days in 2012); signifying that youth are spending shorter amounts of time in RTFs.

3. When looking at psychiatric inpatient and related intensive services only, inpatient hospitalizations accounted for the largest proportion of paid claims (95%) and service users (98%) in this group of services. There were significant increases in the average cost per service user for youth 18-20 years of age in residential treatment facilities for adults and in community-based EAC. This could be attributed to longer stays for some individuals driving the average cost per service user up in 2012.

4. For substance use services only, short and long term non-hospital rehabilitation accounted for the largest proportion of paid claims (76%), while outpatient substance use services accounted for the largest number of service users (81%). In 2012 there was a significant increase in the use of group psychotherapy for outpatient substance use services and a significant decrease in average cost per service user for inpatient detoxification (though the number of consumers was small for this level of care).

5. In 2012, for crisis services, planned mobile crisis follow-up visits were implemented for individuals who were identified as being at high risk for inpatient admissions/readmissions after a crisis residential stay and/or a walk-in crisis visit. As a result, there was a significant increase in use (units and number of users) and the amount paid (total and average cost per person).

Nathan's Story

"The child that I had before receiving services is not the same child I have now and that really means a lot to me. I do not know what I would have done, to be honest, without my services . . . there are [still] some days [when] it is just overwhelming but those days are not as frequent as they used to be."- Nathan's mother

Nathan is 8 years old. He has been diagnosed with Asperger Syndrome (autism spectrum disorder) and attention deficit hyperactivity disorder (ADHD). He also has brain damage which affects his muscular system.

At the age of three he began receiving physical and occupational therapy for his physical disabilities. During that time his extreme sensory sensitivities, which proved to be his biggest challenge, became noticeable. He did not like noises, textures, smells, tastes, or being around people. This would then manifest in behavior problems. At the age of five, Nathan began receiving behavioral health services.

Currently he attends a social skill-buiding program, has a behavioral specialist consultant (BSC)[iii] at school, regular visits with the psychiatrist/psychologist, and has completed the intake process for outpatient therapy.

Since receiving services Nathan has had many successes.

At school, his BSC has worked with him to stay focused, on task, and organized. He has been working on his responses to different sensory triggers via the social skills program, BSC support, and therapy. He has also learned self-regulation techniques. Now, instead of resorting to temper tantrums or self-abusive behaviors, he will take a deep breath, ask for a break, remove himself from the situation and then come back, or ask for help when he needs it. He expresses how he feels (i.e. his dislikes or when something is bothering him) and has a desire to play with his peers and make friends instead of keeping to himself.

His self-confidence, his grades, and his self-esteem have also improved. Instead of crying or having meltdowns he says, *"I can do it mom. I can try . . . [or] I need a little bit of help . . . [or] Mom, remember I have autism, so you know I have a hard time, give me a minute."*

For herself, his mom says the parent support groups have been a life saver, *"When you are with other people who have children with a disability and receive services, it is easier and you feel more accepted. . ."* Her advice to parents that may be struggling to accept that their child may need help is this: *"I would tell them to get themselves connected with somebody else whose child receives services . . . and [that] you are here for your kid and don't worry [about] what anybody else says . . . you just have to remember it is your kid and you want what's best for them."*

[iii] Behavioral Specialist Consultants (BSC) provide specialized behavioral assessments and treatment interventions in homes, schools, and other community locations. They assist families and others working with a child in the development of specific therapeutic interventions to manage or eliminate inappropriate behavior.

Top Diagnoses for Children (0- 20 Years)

There were no significant changes from 2011 to 2012 for children in the amount paid per diagnoses, the number of people with each diagnoses, or the amount paid per person (with the exception of some less common diagnoses - with fewer HealthChoices members).

Children and adolescent service users may be included in more than one diagnostic group due to multiple diagnoses. As a result, the percentage of service users will not equal 100%.

Mental Health

35%
or 5,838 service users had paid claims for the treatment of **ADHD**
$3,815 cost /user

18%
or 3,045 service users had paid claims for the treatment of **conduct disorder or oppositional/ defiant disorder**
$5,303 cost /user

25%
or 4,219 service users had paid claims for the treatment of **adjustment disorders**
$1,963 cost /user

18%
or 2,952 service users had paid claims for the treatment of **autism spectrum disorders**
$9,254 cost /user

Substance Use

69%
or 814 services users had paid claims for treatment related to **cannabis use**
$5,783 cost /user

14%
or 169 service users had paid claims for treatment related to the **use of multiple substances**
$4,220 cost /user

15%
or 176 service users had paid claims for treatment related to **alcohol use**
$3,387 cost /user

13%
or 155 service users had paid claims for treatment related to **opiate use**
$5,004 cost /user

Top Diagnoses for Adults (21+ Years)

There were no significant changes in the amount paid per diagnoses, the number of people with each diagnoses, or the amount paid per person from 2011 to 2012 for adults.

Adult service users may be included in more than one diagnostic group due to multiple diagnoses. As a result, the percentage of service users will not equal 100%.

Mental Health

46%
or 10,919 service users had paid claims for the treatment of **major depression or other depressive disorders**
$2,233 cost /user

18%
or 4,231 services users had paid claims for the treatment of **schizophrenia**
$8,547 cost /user

21%
or 5,087 service users had paid claims for the treatment of **bipolar disorder**
$2,468 cost /user

15%
or 3,639 services users had paid claims for the treatment of **anxiety disorders**
$881 cost /user

Substance Use

55%
or 4,842 services users had paid claims for treatment related to **opiate use**
$4,200 cost /user

24%
or 2,068 service users had paid claims for treatment related to the **use of multiple substances**
$3,219 cost /user

24%
or 2,124 services users had paid claims for treatment related to **alcohol use**
$2,600 cost /user

12%
or 1,024 services users had paid claims for treatment related to **cocaine use**
$3,526 cost /user

Service Utilization for Adults (21+ Years)

Table 2 summarizes the services used and the associated costs for adults in 2012. Services are categorized into four groups: community-based mental health, psychiatric inpatient and related intensive services, substance use 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, 2012 (with highest cost services highlighted)

	$ (millions)	% Change from 2011	Number of Service Users*	Average Cost per Service User
1 Community-Based MH Services	**$47.7 (37%)**	**▲ 2.5%**	**24,201 (87%)**	**$1,972**
Outpatient MH and Med Checks	$15.5 (12%)	▲ 5.6%	22,382 (80%)	$6,925
Community Treatment Teams	$13.7 (11%)	▼ 1.5%	705 (2%)	$19,495
Service Coordination	$11.6 (9%)	▲ 1.4%	4,113 (15%)	$2,826
2 Psychiatric Inpatient and Related Intensive Services	**$37.7 (29%)**	**▲ 6.7%**	**2,882 (10%)**	**$13,216**
Psychiatric Inpatient	$26.6 (21%)	▲ 2.1%	2,804 (10%)	$9,484
Extended Acute Care	$9.5 (7%)	▲ 22.7%	209 (.75%)	$46,408
Residential Treatment Facility-Adults	$1.6 (1%)	▼ 9.2%	62 (.002%)	$25,370
Substance Use Services	**$36.7 (29%)**	**▲ 1.0%**	**8,293 (30%)**	**$4,423**
3 *Long and Short Term Non-Hospital Rehabilitation*	$15.0 (12%)	▲ 0.9%	2,477 (9%)	$6,044
Methadone Maintenance	$7.5 (6%)	▲ 5.6%	2,312 (8%)	$3.243
Outpatient Substance Use	$4.6 (3%)	▼ 10.2%	6,028 (22%)	$765
4 Crisis Services	**$6.5 (5%)**	**▼ 2.6%**	**3,282 (12%)**	**$1,989**
Crisis Services	$3.8 (3%)	▲ 7.1%	3,059 (11%)	$1,238
Respite/DAS	$2.7 (2%)	▼ 13.4%	440 (1%)	$6,233
TOTAL	**$128.6 (100%)**	**▲ 2.7%**	**27,851 (100%)**	**$4,618**

** People may have used more than one service in 2012. As a result the number of service users will be more than 27,851 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, the number of people that used services, or the average cost per service user from 2011 to 2012.

1 Outpatient mental health and medication checks accounted for the largest proportion of paid claims (33%) and service users (92%) under community-based mental health services.

2 For the psychiatric inpatient and related intensive services group only, inpatient hospitalizations continue to account for the largest proportion of paid claims (72%) as well as the highest proportion of service users (98%).

3 For substance use services, paid claims were highest for short and long term non-hospital rehabilitation (41%), methadone maintenance (20%), and outpatient substance use services (13%). Outpatient substance use services accounted for the largest number of users (73%) followed by non-hospital rehabilitation (30%) and methadone maintenance (28%).

4 Though there were no significant changes overall for the crisis services category, similar to what was noted for youth, planned mobile crisis follow-up visits were implemented in 2012. Individuals who were identified as being at high risk for inpatient admissions/readmissions after a crisis residential stay and/or a walk-in crisis visit received follow-up visits. As a result, there was a significant increase in the number of service users (77 in 2011 to 195 in 2012) and the total claims paid ($13,999 in 2011 to $65,876 in 2012) for individually delivered mobile crisis services.

Jackson's Story

"I don't believe recovery [is] a destination. I think It's an ongoing thing [for] the rest of your life... you maintain a certain level of wellness and you just keep growing." - Jackson

Jackson believes he started experiencing symptoms in the 8th grade. He was diagnosed with bipolar disorder in 1988, right after high school. After many hospitalizations, different medications, and stints with drinking he is working on his recovery. For the past four years he has remained sober and has not had any hospitalizations.

Jackson participates in psychosocial rehabilitation services (psych rehab). His initial goal was to obtain help with finding employment. After first volunteering, he now works, twice a week, as the crew leader at a food stand. With his earnings from work he bought an exercise machine to use at home.

Other goals he is working on with his psych rehab counselor and his outpatient therapist are to become a certified peer specialist,[iv] stay healthy, maintain personal goals with his illness, and maybe even go back to school.

When discussing becoming a certified peer specialist he says, *"I really don't know where it's leading me, all I know is I am taking the right steps . . . I wanted to give back a little for what I have gotten in the community with mental health services, so that's why I want to be a peer specialist . . . I think there's more I can provide . . . I've been in the system 25 years so after a while it gets old . . . and you're like I got to do something."*

In maintaining his wellness he said that there are more services available (i.e. re:solve crisis network and peer support programs) than when he first was diagnosed and that some of the stigma has gone away. *"When I was, say, 20, I never mentioned my illness to somebody. I thought maybe it was taboo or something. But now if I mention something, oh yeah I got a sister or my son, my brother . . . so I think it's becoming more acceptable to talk in public about mental illness."*

Jackson now likes to get involved as much as possible and wants to know and understand what is going on politically with behavioral health issues. His best advice to someone on their path to recovery is, *"Just don't ever give up. I've given up too many times and I don't want to give up any more . . . I don't like to call it a disability . . . I think everyone has abilities."* He further notes it involved liking himself first, *"It took me 22 years to understand you got to love yourself [before you can get anywhere in life]."*

[iv] Certified Peer Specialists are individuals who have used or currently use behavioral services that are trained to provide guidance, encouragement, resources, and support to others during their recovery. There is a two-week certification training course that includes learning specific skills relevant to providing effective peer support (i.e. active listening, cultural competency, appropriate self-disclosure, skill building, recovery/life goal setting, problem solving, establishing self-help groups, building and utilizing self-help recovery tools (such as the WRAP), and self-advocacy). More information can be found at http://www.parecovery.org/services_peer.shtml.

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

This section reports on 30-day readmissions rates, 7-day follow-up rates and average length of stay (ALOS) for children and adults (Tables 3 and 4 respectively).[v] Re-hospitalization or readmissions and follow-up treatment continues to be an important indicator related to inpatient treatment, engagement, and continuity of care.[11] ALOS is often used to determine how long it takes to get individuals stabilized and ready to move back back in to the community.

Children and Adolescents (0-21 Years)

For children, ALOS for RTF decreased in 2012, although ALOS for other inpatient services, the number of admissions and readmissions, and 7-day follow-up rates were similar to the rates observed in 2011 (Table 3 below).

Table 3. Admissions, 30-day Readmissions, ALOS, and 7-day Follow-Up for Children and Adolescents, 2012	# of Admissions (Unduplicated Consumers)	# of Readmissions (Unduplicated Consumers)	% of Readmissions**	ALOS (Days)	7-day Follow-Up Rate**
Mental Health* and RTF					
Inpatient Mental Health	**1253** (897)	**149** (107)	**11.98%**	**12.5**	**70.7%**
Residential Treatment Facilities	**241** (215)	**7** (7)	**3.03%**	**171**	**67.5%**
Substance Use Services*					
Short and Long Term Non- Hospital Rehabilitation	**391** (311)	**29** (23)	**7.32%**	**65.3**	**33.0%**

** The use of substance use disorder and mental health services is low for children and youth for 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.*
*** If the OMHSAS standard benchmark was met it is shaded.*

Highlights from Table 3:

- The ALOS for RTFs decreased from 200.8 days in 2011 to 171 days in 2012, which may reflect efforts of various community-based mental health services aimed at keeping children from out-of-home placement.
- When considering the percent of readmissions that occurred within 30 days, the OMHSAS standard benchmark of less than or equal to 10% was not met for inpatient mental health services.
- For 7-day follow-up, the OMHSAS standard was not met for any services, but the HEDIS[vi] 50th percentile benchmark of 46% was achieved for inpatient mental health and residential treatment facilities.

[v] The Office of Mental Health and Substance Abuse Services' (OMHSAS) designated gold standard benchmark is 90% for 7-day follow-up after hospitalization and less than or equal to 10.0% for 30 day readmissions for mental health services.[11] The 50th percentile benchmark for 7-day follow-up, established by the Healthcare Effectiveness Data and Information Set (HEDIS), is 46%.[12] OMHSAS and HEDIS standards were also used for substance use services, as no standard benchmark exists to date. No standard benchmarks have been established for ALOS for mental health or substance use.

[vi] HEDIS performance measures are often used as quality benchmarks in managed care organizations across the United States.

Adults (21+ Years)

Overall, the number of admissions, readmissions, 7-day follow-up rates, and ALOS for adults was similar to the rates observed in 2011 (Table 4 below). Of note is that the number of readmissions for inpatient extended acute care services appears to be higher than in 2011 (eight in 2012 and two in 2011). This may be due to the fact that there were more people using the service, 119 compared to 77 in 2011. Another possibility is that individuals could have been transfered out of the units for medical reasons and then readmitted to the inpatient extended acute care unit.

Table 4. Admissions, 30-day Readmissions, ALOS, and 7-day Follow-Up for Adults, 2012	# of Admissions (Unduplicated Consumers)	# of Readmissions (Unduplicated Consumers)	% of Readmissions*	ALOS (Days)	7-day Follow-Up Rate*
Mental Health and RTF - Adult					
Inpatient Mental Health	**4951** (3059)	**926** (554)	**18.67%**	**13.7**	**71.8%**
Inpatient Extended Acute	**125** (119)	**8** (8)	**6.90%**	**97.3**	**97.3%**
RTF - Adult	**56** (55)	**0** (0)	**0%**	**63.7**	**88.7%**
Substance Use Services					
Short and Long Term Non-Hospital Rehabilitation	**3245** (2383)	**266** (212)	**8.16%**	**27.1**	**54.7%**
Non-Hospital Detoxification	**1648** (1201)	**130** (102)	**7.84%**	**3.4**	**83.9%**
Inpatient Detoxification	**602** (414)	**89** (53)	**14.74%**	**4.7**	**61.5%**
Halfway House	**455** (428)	**18** (16)	**3.99%**	**77.9**	**31.7%**
Inpatient Rehabilitation	**56** (53)	**1** (1)	**1.75%**	**7.7**	**83.3%**

**If the OMHSAS standard benchmark of less than or equal to 10% for 30 day readmissions and/or 90% for 7-day follow-up was met, it is shaded.*

Highlights from Table 4:

- When considering the percent of readmissions that occurred within 30 days, the OMHSAS standard benchmark of less than or equal to 10% was not met for inpatient mental health services or inpatient detoxification.
- For 7-day follow-up, the OMHSAS standard was only met for inpatient extended acute services. The HEDIS[vii] 50th percentile benchmark of 46% was achieved for all services except the halfway house.

[vii] HEDIS performance measures are often used as quality benchmarks in managed care organizations across the United States.

Moving Forward

In general, with some exceptions, the HealthChoices population (enrollees and service users), service utilization and cost, diagnoses, readmissions, average length of stay, and follow-up rates for children and adults were similar in 2012 to 2011. Despite this, there are some areas in which additional monitoring and analysis is indicated.

Early Detection and Treatment of Mental Health and Substance Use Disorders

For both mental health and substance use disorders, early intervention is critical to long-term outcomes.[13] Researchers have found that mental illness begins very early in life (i.e. half of all lifetime cases begin by age 14) and when undetected it frequently continues into adulthood.[14-15] Mental disorders that occur before the age of six can interfere with critical emotional, cognitive, and physical development, and can predict a lifetime of problems in school, at home, and in the community.[14] Early interventions can interrupt the negative course of some mental illnesses and maybe even lessen long-term disability, yet it is known that there can be a delay of years between the first onset of symptoms and when people seek and/or receive treatment.[5,14] Therefore, early detection would prove invaluable.

Currently, AHCI supports early detection by sponsoring and providing community education/training in Youth Mental Health First Aid (YMHFA). YMHFA introduces participants to the unique risk factors and warning signs of mental health problems in adolescents, builds understanding of the importance of early intervention, and teaches individuals how to help a youth in crisis or experiencing a mental health or substance use challenge.[16]

Racial Differences in Service Use

As previously stated, blacks access mental health services at a much lower rate than whites.[8,10] This has been consistently seen within the HealthChoices population. Although there are many individuals with mental health disorders that do not use mental health services, studies show that the level of unmet need for mental health care is substantially higher for blacks than for whites.[8,10] The literature states that reasons for this trend are attributed to the fact that different cultures recognize, accept, diagnose, and treat mental health concerns in significantly different ways.[9] In particular, blacks tend to seek help from informal sources, such as family, friends, and religious communities.[8-9,17] When treatment is sought it is usually from a primary care physician as a result of somatization – the manifestation of physical illness related to mental health.[8-9] Mental illness is also frequently stigmatized and misunderstood within the black community.[8,17] Given this, these cultural differences may need to be considered when trying to provide behavioral health services and supports.

AHCI, managed care organizations, Allegheny County, and providers should work together to find ways to integrate physical and behavioral health data. This would aid in capturing individuals with underlying mental health concerns that are seen by primary care physicians. In turn, individuals can be referred to the appropriate behavioral or physical health services. Specific activitices include:

- One current provider, Mercy Behavioral Health (MBH), has established a primary care clinic that serves almost 100 people on the community treatment teams (CTTs). They are looking at ways to measure improvements in physical health and coordination of care with behavioral health services.
- AHCI, Community Care, and Allegheny County are working with OMHSAS and the Office of Medical Assistance Programs (OMAP) on a grant to look at quality measures for adult medicaid recipients. This entails combining behavioral and physicial health data to analyze outcomes.

- AHCI staff also serve on state level committees that are addressing ACA and the integration of behavioral and physical health data.

Integration of Physical Health and Behavioral Health

Mental health and substance use problems frequently co-occur along with medical illnesses.[15,18] In fact, three out of ten people with a medical disorder may also have a mental health condition, and seven out of ten people with a mental health condition may also have a medical condition.[13] Moreover, findings suggest that those with serious behavioral health conditions experience earlier death as a result of undertreated medical conditions.[15,18] As mentioned in the previous section, people with mental health disorders are routinely seen in primary care settings. In fact, underlying mental health and substance use disorders account for 70% of all primary care visits.[18] Since primary care physicians have reported feeling unequipped to fully address mental health concerns[13,15] mental disorders often go undiagnosed, untreated, or under-treated.[18] Additionally, referrals to specialty behavioral health services are often not completed or limited by issues of access and stigma.[13-14] As a result of this information and early death statistics, Health Care Reform (HCR)/Affordable Care Act (ACA) is placing emphasis on health systems to coordinate care and for integration of care across behavioral health and physical health systems.

AHCI is supporting these efforts through facilitating the hiring of a Chief Strategy Officer (CSO) by a local provider group. The CSO will help local providers implement and understand HCR/ACA. This will help with integration by encouraging collaboration/partnerships among providers to discover ways to work together to best serve HealthChoices members. AHCI is also working with Allegheny County and Community Care to train CTTs in wellness coaching. Often times HealthChoices members on CTTs have co-occuring physical conditions and wellness coaching will help with motivating them to not only set and strive to achieve their behavioral health recovery goals but to set and maintain physical wellness goals also. Wellness coaching can also be offered to other providers if interested. Additionally, AHCI staff serves on the HCR committee with RCPA (Rehabilitation and Community Providers Association).

Crisis Services

With the introduction of planned crisis follow-up visits for high risk individuals, AHCI will continue monitoring the impact this has on response time to non-planned crises throughout the next year.

Readmissions, Follow-up, and Average Length of Stay

Since treatment received can impact an individual's wellness and recovery, it is important to continue to examine readmissions and follow-up rates in comparison to the OMHSAS and HEDIS gold standard benchmarks to consider what barriers or challenges should be addressed and what actions and/or interventions can be implemented to meet the standards. Though no benchmark exists for average length of stay it remains an important measure in how long it takes to help stabilize individuals for re-entry into the community.

In regards to quality benchmarks, Community Care's contract with Allegheny County includes performance standards that aim to improve the Allegheny County system of care and provider capacity in order to improve consumer's outcomes. In turn, Community Care has measures in place for providers which include standards related to psychiatric readmissions and follow-up within 7 and 30 days after discharge from an inpatient psychiatric hospital or a non-residential hospital rehabilitation service. Providers that do not meet these benchmarks are required to complete quality improvement plans, which are reviewed and monitored by Community Care.

Citations

1 Cohen, J. (1988). Chapter 6: Differences between Proportions. In J. Cohen, *Statistical Power Analysis for the Behavioral Sciences* (pp. 179-185). Hillsdale, New Jersey: Lawrence Erlbaum Associates.

2 Rosner, B. (2011). Chapter 10. Hypothesis Testing: Categorical Data. In *Fundamentals of Biostatistics* (Seventh ed., pp. 352-426). Boston, MA: Brooks/Cole.

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 Ireys, H. T., Barrett, A. L., Buck, J. A., Croghan, T. W., Au, M., & Teich, J. L. (2010, September). Medicaid Beneficiaries Using Mental Health or Substance Abuse Services in Fee-for-Service Plans in 13 States, 2003. *Psychiatric Services*, 61(9), 871-877. Retrieved from http://ajp.psychiatryonline.org/data/Journals/PSS/3915/10ps871.pdf

5 Kitchener, B. A., Jorm, A. F., & Kelly, C. M. (2009). *Mental Health First Aid USA*. Maryland Department of Health and Mental Hygiene, Missouri Department of Mental Health, and National Council for Community Behavioral Healthcare.

6 Wang, P., Angermeyer, M., & et al. (2007, October). Delay and Failure in Initial Treatment Seeking After First Onset of Mental Disorders in the World Health Organization's World Mental Health Survey Initiative. *World Psychiatry*, 6(3), 177-185. Retrieved from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2174579/pdf/wpa060177.pdf

7 Wang, P., Berglund, P., & et al. (2005, June). Failure and Delay in Initial Treatment Contact After First Onset of Mental Disorders in the National Co-Morbidity Survey Replication. *General Psychiatry*, 62(6), 603-613. Retrieved from http://archpsyc.jamanetwork.com/article.aspx?articleid=208684

8 National Alliance on Mental Illness (NAMI) Multicultural Action Center. (2009). *African American Community Mental Health Fact Sheet*. Retrieved from http://www.nami.org/Template.cfm?Section=Resources&Template=/ContentManagement/ContentDisplay.cfm&ContentID=21024

9 Sanchez, K., Chapa, T., Ybarra, R., & Martinez, O. (2012). *Eliminating Disparities through the Integration of Behavioral Health and Primary Care Services for Racial and Ethnic Minorities, Including Populations with Limited English Proficiency: A Review of the Literature.* U.S. Department of Health and Human Services, Office of Minority Health and the Hogg Foundation for Mental Health.

10 Broman, C. L. (2012). Race Differences in the Receipt of Mental Health Services Among Young Adults. *Psychological Services*, 9(1), 38-48.

11 Commonwealth of Pennsylvania Department of Public Welfare (DPW) Office of Mental Health and Substance Abuse Service (OMHSAS). (April 10, 2013). *2012 External Quality Review Report: Community Care Behavioral Health.* Lake Success: n.a.

12 Dahill, P. (March 15th, 2013). *2013 Accreditation Benchmarks and Thresholds*. National Committee for Quality Assurance (NCQA).

13 King, J. K. (2011). *Bringing Together Physical and Behavioral Health Care: An Exploration of Current Practice and Future Directions in Pennsylvania.* Pennsylvania Health Funders.

14 National Alliance on Mental Illness (NAMI). (n.d.). President's New Freedom, Achieving the Promise:Transforming Mental Health Care in America. *(Understanding the Goal) Goal 4: Early Mental Health Screening, Assessment, and Referral to Services Are Common Practice.* Retrieved from http://www.nami.org/Template.cfm?Section=New_Freedom_Commission&Template=/ContentManagement/ContentDisplay.cfm&ContentID=28321

15 Collins, C., Hewson, D. L., Munger, R., & Wade, T. (2010). *Evolving Models of Behavioral Health Integration in Primary Care.* New York: Milbank Memorial Fund

16 National Council for Community Behavioral Healthcare. Mental Health First Aid USA. *Youth Mental Health First Aid.* [Online] [Cited: July 12, 2013.] http://www.mentalhealthfirstaid.org/cs/youth-mental-health-first-aid.

17 Givens, J. L., Katz, I. R., & Holmes, W. C. (2007). Stigma and the Acceptability of Depression Treatments among African Americans and Whites. *Journal of General Internal Medicine*, 22(9), 1292-1297.

18 Health Management Associates. (2007). *Integrating Publicly Funded Physical and Behavioral Health Services:A Description of Selected Initiatives FINAL REPORT*

Appendix 1: Description of Services

Community-Based 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

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-deliveredmental 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

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 (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 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.

444 Liberty Avenue, Suite 240, Pittsburgh, PA 15222
P: 412.325.1100 • F: 412.325.1111 • WEB:www.ahci.org

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