The Allegheny County HealthChoices Program 1999 – 2009

Improving Access and Quality of Services
Through Collaboration, Fiscal Management, and Quality Oversight

Allegheny HealthChoices, Inc.

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Many states have implemented Medicaid managed care programs to improve access to services, quality, continuity of care, and the coordination and distribution of finite Medicaid resources to better control the rate of spending. In order to meet these goals, Pennsylvania's Department of Public Welfare (DPW) established the HealthChoices program, which carved out behavioral health services from physical health services. DPW also gave the counties the first right of opportunity to manage behavioral health services directly or contract with managed care organizations.

In 1999, Allegheny County established a public-private partnership to manage the local behavioral health HealthChoices program. Responsibilities are divided among the County Office of Behavioral Health, Community Care Behavioral Health, a non-profit managed care organization, and Allegheny HealthChoices, Inc. (AHCI), an independent non-profit oversight and monitoring agency.

The Allegheny County HealthChoices program has evolved and grown in the last 10 years in response to local needs and priorities—including the closure of the regional state mental hospital—making considerable progress in meeting the goals of the HealthChoices program. Financial and quality oversight activities have expanded from a focus on Community Care meeting minimum requirements for managed care operations to a focus on improving access, quality, and allocation of resources while monitoring efforts to prevent and detect fraud, waste and abuse of Medicaid funds. Key accomplishments include:

- **INCREASING ACCESS.** The penetration rate—the proportion of people in the enrolled population who access services—has increased from 19% in 1999 to 26% in 2009. The number of children and adults using mental health and/or drug and alcohol services has approximately doubled between 2000 and 2009. During this same time period, the number of people enrolled in the HealthChoices program in Allegheny County increased by 31%. Providing services to a larger proportion of a growing Medicaid population is an important accomplishment, indicating that more people who need services are getting them.

- **IMPROVING PLANNING AND OVERSIGHT.** Allegheny County, Community Care, and AHCI have developed coordinated management practices and use data extensively to guide decision-making, oversight, and quality improvement in order to integrate HealthChoices with County-funded treatment services and supports. Having an infrastructure in place that collects, stores, analyzes, and reports on the processes and trends throughout the service system allows for flexibility and adaptation, acts as a stabilizing influence, and affords decision-makers greater confidence in their decisions.

- **CONTAINING ADMINISTRATIVE COSTS.** Administrative costs—the management costs of Community Care's operations, and AHCI and Allegheny County's oversight costs—have remained stable, and currently account for less than 9% of capitation payments.

- **SHIFTING RESOURCES TO FUND COMMUNITY-BASED SERVICES.** Funds are increasingly allocated to community-based rather than psychiatric inpatient services, particularly in the adult system, where the proportion of claims paid for community psychiatric hospitalizations has decreased from 57% in 2000 to 34% in 2009. Providing more comprehensive, high-quality community-based services like Community Treatment Teams has led to this shift in resources. Furthermore, the system is not relying on state mental hospital services to provide inpatient care.

- **REINVESTING IN THE LOCAL SYSTEM.** To date, HealthChoices has allocated a significant amount of funds to projects and programs developed to support innovative approaches to promoting a recovery-oriented behavioral health system. The reinvestment of funds remaining after medical claims and other obligations are paid has had a particularly large effect in the adult system as it has begun to transition to a more community-based, recovery-focused system with the closure of Mayview State Hospital in December 2008.

- **BUILDING CAPACITY FOR EVIDENCE-BASED SERVICES.** New services focusing on evidence-based practices have been added in both the child and adult systems, and access to crisis services has been greatly expanded with the development of the re:solve Crisis Network.

These key achievements have been possible through the local public-private partnership and the collaborative management and oversight practices that have evolved over the last 10 years. As the program looks to the next 10 years, the priorities will continue to broaden the ability of the Allegheny County behavioral health HealthChoices program to improve the overall quality of life for people coping with mental illness and substance use problems. These priorities will include:

- **BUILDING ON THE COUNTY'S SINGLE POINT OF ACCOUNTABILITY INITIATIVE** to improve service coordination services, ultimately improving access to care, coordination of care, and system accountability.
- **EXPANDING COLLABORATION** with other systems, including Juvenile Justice, Children, Youth and Families, and the criminal justice system for adults.
- **INTEGRATING** behavioral health and physical health care.
- **CONTINUING TO FOCUS** on housing and employment for adults with mental illness and/or substance use disorders.
- **OPERATIONALIZING RECOVERY** throughout the service system.

With health care reform implementation on the horizon, including a likely expansion of Medicaid enrollment, the Allegheny County HealthChoices program has already demonstrated the capacity to provide services to an increasing proportion of a growing Medicaid population. This locally operated and monitored carve-out has the planning and management processes and information technology infrastructure in place to respond to changing state and federal requirements as the health care landscape changes in 2011 and beyond.

The HealthChoices Program: Introduction

Mental Illness and Substance Abuse in the United States

- An estimated 26.2% of Americans over 18 years—approximately 57.7 million people—experience a mental illness each year (National Institute for Mental Health, n.d.).
- 7.9% of Americans over 18 years experienced alcohol dependence or abuse and 2.6% experienced illicit drug dependence or abuse in the past year (Hughes, Sathe, & Spagnola, 2008).
- Veterans are at high risk for mental illness and substance use disorders. Thirty-seven percent (37%) of returning veterans from Iraq and Afghanistan seeking healthcare at a Veteran's Administration Center were found to have at least one behavioral health diagnosis, primarily post-traumatic stress disorder, depression, and substance abuse (Seal et al., 2009).
- Nearly half of adolescents have experienced at least one mental disorder leading to impairment in their daily lives, including 11% with mood disorders like depression, 10% with behavior disorders like attention deficit hyperactivity disorder (ADHD), and 8% reporting anxiety disorders (Merikangas et al., 2010).
- The prevalence of autism is estimated to be one in 110 (Centers for Disease Control and Prevention, 2009).

Mental illness and substance use disorders rank among the most prevalent and costly illnesses in the United States, and are a leading cause of disability (World Health Organization, 2008).

Serious mental illness results in at least $193 billion in lost income each year in the United States, and when mental illness goes untreated the result is often higher utilization of costly emergency services and jail placements (Kessler et al., 2008). As much as 15% of total state spending results from the failure to treat and prevent addiction (National Council for Community Behavioral Health Care, n.d.).

Medicaid, the publicly funded health and long-term care coverage program for people with low incomes, is the largest public funding source for mental health care, and plays a critical role in the public safety net today. Pennsylvania, like many other states, has implemented managed care within the Medicaid program to improve access to services, quality, continuity of care, and to control the rising costs of behavioral healthcare. The Pennsylvania Department of Public Welfare (DPW) "carved out" all Medicaid-funded mental health and substance abuse services into the HealthChoices behavioral health program. DPW gave counties the first right of opportunity to manage their behavioral health services or contract with a managed care organization (MCO) to manage services and financial risk.

The Allegheny County HealthChoices program began in 1999. Allegheny County took a novel approach to implementing the behavioral health carve-out locally by developing a public-private partnership where responsibilities are divided among the County Office of Behavioral Health, Community Care Behavioral Health, a non-profit MCO, and Allegheny HealthChoices, Inc. (AHCI), an independent non-profit oversight and monitoring agency.

The Allegheny County HealthChoices program has evolved and grown in the last 10 years in response to local needs and priorities—including the closure of Mayview State Hospital—while fulfilling state requirements for managed care. The first 10 years of the program have seen significant reinvestment in the service system and a shift towards community-based treatment, with a shared grounding in the principles of recovery. This evolution has affected the local behavioral health system as a whole, where the efficient leveraging of funds has led to a wider array of both Medicaid and non-Medicaid services becoming available, reaching more people.

Between 1999 and 2009:

- Over 100,000 people have used behavioral health services in the Allegheny County HealthChoices program, including 62,000 adults and 43,000 children and adolescents.
- 93,000 people have used mental health services, and 30,000 people have used drug and alcohol services.
- The average annual cost per service user is $4,500.
- Paid claims over 10 years total $1.54 billion.

Several management strategies within the locally controlled carve-out structure have contributed to the program's success:

- A unified systems approach to planning and delivering all publicly funded behavioral health treatment and supports, across both County and Medicaid funding streams;
- Data integration, allowing for analysis and monitoring of the behavioral health system (both Medicaid and non-Medicaid) as a whole and making decisions based on the results of data analysis; and
- A collaborative relationship among the County, Community Care and AHCI, encouraging use of data to inform decisions, open dialogue, and joint ownership in the system.

This report covers the first 10 years of the HealthChoices program in Allegheny County. This report is organized into three sections:

- *Description of the Unified Local Behavioral Health System.*
  This section provides an overview of the operation and structure of the Allegheny County HealthChoices behavioral health program. The increase in access to services during the last 10 years is described, and the system's capacity for innovation is demonstrated through reinvestment activities and the closure of Mayview State Hospital.
- *Fiscal Management and Oversight.*
  This section provides an overview of fiscal management and oversight activities. The effective management of Medicaid resources through this locally controlled carve-out is demonstrated through the shift in resources toward community-based services and controlled administrative costs.
- *System Quality and Program Integrity.*
  This section provides an overview of the quality monitoring of the Allegheny County HealthChoices program. These activities have supported increased access to quality services and continuity of care, as evidenced by current service utilization patterns, the emphasis on recovery, and incorporation of evidence-based practices.

The report concludes with a discussion of the priorities in the HealthChoices program moving into the next 10 years, in the context of SAMHSA strategic initiatives and the recovery movement. It is important to note that this report does not include an exhaustive catalog of behavioral health initiatives and programs in Allegheny County over the last 10 years, but focuses on the key characteristics of the local system and how they have influenced Medicaid-funded behavioral healthcare in Allegheny County.

Primer on Medicaid and Managed Care for Behavioral Health Services

What is Medicaid?

Medicaid is the publicly funded health and long-term care coverage program for people with low incomes, including parents and children, individuals with a range of physical and mental disabilities and conditions, and senior citizens. Medicaid has expanded greatly since it began in 1965, and now provides healthcare benefits to more people in the United States than any other private or public insurance program. Medicaid is the largest public funding source for mental health care, and plays a pivotal role in the public safety net today (Kaiser Family Foundation, 2010).

States and the federal government share the financing of Medicaid. The federal government sets match rates for Medicaid based on state per capita income compared to the national average, and is at least 50% (Kaiser Family Foundation, 2010). The federal government does not cap funding and matches state spending. States have significant flexibility in how they structure their Medicaid programs, as long as they follow minimum federal guidelines determined by the Centers for Medicare and Medicaid Services (CMS). As a result, state Medicaid programs vary in terms of eligibility, benefits, provider payments, and how services are delivered. States can also apply for waivers to operate differently from the federal guidelines. This flexibility allows Medicaid to respond to changing national, state and local economic and demographic conditions (Kaiser Family Foundation, 2010).

How do states manage behavioral health services in the Medicaid program?

To allow states flexibility to better control health care costs, the federal government instituted a waiver program permitting states to begin managed care programs. In addition to cost control, states initiated managed care with the goals of improving access to services by reinvesting cost savings into the program and establishing more accountability, efficiency, and predictability for costs through capitation arrangements (Coleman et al., 2005). The waiver process allows states flexibility in how they structure managed care arrangements. Under a waiver program, states can request relief from certain regulations if they can ensure that as many or more individuals will be served in the new program, individuals will receive the same or more services, and the cost increases will be less than without the waiver program.

Carve-out programs are common in Medicaid managed care behavioral health programs. When a managed care capitation rate* includes both behavioral health and physical health services, it is a "carve-in." Behavioral health carve-outs are contracted separately from physical health, with a separate capitation funding stream, assuring that resources will be used in the provision of behavioral health care (Coleman et al., 2005). Carve-out programs maintain their own networks of providers, administrative functions, and coverage rules. Carve-out programs do not typically include prescription drugs (Frank & Garfield, 2007).

Managed behavioral health carve-outs present several potential advantages for state Medicaid programs:

- By specializing in mental health and substance abuse treatment, managed care organizations bring more expertise in clinical care, information systems, and existing relationships with local providers to improve the quality of care, assure an adequate network of providers, and better allocate resources.
- Because managed behavioral healthcare organizations often serve a larger pool of enrollees than individual health plans, they have more bargaining power with providers in terms of payment rates and quality standards (Frank & Garfield, 2007).
- Carve-outs preserve behavioral health resources. Depending on the contract arrangements, carve-outs may better permit reinvestment into the behavioral health system.
- Carve-outs also can provide greater fiscal and clinical accountability to the behavioral health community.

A carve-out model does not prevent integration of services. Services—whether behavioral health care, physical health care, or other social services—all need to be integrated at the individual level across systems. Better integration of physical and behavioral health remains a challenge regardless of the managed care arrangement, and is an area for future development.

Managed care programs use a variety of strategies to reduce unnecessary healthcare costs, including cost sharing with enrollees, programs for reviewing the medical necessity of some services (particularly inpatient admissions), financial incentives for providers to use less costly services, and care management for enrollees with high healthcare costs (National Library of Medicine, n.d.).

*In the context of the HealthChoices program, a capitation rate is a set amount paid per enrolled person per month to a managed care organization. Capitation rates for different groups will vary, based on the projected average costs of providing services for the group. MCOs are responsible for using capitation to cover administrative costs, medical costs, and other financial obligations; excess funds are required to be reinvested back into the system. Using a capitation model passes the financial risk for covering services from the County to the MCO.

Implementation of the HealthChoices Program in Allegheny County: a Unified Local Behavioral Health System

HEALTHCHOICES GUIDING PRINCIPLES AND PUBLIC-PRIVATE SYSTEM MODEL

Pennsylvania's Department of Public Welfare (DPW) developed the HealthChoices program, the state-wide mandatory managed care initiative for Medicaid recipients, in response to the rising costs of the state's Medicaid program. The HealthChoices program has four goals–to improve:

- Access to services;
- Quality of care;
- Continuity of the care provided in a multi-system environment; and
- Coordination and distribution of finite Medicaid resources to better control the rate of spending.

Two key policy decisions have guided how the behavioral health system has evolved under HealthChoices: DPW followed a "carve-out" strategy, and DPW gave the counties the first right of opportunity to manage behavioral health services directly or to contract with a managed care organization to manage services (as well as financial risk). The majority of Pennsylvania counties opted to contract individually with a managed care organization, with only a few delegating this responsibility to the state. Those that have opted to have the state hold the contract tend to be less populated counties for which the financial risk is greater.

HealthChoices began in Allegheny County in 1999. Because of the design of the Centers for Medicare and Medicaid Services (CMS) waiver program and the flexibility it afforded DPW, and thus the counties, Allegheny County was able to take a pioneering approach to the management of Medicaid-funded behavioral health care through developing local public-private partnerships that are accountable to the community.

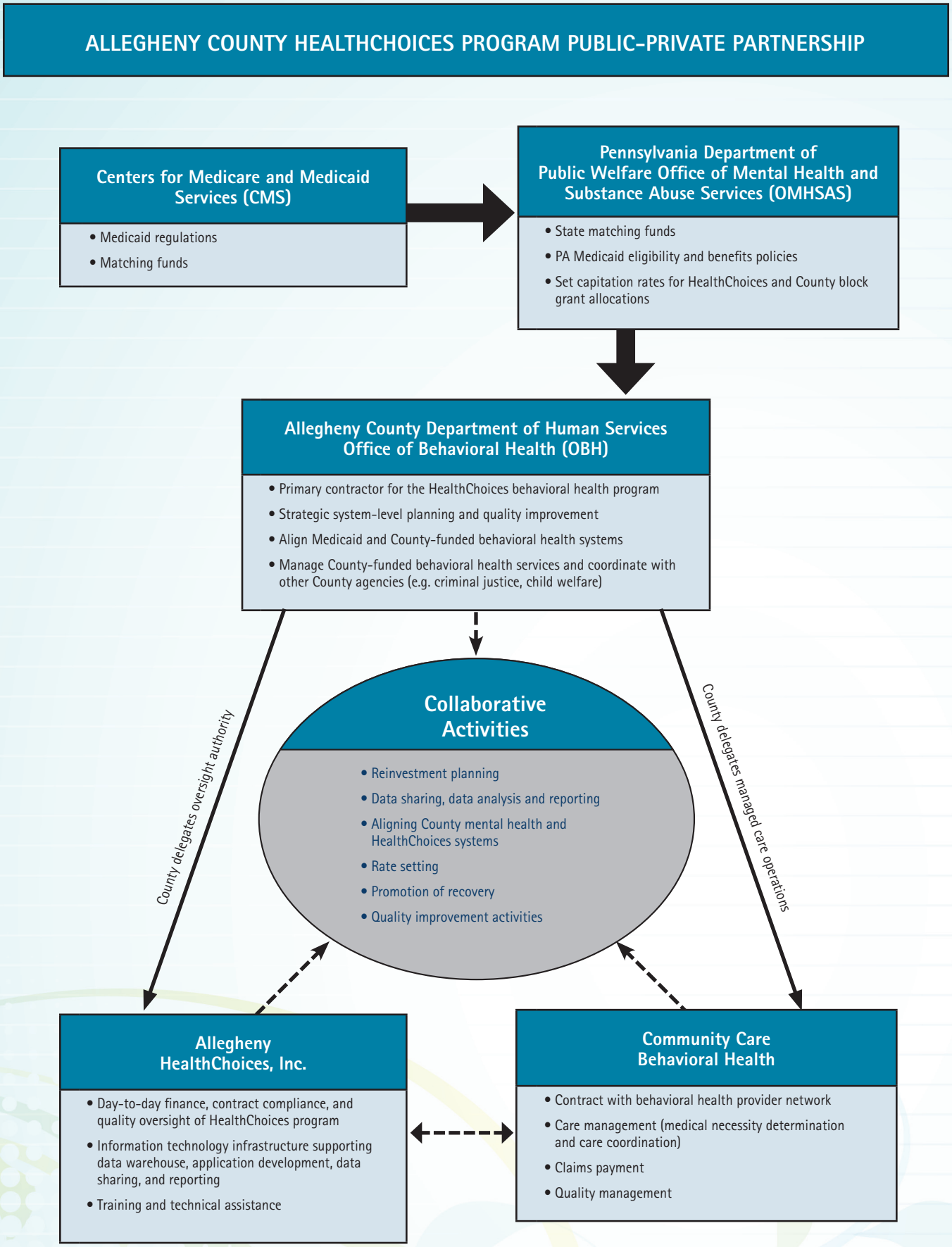
- Allegheny County selected the non-profit Community Care Behavioral Health Organization as its MCO.
- Allegheny County subcontracted with Allegheny HealthChoices, Inc., a 501(c)(3) non-profit corporation staffed with managed care and public behavioral health expertise, to complete the necessary oversight and monitoring functions of the HealthChoices program.

The County's overall approach embraces guiding principles that were established by stakeholders and focus managed care goals on the following:

- Improved health outcomes and quality of life for vulnerable citizens;
- A system of care that is truly responsive to the needs and preferences of consumers and their families;
- Responsible efficiencies in the way care is provided; and
- Reinvestment of any saved dollars in the local system of behavioral health care based on priorities established by community stakeholders.

Over time, the responsibilities and relationships among Allegheny County, Community Care Behavioral Health, and Allegheny HealthChoices, Inc. (AHCI) have evolved, mirroring the evolution of behavioral health carve-out systems across the country. AHCI initially focused on monitoring and oversight, and the system's focus was on compliance with the managed care contract. Now, the system is increasingly focused on collaboration, coordination of care, and quality improvement—building a local system capable of innovation to provide comprehensive, recovery-oriented mental health and substance abuse treatment, poised to meet the goals of healthcare reform, while still protecting the County from risks associated with holding the HealthChoices contract. Figure 1 shows a model of this system. A description of the flow of funds is included in the Appendix.

Figure 1

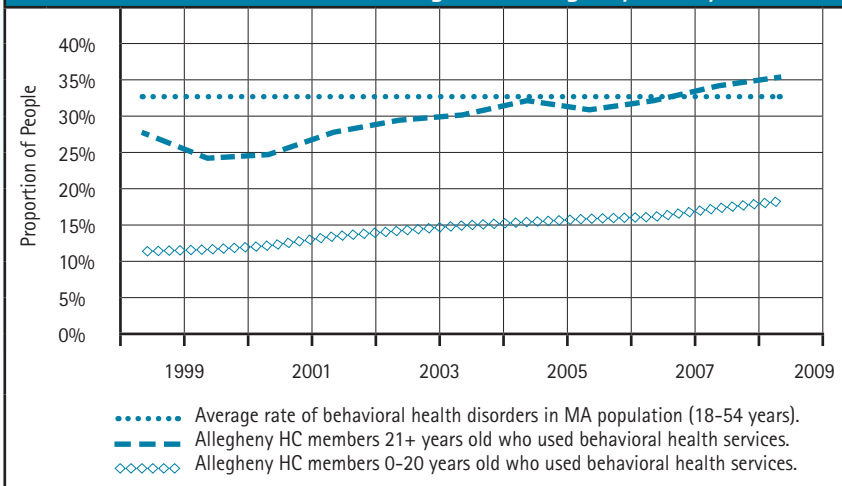

ALLEGHENY COUNTY HEALTHCHOICES PROGRAM PUBLIC-PRIVATE PARTNERSHIP
Centers for Medicare and Medicaid Services (CMS)
• Medicaid regulations
• Matching funds
Pennsylvania Department of Public Welfare Office of Mental Health and Substance Abuse Services (OMHSAS)
• State matching funds
• PA Medicaid eligibility and benefits policies
• Set capitation rates for HealthChoices and County block grant allocations
Allegheny County Department of Human Services Office of Behavioral Health (OBH)
• Primary contractor for the HealthChoices behavioral health program
• Strategic system-level planning and quality improvement
• Align Medicaid and County-funded behavioral health systems
• Manage County-funded behavioral health services and coordinate with other County agencies (e.g. criminal justice, child welfare)
County delegates oversight authority
Collaborative Activities
• Reinvestment planning
• Data sharing, data analysis and reporting
• Aligning County mental health and HealthChoices systems
• Rate setting
• Promotion of recovery
• Quality improvement activities
County delegates managed care operations
Allegheny HealthChoices, Inc.
• Day-to-day finance, contract compliance, and quality oversight of HealthChoices program
• Information technology infrastructure supporting data warehouse, application development, data sharing, and reporting
• Training and technical assistance
Community Care Behavioral Health
• Contract with behavioral health provider network
• Care management (medical necessity determination and care coordination)
• Claims payment
• Quality management

INCREASED ACCESS TO BEHAVIORAL HEALTH SERVICES IN A GROWING MEDICAID POPULATION UNDER HEALTHCHOICES

Between 2000* and 2009, the number of people enrolled in the HealthChoices program in Allegheny County increased by 31% (3% on average annually during this time period). Children and adolescents under 21 years old make up 54% of total enrollees in any given year, and enrollment for child and adult age groups has increased at the same rate as overall enrollment.

Figure 2

National estimate of Behavioral Health Disorders in the Medicaid population, and service penetration for adults and children in the HealthChoices Program in Allegheny County



In the context of increasing enrollment, the Allegheny County HealthChoices program has been able to provide services to an increasing proportion of both children and adults. The penetration rate—the proportion of people in the enrolled population who access services—has increased from 19% in 1999 to 26% in 2009. Published estimates among people enrolled in Medicaid indicate that as many as 34% of adults between the ages of 18 and 54 have a behavioral health disorder (there are no such studies for children under 18 enrolled in Medicaid) (Adelman, 2003). As shown in Figure 2, the adult penetration rate was 35% in 2009, and the penetration rate among 0-20 year olds was 19%. Based on this benchmark, a high proportion of those expected to need behavioral health services have access in the HealthChoices program. The gender and race characteristics of HealthChoices service users have remained consistent over the 10 years of the program (see Figure 3).

The HealthChoices program in Allegheny County has provided behavioral health services to more than 100,000 adults and children since 1999, totaling $1.54 billion in paid claims. The majority of paid claims are for mental health services, with claims for drug and alcohol services totaling 15% over the 10 years (see Figure 4). The total cost of the HealthChoices capitation in Allegheny County has increased at the rate of 10 percent annually from 2000 to 2008.

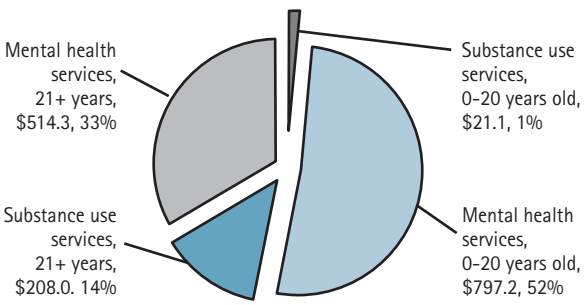
Figure 3

Gender and Race Characteristics of HealthChoices Service Users, 2009

		% service users
Children and Adolescents	Female	38%
	Male	62%
	White	56%
	African-American	39%
	Other race	5%
Adults	Female	58%
	Male	42%
	White	65%
	African-American	32%
	Other race	2%

Figure 4

Paid Claims in Millions for Services From 1999 to 2009, by Age and Service Type



* 2000 is used for most comparisons throughout the report, as mandatory managed care enrollment began in July 1999.

Growth in costs are driven by several factors: increased access to services, increased capacity within the network to provide services, increased payment rates to providers, and increased intensity or length of stay of services. Generally, provider capacity within the HealthChoices network has increased rather than decreased under managed care (e.g., providers have not stopped accepting Medicaid, or shut down, and in many instances, have added beds and staff). With few exceptions, the system meets geographical access standards set by DPW.

While both systems have expanded capacity, the adult system and child/adolescent system have evolved differently over the 10 years of the HealthChoices program because of differences in the pre-existing service systems and in the distinct needs of the two populations when HealthChoices began.

Figure 5 shows the growth in overall service utilization for children and adolescents. While both the number of mental health service users and total claims have approximately doubled in 10 years, the average cost per user has only increased slightly in comparison. This suggests the system has continued to allocate resources for community-based services in similar proportions (see page 18 for further discussion).

While a much smaller proportion of adolescents seek drug and alcohol treatment, the number has increased substantially (over 200%). Research indicates that many adolescents who need substance abuse treatment do not receive it, so this increase in penetration for substance abuse treatment is a positive development.

Figure 6 shows the growth in service utilization for adults. The number of service users has increased substantially (84%). Paid claims have increased 182%, as more adults are using mental health services and more intensive, evidence-based community services to treat adults with serious mental illness (like Assertive Community Treatment) have become available. With the closure of Mayview State Hospital in December 2008, the system used reinvestment funds and state hospital funds to expand the community-based services available.

Drug and alcohol treatment services have also grown substantially for adults over the 10 years of HealthChoices. A combination of increased capacity, rate increases, and an emphasis among providers on assisting eligible individuals to enroll in HealthChoices when entering substance abuse treatment* has resulted in the increases observed in the adult system.

The growth in access to behavioral health services among both children and adults indicates the Allegheny County HealthChoices program has made substantial progress in meeting the HealthChoices goal of improved access. The local program's ability to reinvest in the system and focus on community-based services—a better allocation of finite Medicaid resources—as well as the local, collaborative efforts to plan, monitor, and improve the quality of services have guided this growth in service capacity and utilization. These themes are explored further below.

* Expedited enrollment for the behavioral health HealthChoices program began statewide in January 2005. With this policy change, DPW decreased the time from eligibility determination to enrollment so individuals began their coverage under managed care more quickly.

Figure 5

Growth in Mental Health and Substance Abuse Services for Children and Adolescents, 2000-2009

		2009	% change 2000-2009
Mental Health Services	Number of service users	15,222	97%
	Total paid claims (millions)	$102.0	111%
	Average cost per service user	$6,698	7%
Drug and Alcohol Services	Number of service users	1,275	225%
	Total paid claims (millions)	$4.3	633%
	Average cost per service user	$3,407	125%

Figure 6

Growth in Mental Health and Substance Abuse Services for Adults, 2000-2009

		2009	% change 2000-2009
Mental Health Services	Number of service users	22, 376	84%
	Total paid claims (millions)	$80.1	182%
	Average cost per service user	$3,580	53%
Drug and Alcohol Services	Number of service users	7,714	99%
	Total paid claims (millions)	$31.7	195%
	Average cost per service user	$4,109	48%

Key Characteristics of the Allegheny County HealthChoices Public-Private System Model

Throughout the implementation of the HealthChoices program in Allegheny County, local leadership has made it a priority to serve vulnerable populations with the greatest needs by integrating HealthChoices with County-funded treatment services and supports. Many individuals will use both HealthChoices and County-funded behavioral health services that are not Medicaid-funded (e.g., residential services, social rehabilitation services), and some individuals may move in and out of Medicaid eligibility yet remain in need of public safety net mental health and substance abuse services.

The goal at the local level is that consumers' experience with the publicly funded treatment system, whether they have Medicaid or County-funded services, is seamless. This commitment extends to providers, where the County and Community Care have worked to avoid a dual system. This commitment has been operationalized successfully at the local level through the unique management structure, commitment and capacity for innovation, and reliance on data and technology.

EFFICIENCIES IN MANAGEMENT STRUCTURE

- *Contracts and payment rates.*
  Allegheny County aligns contract requirements and payment rates with Community Care's contracted rates.
- *Uniform authorization and care management processes across funding streams.*
  The County delegates the authorization and care management processes for all County-funded substance abuse services, and certain mental health services, to Community Care. This assures a single point of contact for providers and a seamless experience for consumers.
- *Coordinated management of behavioral health systems working with HealthChoices.*
  The Allegheny County Office of Behavioral Health increasingly integrates planning and management of services and supports essential to the overall system but outside of Medicaid treatment services. For example, the County has recently centralized the referral system for adult residential programs. Other examples include: critical incident tracking, admissions and discharges from extended acute services, admissions and discharges from adult residential treatment facilities, and community treatment teams (CTTs).
- *Coordinated management and intervention to meet complex individual needs and manage critical incidents.*
  Several mechanisms have been developed locally to foster highly responsive and collaborative intervention in individual situations, as needed. For example:
  - For children and adolescents, the interagency meeting process involves County staff, care management staff from Community Care, behavioral health providers, representatives from other systems (e.g. education), and families to develop plans and assure accountability to meet complex needs.
  - The Residential Treatment Facilities Group (RTF Group) handles referrals and coordination activities related to children and adolescents needing residential treatment.
  - For adults who are high utilizers of inpatient services and have complex needs making disposition challenging, the Acute Community Support Plan (ACSP) process has been developed. Coordinated by an independent facilitator, the ACSP process involves a series of meetings with the consumer, inpatient and community providers, families and other natural supports, and advocates to develop individualized, comprehensive disposition plans.

Commitment and Capacity for Innovation in Behavioral Health Services and Supports

"Having my own apartment makes me feel a part of the community. It's a footloose and fancy-free feeling… I didn't feel like I was left alone."

–A person living in PSH

Since 2006, the Allegheny County Permanent Supportive Housing (PSH) program has offered new housing opportunities to people with serious mental illness. PSH is safe, affordable, and permanent, as long as people follow the terms of their leases. The PSH program helps people in two primary ways: by providing rental subsidies and through the supportive services of the Housing Support Team. Between February 2007 and July 2010, the PSH program has helped 205 people find housing in the communities of their choice. The PSH program is one example of the Allegheny County HealthChoices program using reinvestment funds to support people in the community by meeting critical needs beyond treatment.

REINVESTING IN THE LOCAL SYSTEM

During the 10 years of HealthChoices in Allegheny County, Community Care, in collaboration with the County and AHCI, has used reinvestment funds to expand access and capacity, one of the key goals of the HealthChoices program. Reinvestment funds are funds remaining after medical claims and other obligations are paid, and are therefore available for developing or expanding services and supports based on local needs. To date, HealthChoices has allocated substantial funds to projects and programs developed to support innovative approaches to promoting a recovery-oriented behavioral health system.

Reinvestment in the local system has supported innovative, evidence-based approaches to behavioral health services.

Reinvestment is the primary way that HealthChoices is able to support pilot projects to implement evidence-based or promising practices, as well as innovative approaches to outreach and support programs based on local needs.

- Projects are identified by system stakeholders through a planning and proposal process during which the goals, methods, budgets, and measureable criteria to assess the success of the program are developed.
- Projects that prove effective in meeting goals have the potential to become more widely available services funded through the normal claims process as supplemental services.
- New services may be supported through reinvestment as they expand in capacity and/or become established in different provider agencies.
- Reinvestment has also provided resources for capital projects including building purchases and renovations.

Figure 7

Key Reinvestment Projects, 1999–2009

Program	Allocated reinvestment funds (millions)
Community treatment teams (CTT or ACT)*	10.7
Community-based extended acute care	2.5
Forensic supports	1.5
Joint planning teams/Hi-fidelity wraparound*	1.5
Permanent supportive housing	12.9
Psychiatric rehabilitation	3.8
re:solve crisis network*	1.7
Residential treatment facility for adults	0.9
Warmline	2.3

*Joint planning teams are a service for adolescents, and the re:solve crisis network serves both the child and adult systems. One CTT is for transition-age youth. Other reinvestment projects included are for adults.

Examples of services that began initially as pilot programs under reinvestment that have since been established as local in-plan services include community treatment teams (CTTs, that follow the ACT model), a comprehensive crisis support network, a residential treatment facility for adults, and extended acute care.

Reinvestment has had a particularly large effect on the adult system as it has supported the transition to a more community-based, recovery-focused system. Figure 7 summarizes key reinvestment projects during the first 10 years of HealthChoices.

CLOSURE OF MAYVIEW STATE HOSPITAL

The Mayview State Hospital closure in December 2008 is a clear example of how the integrated local system—County and Medicaid managed care across five counties—has the capacity to work together to fundamentally change how behavioral health treatment and supports are delivered. The closure successfully shifted resources from an inpatient state institution to community-based care, demonstrating the local system's commitment to meeting the requirements for providing treatment in the community as set forth in the 1999 Olmstead decision. This expanded the capacity to meet the complex needs of a highly vulnerable group of individuals—those who had been institutionalized at Mayview and future consumers who will need intensive supports to avoid institutionalization.

The HealthChoices program played a key role in the closure of Mayview State Hospital at the end of 2008. Leadership across organizations was involved in planning for the closure and developing new services and supports; local leadership also successfully lobbied for the transfer of a significant amount of state hospital operating funds to the local community-based system. Also, with significant coordination, cooperation, and stakeholder involvement, County funds were blended with reinvestment funds to develop community treatment teams (CTTs), small community-based residential programs, and extended acute care programs, as well as peer mentor and warmline services to meet the needs of a local system operating without a state hospital.

87% of people report that life is better since being discharged from Mayview State Hospital. When asked what makes life better, many people talk about the new freedom that comes from living in the community.

By December 2008, 269 people were discharged with community support plans, and only a very small proportion (7%) was transferred to Torrance State Hospital. People moved to a variety of housing arrangements, all with the support of CTTs or service coordination. No Allegheny County residents have been admitted to a state hospital through the civil commitment process since November 2007.

"I would say to anyone who has felt like giving up to try the [re:solve] crisis center before you think you have run completely out of options."

–A person using Crisis Services

The re:solve Crisis Network is designed to incorporate best practices while addressing local needs through a comprehensive range of crisis intervention services. A planning committee with members from Community Care, OBH, AHCI, providers, and consumers oversaw the development of crisis services. According to the Technical Assistance Collaborative (2005), effective crisis systems provide timely access to varied services, including phone, mobile, walk-in, and residential services, and coordinated, efficient care. These best practices were incorporated into the development of the re:solve Crisis Network. With start-up supported by reinvestment, re:solve provided an array of services to more than 1,500 children and adolescents and 2,800 adults in 2009.

Successful Integration of Data and Technology

From the inception of HealthChoices, data collection, integration, and management have been critical for monitoring the HealthChoices program, supporting integration and collaboration across funding streams and providers, and system planning. Data is shared across entities effectively within HIPAA regulations, and is used extensively in quality improvement activities.

AHCI has developed a data warehouse using an open, extensible framework that is highly responsive to meeting changing data collection needs, changing reporting needs, and taking advantage of new opportunities for integrating data sources from other systems. Key projects demonstrating successful integration of technology include:

- Online application development for data collection;
- Web-based tools to facilitate cross-provider communication;
- Continued expansion of data warehouse; and
- Flexible, responsive reporting and data sharing.

This investment in technology, systems, and data management has served to alleviate administrative burdens and has helped foster a more productive environment. These investments have also helped re-focus resources towards better coordination, communication, and treatment within the system of care.

ONLINE APPLICATION DEVELOPMENT FOR DATA COLLECTION

As the local system has identified new data collection needs, web-based applications have been developed to provide important data for program monitoring, evaluation, and planning. These applications include:

- CTT outcomes, including housing, employment, crisis interventions, supports, and hospitalizations;
- Waiting lists, length of stay, and discharge arrangements for people using extended acute care (EAC) and residential treatment facility for adults (RTF-A) services;
- Critical incidents and early warning signs, initially developed as part of the monitoring of the Mayview closure and since expanded to include incidents related to all publicly funded mental health services;
- Monthly status updates on people discharged from Mayview State Hospital with a community support plan;
- Daily psychiatric hospital utilization;
- Residential program utilization; and
- Acute community support plan tracking.

WEB-BASED TOOLS TO FACILITATE CROSS-PROVIDER COMMUNICATION

AHCI has also developed secure website portals to facilitate online communication among AHCI, County, and Community Care staff, providers, advocates, and peer mentors who are involved in the community support planning process (both as part of the Mayview closure and as this process is applied in the community). These tools allow meeting times, summaries, assigned tasks, and community support plans to be shared.

FLEXIBLE, RESPONSIVE REPORTING AND DATA SHARING

Because the data warehouse is developed and maintained locally and merges key data sources, relevant reporting and data sharing can be accomplished quickly and flexibly—primarily to support monitoring, quality assurance, and planning efforts at the system level but also to facilitate collaboration and problem-solving at the individual consumer level. For example:

- Quarterly and annual HealthChoices utilization reports are developed on an ongoing basis. Customized reports to assist in monitoring and system planning are continually under development. These reports are often integrated into fiscal and quality oversight.
- Quarterly and annual summaries of CTT outcomes are distributed to providers and funders.
- Weekly reports on residential program capacity and EAC and RTF-A waiting lists are generated automatically.
- Email notifications of critical incidents are sent immediately to authorized system staff. If details are needed, those staff are able to log-in to a secure database and view the complete incident documentation. From this location, they may also view relevant service history.
- Weekly and monthly reports summarize consumer-level activity for quality improvement activities for CTTs, including efforts to increase community tenure and supported employment.

Community Care and Allegheny County also have invested in technology to increase system efficiencies. The HealthChoices claims payment system has undergone upgrades to permit web entry of claims for smaller providers to make the claims submission and payment processes less burdensome, and Community Care's care management software has undergone several enhancements over the years for quality improvement and to increase efficiencies.

CONTINUED EXPANSION OF DATA WAREHOUSE

AHCI's data warehouse integrates County-funded mental health and substance abuse treatment data, HealthChoices eligibility, service authorization, and claims data, and state mental hospital data. AHCI has also integrated some data from other systems, including pharmacy data from physical health MCOs, involvement in Children, Youth and Family (CYF) and Juvenile Probation services, and County jail data for some high-risk populations. Data from AHCI online applications are integrated as well.

Sound Fiscal Management

The fiscal management of the HealthChoices program illustrates how a locally controlled carve-out can successfully manage the allocation of finite Medicaid resources, one of the key goals of the HealthChoices program.

SUMMARY OF OVERSIGHT ACTIVITIES

Allegheny County has delegated day-to-day financial oversight of HealthChoices to AHCI. The County continues to be involved in overall monitoring and policy making. This day-to-day financial oversight involves a number of different activities, shown in Figure 8.

Figure 8

Summary of AHCI Fiscal Management Activities	
Review of Financial Reports	Monthly, quarterly and annual review of DPW-required financial reports. The reports are reviewed by AHCI and the county prior to submission and certified by the county.
	Quarterly review of Community Care financial reports with an independent actuary to confirm that estimated expenditures are fiscally sound.
Monitoring for Fraud, Waste and Abuse	Monthly Compliance Committee meetings, through which provider audits and resulting provider and Community Care actions are monitored to eliminate fraud, waste and abuse.
	AHCI also monitors Community Care's development of their compliance plan incorporating proactive measures to detect potential areas of fraud, waste and abuse.
Management of Reinvestment Funds	Management of the financial reporting and cash flow activities related to reinvestment.
Audit Coordination	Coordination of the HealthChoices program audit.
Capitation Rate Negotiation	Involvement in the development, negotiation and acceptance of the capitation rates received from DPW for the HealthChoices program.

Financial oversight activities have shifted from a focus on Community Care meeting minimum requirements for managed care operations to a focus on improving access, quality, and allocation of resources in the HealthChoices program while monitoring efforts to prevent and detect potential instances of fraud, waste and abuse of Medicaid funds. This evolving role is evidenced by:

- ***The increasingly sophisticated use of data to monitor and forecast enrollment, utilization, and capacity.***
  Over time, enrollment and claims monitoring increasingly informs programming decisions—in particular, where excess or insufficient capacity exists within the system. This data feeds into discussions among Community Care, Allegheny County, and AHCI on service expansion and development. Increasingly, data sources other than claims are used (for example, EAC waitlist reporting) to identify not only capacity needs but problems or inefficiencies in care management and billing functions.

- *The Use of Performance Incentives in Contracting to Influence Allocation of Resources.*
  During the first several years of HealthChoices in Allegheny County, performance incentives built into the contract between Allegheny County and Community Care focused on contractual compliance and meeting minimum standards for claims payment. Over time, contract performance standards have shifted to incentivize allocating resources to community-based rather than inpatient services (for example, maintaining current levels of inpatient psychiatric bed use) and increasing quality of services (for example, through decreasing psychiatric inpatient readmission rates).
- *The Increased Emphasis on Provider Accountability.*
  This involves an increase in provider audits, additional reviews of claims submission to detect potential instances of fraud, waste, and abuse, and increased provider training for proper financial claims documentation and submission.

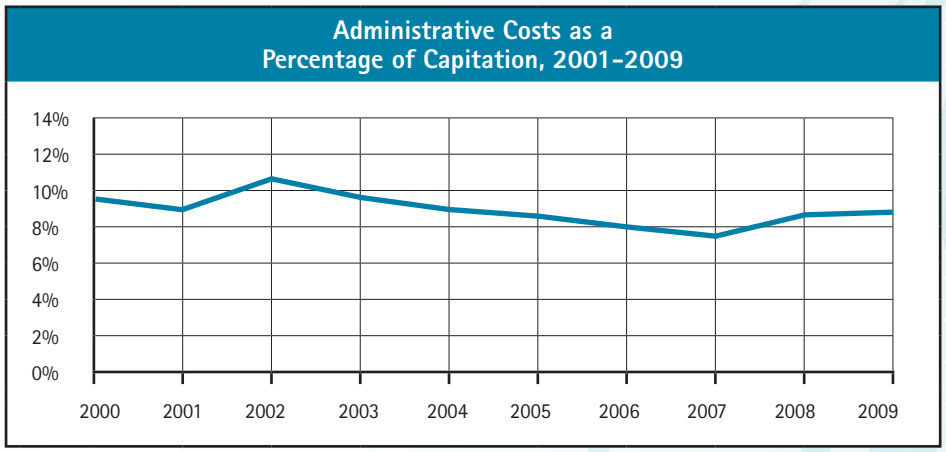
INDICATORS OF SUCCESSFUL FISCAL MANAGEMENT

The above processes indicate that the fiscal management of the HealthChoices program in Allegheny County is strong. The program increasingly funds community-based programming and increased access and the program has maintained low administrative costs.

ADMINISTRATIVE COSTS

Administrative costs are broadly defined as the management costs of Community Care's HealthChoices operations and the costs of overseeing (through AHCI and Allegheny County) the HealthChoices program. Administrative costs are calculated as the portion of capitation payments not used to pay medical claims, other financial obligations, or fund reinvestment activities. In its early years, administrative costs for the Allegheny County HealthChoices program reached 12 percent of capitation annually; in the last four years, administrative spending has amounted to less than nine percent of capitation. Figure 9 shows the proportion of capitation used for administrative costs between 2000 and 2009. Viewed as inflation adjusted dollars per enrollee, administrative costs in 2009 were identical to those in 2001.

Figure 9



INCREASING ALLOCATION OF FUNDS TO COMMUNITY-BASED RATHER THAN INPATIENT SERVICES

Because inpatient services cost more per person, decreasing overall inpatient utilization allows financial resources to shift to community services that are able to serve more people (thus improving access) and are better suited to promote long-term recovery (thus improving quality and outcomes).

Resource Allocation in the Children's Mental Health System

For children and adolescents, averting the need for psychiatric hospitalizations and for placement outside the home in residential treatment facilities (RTF) are both important goals. While these restrictive and intensive services are important within the continuum of care, providing services in a community setting not only conserves resources but helps foster recovery. Figure 10 compares the proportion of paid claims and service users of inpatient hospitalizations, RTF, and community-based services in 2000 and 2009.

Figure 10

Comparing Resources for RTF, Psychiatric Hospitalizations, and Community-Based Mental Health Services for Children and Adolescents

	Proportion of paid claims		Proportion of service users	
	2000	2009	2000	2009
Residential treatment facilities	10%	15%	2%	3%
Inpatient psychiatric hospitalizations	16%	9%	11%	6%
Community-based mental health services	74%	76%	98%	99%
Total	$48,243,407	$101,996,435	7,738	15,224

Between 2000 and 2009, the proportion of claims paid for inpatient services has decreased, from 16% of claims to 9% of claims, and the proportion of child and adolescent service users who have been hospitalized has decreased from 11% to 6%. The proportion of paid claims for community-based services has remained constant (74% in 2000, and 76% in 2009), and nearly all children and adolescents who use mental health services access community-based mental health services.

Between 2000 and 2009, the proportion of claims paid for RTF has increased from 10% to 15% while the proportion of child and adolescent service users in RTF remains small (2-3%). The implementation of DPW's Integrated Children's Services Initiative (ICSI) in 2005 led to these changes within RTF services, and also affected some community-based services (including family-based mental health and family-focused, solutions-based services, discussed below).

The goal of this DPW initiative was to ensure that all children have access to a comprehensive range of services available through all public systems, regardless of how the child enters the system. As a result of ICSI, residential treatment facilities were added to the network to assure children and adolescents with mental health needs in the Office of Children, Youth and Family (CYF) or Juvenile Probation systems could receive medically necessary behavioral health treatment. In the first two years of ICSI, RTF use increased significantly; since that time, CYF and Juvenile Probation have made fewer referrals to RTF as part of a concerted effort to reduce the need for out of home placements by working with families to access appropriate community supports and treatment services in their home communities.

Resource Allocation in the Adult Mental Health System

Throughout the 10 years of HealthChoices, the system has worked toward the goal of reducing the use of psychiatric hospitalizations by providing more comprehensive, high-quality, evidence-based, community-based services like Community Treatment Teams. When this goal was combined with the closure of Mayview State Hospital, the adult service system experienced a substantial shift in the allocation of resources to community-based services.

As shown in Figure 11, the proportion of claims paid for psychiatric hospitalizations has decreased from 57% in 2000 to 34% in 2009, and a smaller proportion of adult service users were hospitalized in 2009 (14%, compared to 22% in 2000). This shift has occurred while the system has eliminated state mental hospital utilization. Approximately 60% of paid claims in 2009 were used for community-based services.

In planning for the December 2008 closure of Mayview State Hospital, the system determined there was a need for some capacity for extended acute care (EAC) services. EAC services provide longer periods of stabilization in a recovery-oriented environment for people who would have previously used state hospitalization services. In late 2006, Western Psychiatric Institute and Clinic (WPIC) began operating the Transitional Recovery Unit (TRU) within the main WPIC hospital in Oakland. In July 2009, Mercy Behavioral Health began operating a community-based EAC program. While EAC services play a critical role in the system with the Mayview closure, they use a small proportion of resources (6% of paid claims in 2009).

In sum, the comprehensive fiscal management of the HealthChoices program indicates that the program has maintained low administrative costs and shifted resources toward a community-based system.

Figure 11

Comparing Resources for Psychiatric Hospitalizations, Inpatient Extended Acute Care, and Community-Based Mental Health Services for Adults

	Proportion of paid claims		Proportion of service users	
	2000	2009	2000	2009
Inpatient psychiatric hospitalizations	57%	34%	22%	14%
Inpatient extended acute care services*	0%	6%	0%	0%
Community-based services**	43%	60%	94%	99%
Total	$28,431,128	$80,591,006	12,169	22,379

* A community-based extended acute care program began July 2009. Because start-up was funded by reinvestment, service costs during 2009 are not reflected above.
** All mental health services except inpatient psychiatric hospitalizations and extended acute care services are included in the community-based services totals.

System Quality and Program Integrity: Moving Beyond Compliance

As the HealthChoices program has developed, monitoring and oversight has extended beyond basic contract compliance activities to focus on quality improvement and bringing recovery principles and evidence-based practices to the system. The quality management processes illustrate how a locally controlled carve-out can improve access to and quality of services, as well as continuity of care—all important goals of the HealthChoices program.

Allegheny County has delegated day-to-day quality and compliance monitoring of HealthChoices to AHCI; these monitoring activities are summarized in Figure 12.

Figure 12

Summary of AHCI Quality Oversight and Monitoring Activities	
Management of provider network	Monitor Community Care's management of specific levels of care through membership on provider committees.
	Participate in Community Care/Provider/County committees developing performance standards for specific levels of care and monitor Community Care's chart review and corrective action plan process.
	Monitor timely access to behavioral health and rehabilitation services (BHRS) and availability of required services.
	Monitor implementation and outcomes of programs funded through reinvestment (e.g., CTTs, Permanent Supported Housing program) using data analysis and program evaluation.
Quality and care management	Monitor Community Care's annual quality work plan development, participate in quarterly Quality and Care Management Committee meetings, and review associated reports and interventions.
	Review and submit reports required by DPW.
	Monitor and track member incidents to assure Community Care is proactively pursuing any potential quality of care issues both internally and at the provider level.
	Monitor and track denial letters and monthly denial reports.
	Review and request of improvement plans related to care management documentation of the authorization, continued stay, and discharge review processes.
Utilization monitoring	Develop, review, and disseminate quarterly and annual enrollment and utilization reports to monitor trends.
	Develop, review, and disseminate reports on utilization of specific services (e.g., BHRS Brief Treatment) or for specific populations (e.g., older adults with substance abuse problems).
	Share results with Community Care, solicit interpretation of findings, and collaborate with OBH and Community Care on monitoring changes at the provider level and providing training as needed.
Responsiveness to stakeholders	Review the Consumer Action and Response Team's (CART) activities and consumer satisfaction survey results for HealthChoices, including results for special populations.
	Review provider responses to CART survey results to ensure that providers are using this information to inform care delivery.
	Ensure that Community Care responds to all complaints and grievances filed by members within an established timeframe.

UTILIZATION TRENDS AS EVIDENCE OF A HIGH-QUALITY HEALTHCHOICES PROGRAM

The quality management activities, combined with fiscal oversight, reinvestment activities, and commitment to evidence-based practices, all support a high-quality HealthChoices program that has expanded capacity greatly over its 10 years. The children's system and adults' system have evolved differently to meet different needs.

CHILDREN AND ADOLESCENTS

Figure 13 summarizes the most commonly used mental health and substance abuse treatment services for children and adolescents (service category definitions are included in the Appendix). The number of children using mental health services and paid claims approximately doubled between 2000 and 2009. Attention deficit and hyperactivity disorder (ADHD) and adjustment disorders are the most common mental health diagnoses, followed by autism spectrum disorders, depressive disorders, oppositional defiant disorder, and conduct disorder.

Community-based mental health services:

- ***Behavioral health rehabilitation services (BHRS)*** are community-based treatment services provided in the person's own environment. More than twice as many children accessed BHRS services in 2009 than in 2000. Increasing access is the result of an increase in the number of children with autism spectrum disorders needing BHRS, and an increase in the number of children with ADHD and other behavioral disorders needing BHRS.

  In 2004, Community Care began authorizing Brief BHRS to facilitate rapid access to community-based clinical services. Brief BHRS is delivered by one clinician, for up to 72 weeks, and is often used for children new to services. Brief BHRS has contributed to the overall increase in the number of children using BHRS, and a decrease in the average cost of BHRS per service user.

- ***Family focused, solution based services (FFSBS) and family-based mental health services*** are two other community-based services that focus on therapy and skill building with children and their families and also assist with case management. The number of children using family-based services has more than doubled since 2000, and FFSBS was a new service introduced in 2005 to meet the needs of children involved in Children, Youth and Family Services (CYF) or Juvenile Probation as part of ICSI (see sidebar on next page).

- ***Crisis services.*** The re:solve Crisis Network began offering telephone and mobile crisis services in July 2008, and walk-in and residential crisis services in January 2009. With startup of the network supported by reinvestment, the redesigned crisis system has greater capacity to provide community-based crisis services.

- ***Service coordination*** continues to be an important service for many children and adolescents, with the number of people accessing services increasing 68% between 2000 and 2009.

Figure 13

Mental Health and Substance Abuse Treatment Services for Children and Adolescents, 2009

		Number of service users 2009	Paid claims 2009
Community-based services	BHRS	4,772	$43.1
	Crisis	1,520	$1.0
	Family-focused, Solution-based Services	227	$1.3
	Family based mental health	864	$8.4
	Service coordination	2,114	$5.1
Clinic/facility based services	Med Check	5,455	$1.3
	Outpatient mental health	10,210	$6.2
	Partial hospitalization	1,140	$8.0
Restrictive services	Inpatient psychiatric hospitalizations	851	$9.5
	RTF	394	$14.8
Drug and alcohol treatment services	Community-based services*	1,142	$1.2
	Residential or inpatient services*	298	$3.1
All Services		15,766	$106.3

Note: Gray, bolded cells indicate a growth rate of more than 100% from 2000 to 2009.
* Community-based drug and alcohol services include partial programs, outpatient and intensive outpatient programs, and methadone maintenance. Residential and inpatient drug and alcohol services include both rehabilitation and detoxification services as well as halfway house.

Clinic/Facility-Based Services:

- ***Medication checks and outpatient mental health services*** (e.g. psychiatric evaluations, therapy) continue to serve the largest number of children and adolescents.
- ***Partial hospitalization services*** grew at a slower rate when compared to community-based services.

Restrictive Services:

- ***Inpatient psychiatric hospitalizations.*** The number of children and adolescents using inpatient mental health services has decreased 3% between 2000 and 2009 despite increases in HealthChoices enrollment, suggesting that the community-based system may now better able to meet children's needs in the community. Length of stay has increased 7% to 12 days in 2009, while the readmission rate has decreased 20% over 10 years, with 13% of discharges in 2009 resulting in a readmission within 30 days.
- ***RTF.*** The number of children using RTF in 2009 has increased 200% when compared to 2000. As discussed on page 18, this increase was driven by a DPW policy change to add capacity to provide services to children and adolescents involved in CYF or the Juvenile Probation system.

Drug and Alcohol Services:

While a relatively small percentage of adolescents access drug and alcohol services, access has increased dramatically. Outpatient services are most commonly used, although an increasing number of adolescents access non-hospital rehabilitation services. As discussed above, this increased penetration of treatment services is a positive improvement.

Cannabis abuse or dependence is, by far, the most commonly received substance use diagnosis, followed by opiate dependence or abuse, dependence on multiple substances, and alcohol abuse or dependence.

"They gave me the tools to work with my children. My relationship with my daughter is much, much better… I would recommend this service to other families. It really helped me and my family!"

–A mother whose family received FFSBS

Family-focused, solution-based services (FFSBS) began in 2005 as part of the Integrated Children's Services Initiative (see page 18). Services are intended for children and families involved with the Children, Youth and Families or Juvenile Probation systems. Therapy, family support, crisis intervention, and case management services are provided in the community by a master's level therapist and a family support person. As a less intensive service than traditional family-based services, the addition of this service to the continuum of care filled an unmet need in the children's system.

ADULTS

Figure 14 summarizes the most commonly used mental health services for adults (service category definitions are included in the Appendix). The number of adults using mental health services increased 84% and paid claims increased 182% between 2000 and 2009. Major depression and other depressive disorders are the most commonly received diagnoses, followed by bipolar disorder, schizophrenia, and anxiety and adjustment disorders.

Community-Based Services:

- With the exception of service coordination (previously called case management), all other community-based services shown in Figure 14 (first category) started during the HealthChoices program.
- *CTT* is an evidence-based, team-delivered service for people with serious mental illness and often co-occurring substance abuse disorders. The local system has made a significant commitment to bringing this critical service to Allegheny County. See sidebar for more information.
- ***Enhanced clinical service coordination*** and ***mobile medication teams*** are also team-delivered in the community, providing less intensive and less comprehensive services than CTT. These services were developed locally for individuals who needed additional services beyond service coordination.
- ***Psychiatric rehabilitation*** helps individuals gain or regain important roles in their lives. While a relatively small service, it is important in the continuum of services offered.

Figure 14

Mental Health Services for Adults, 2009

		Number of service users 2009	Paid claims 2009 (millions)
Community-based services	Community treatment teams	559	$10.7
	Enhanced clinical service coordination	117	$1.1
	Mobile medication teams	172	$1.0
	Psychiatric rehabilitation	378	$0.8
	Service coordination	3,720	$11.1
Crisis and diversion services	Crisis services	2,878	$3.1
	Respite/Diversion and acute stabilization	454	$2.9
	RTF-Adult	90	$2.4
Clinic/facility-based services	Med Check	14,065	$3.1
	Outpatient mental health	16,175	$9.3
	Partial hospitalization	673	$1.2
Restrictive services	Inpatient extended acute	72	$4.5
	Inpatient psychiatric hospitalizations	3,096	$27.2
Other mental health services		2,631	$1.6
All Mental Health Services		22,376	$80.1

Note: Gray, bolded cells indicate a growth rate of more than 100% from 2000 to 2009.

"CTT saved my life."

–A person using CTT services

This sentiment is shared by many individuals who receive CTT services. When consumers are asked to explain how CTT helped them, consumers talk about the teams' assistance in finding housing and helping them meet their daily needs. Consumers talk about their trust in staff, and how accessible the team is.

CTTs in Allegheny County play a critical role in the service system—they work with individuals with very complex needs and have been instrumental in providing intensive services to people being discharged from Mayview State Hospital as part of the closure, as well as to people who in the past would have been institutionalized. As an evidence-based practice (Assertive Community Treatment) with widely demonstrated success in helping people with serious mental illness live in the community and move towards recovery, the multi-disciplinary staff provides comprehensive, community-based services. CTT capacity has more than doubled since 2001, with the nine teams in 2009 able to work with 850-900 individuals.

Crisis and Diversion Services:

- *Crisis services.* In a system dedicated to decreasing reliance on hospitalizations, comprehensive crisis services are essential. As discussed above, the Allegheny County service system has developed a comprehensive crisis system, the re:solve Crisis Network, providing telephone, mobile, walk-in, and overnight services. Use has grown substantially since re:solve began operations in 2008.
- *Respite and Diversion/Acute Stabilization programs.* These services have also grown during the HealthChoices program, providing an alternative to hospitalization.
- *RTF-Adults.* This service began in 2004 as a hospital diversion or step-down program. Providing intensive services for an average of 45-60 days, capacity and use of these services has grown over the last five years.

Clinic and Facility-Based Services:

- ***Medication checks and outpatient mental health services*** (e.g. psychiatric evaluations, therapy) continue to serve the largest number of adults. Payment rate increases contributed to the comparably larger increases in paid claims when compared to increases in service users.
- ***Partial hospitalization services*** grew at a slower rate when compared to community-based services.

Restrictive Services:

- ***Inpatient psychiatric hospitalizations*** grew at a slower rate than most other services during the last 10 years. Length of stay has increased from 9 days to 12 days (33% increase) from 2000 to 2009. While the 30-day readmission rate has decreased 8% from 2000 to 2009, the 18% rate remains high.
- ***Extended acute services*** were also added to the service continuum during this time period. As discussed above, they provide a necessary longer-term hospitalization option for the very small percentage of people who are not yet able to successfully transition to the community.

Figure 15

Drug and Alcohol Treatment Services for Adults, 2009

		Number of service users 2009	Paid claims 2009 (millions)
Community-based services	Intensive outpatient	1,480	$1.9
	Methadone maintenance	2,214	$6.9
	Outpatient	4,992	$3.3
	Partial hospitalization	1,121	$1.9
Inpatient and residential services	Halfway house	586	$3.1
	Inpatient detoxification	300	$0.9
	Inpatient rehabilitation	30	$0.1
	Non-hospital detoxification	1,104	$1.0
	Non-hospital rehabilitation	2,424	$12.6
Total		7,714	$31.7

Note: Gray, bolded cells indicate a growth rate of more than 100% from 2000 to 2009.

Drug and Alcohol Services:

Figure 15 summarizes adult use of drug and alcohol services. Nearly all services grew substantially during the 10 years of HealthChoices. Opiate abuse and dependence are the most common diagnoses for adults seeking substance abuse treatment, followed by dependence on multiple substances, alcohol abuse or dependence, and cocaine abuse or dependence.

Thirty-day readmission rates for rehabilitation and detoxification services have remained at about 11%. Community Care is working with several providers to identify opportunities to improve engagement in community-based services after detoxification and rehabilitation, thus reducing recidivism.

Additional Indicators of A High-Quality HealthChoices Program

Evidence of the high quality of the Allegheny County HealthChoices program extends beyond these utilization trends. Additional key themes illustrating the quality and innovation of the HealthChoices program include:

PROVIDER AND CONSUMER SATISFACTION

Annual satisfaction surveys conducted by a professional survey organization on behalf of Community Care assess how members, parents of children receiving services, and providers feel about many aspects of the HealthChoices program. In 2009, over 1,400 member and parent surveys and 185 provider surveys were received and analyzed, with 71% and 100% of respondents, respectively, expressing overall satisfaction with Community Care. Each year the Community Care selects several items from each survey to target for improvement through increased outreach, training, or other quality improvement activities.

ESTABLISHING RECOVERY AS THE SYSTEM GOAL

Shifting the system to embrace recovery as the goal is a shared priority of Allegheny County, Community Care and AHCI, and a variety of events and initiatives have built momentum for recovery.

- Training and technical assistance has increasingly focused on moving recovery into the mainstream and building recovery-promoting practices among providers. AHCI has conducted two system-wide Recovery Conferences, involving not only the provider community but families and consumers in learning about recovery and recovery-oriented practices.
- Community Care has established a Recovery Institute with the consultation of one of the leading national voices in the recovery movement—Pat Deegan, PhD. This Institute reaches across all counties in which Community Care works. Through training, mentoring, consultation and infrastructure support, the Institute is working to change community practices to better facilitate recovery.
- Now on a routine basis, reviews of provider charts and care management documentation include recovery indicators. Employing peer specialist staff in a variety of programs, including extended acute care services, is becoming a common practice as more peers have become certified.

IMPLEMENTING EVIDENCE-BASED PRACTICES

Allegheny County has been a leader in Pennsylvania in implementing the Assertive Community Treatment (ACT) evidence-based practice within its CTTs. One of the original pilot sites for the new fidelity assessment process, the local system through AHCI's coordination and technical assistance provides extensive support to CTTs to assure they have the training and resources needed to provide high-quality services. Through CTTs, evidence-based practices of supported employment and integrated dual disorders treatment are also being implemented.

Evidence-based practices have informed the development of the Permanent Supportive Housing program and the re:solve Crisis Network, as discussed above. Training efforts have also focused on bringing evidence-based clinical practices like motivational interviewing into daily practice in a variety of services.

Several local initiatives have supported the implementation of evidence-based practices within services working with children and adolescents, including improving system capacity to provide trauma-informed services, multi-systemic therapy, high fidelity wraparound, and functional behavioral assessments. Many of these initiatives build on DPW priorities and initiatives. For example:

- Building on DPW efforts to build trauma-informed services for children and adolescents, local behavioral health leadership has funded intensive clinician training for the treatment of trauma. Community Care has also continued to consult with national experts on building a trauma-informed service system, impacting both the Allegheny County HealthChoices program and the other HealthChoices programs Community Care manages.
- Multi-systemic therapy (MST) services are provided in home and community settings, with the goal of improving youth functioning through increasing positive social behavior for adolescents at risk of out-of-home placements or who are returning to their homes after placement.
- In the high fidelity wraparound model (also called joint planning teams), families with children who have complex needs and team members engage in a collaborative, culturally competent process to develop an integrated, community-based plan to address individualized needs.
- The local network maintains sufficient capacity (nearly 500 trained Behavioral Specialist Consultants) to conduct functional behavioral assessments to determine the best treatment approach for children with behavioral health needs compounded by developmental disabilities.

Perhaps most importantly, as OBH, Community Care, and AHCI have identified areas of improvement for the HealthChoices program, the local, collaborative relationships supported by knowledge of the local system and needs result in responsive and flexible quality improvement activities. For example, the three entities partnered on program reviews of the two extended acute care programs and the RTF-A during 2010, and collaborate closely on improvement projects related to CTTs.

The Next Ten Years of HealthChoices: "While Systems, Services, and Programs Are the Means, People's Lives Matter Most"

Allegheny County HealthChoices program has been successful in meeting the initial goals of increasing access, improving quality and continuity of services, and appropriately allocating Medicaid resources.

- Access to services has expanded, both for mental health and drug and alcohol treatment, in both the child and adult systems;
- Reinvestment has contributed to starting or expanding many community-based services, particularly for the adult system;
- The program has shifted resources toward community-based services; and
- The program increasingly focuses on bringing recovery principles and evidence-based and promising practices into service delivery.

These achievements have been possible through the local public-private partnerships among Allegheny County, Community Care, and AHCI, and the collaborative management and oversight practices that have evolved in the last 10 years.

As the program looks to the next 10 years, the priorities will continue to broaden the ability of the Allegheny County HealthChoices program to improve the overall quality of life for people coping with mental illness and substance use problems. As stated by the Substance Abuse and Mental Health Services Administration (2010), this encompasses:

- ***Health.*** A physically and emotionally healthy lifestyle;
- ***Home.*** A stable, safe and supportive place to live;
- ***Purpose.*** Meaningful daily activities, including work, school, volunteering, family caretaking, and the independence, income, and resources to participate in society; and
- ***Community.*** Relationships and social network that provide support, friendship, love, and hope.

Health care reform is slated to increase Medicaid enrollment significantly; successful implementation of health care reform requires using technology to improve the effectiveness, efficiency, and quality of health care delivery. The Allegheny County HealthChoices program has much of this infrastructure in place to support the County and Pennsylvania in meeting these challenges and achieving the goal of health, home, purpose, and community for all those who experience mental illness and substance abuse problems. The existing infrastructure allows for flexibility and adaptation, and provides decision-makers greater confidence in their decisions. Looking ahead to the next 10 years of HealthChoices, the system will build upon the successes of the last 10 years to address the following goals:

SAMHSA Strategic Initiatives

- Prevention of substance abuse and mental illness
- Reduce the pervasive, harmful and costly health impact of violence and trauma
- Support America's service men and women
- Implement health care reform to broaden health coverage and reduce disparities between the availability of behavioral health and physical health care services
- Provide housing and reduce barriers to accessing effective programs for the people with mental illness and substance use disorders who are homeless
- Expand the use of health information technology
- Develop integrated data strategies to inform policy and measure impact to improve services and outcomes
- Increase public awareness and support for the prevention and treatment of mental health and substance use disorders

- *Building on the County's Single Point of Accountability (SPA) initiative.* Through a combination of training, mentoring, workforce retention, payment, and quality initiatives, OBH and its partners are working to establish service coordinators as the single point of accountability for adults with serious mental illness and children and adolescents with serious emotional disturbances. This will improve access to care, coordination of care, advocacy, emphasis on recovery, and system accountability. This large-scale transformation project is underway, and the system will continue to build on this critical initiative in the next years.
- *Expanding Collaboration with Other Systems.* Over the first 10 years of HealthChoices, collaboration with other systems has begun. From establishing mental health services for youth involved with CYF and Juvenile Probation (e.g., FFSBS services through ICSI), to developing justice-related services for adults with mental illness and/or substance abuse problems, the local behavioral system already recognizes the importance of collaborations beyond behavioral health. In the next 10 years, it will be critical to continue formalizing these collaborations and engaging in joint planning and quality improvement.
- *Integration of Behavioral Health and Physical Health.* Community Care had begun a care management initiative to better coordinate care with physical health plans, and several collaboration projects examining prescribing patterns have also been underway. For adults discharged from Mayview State Hospital as part of the closure, an enormous amount of attention was paid to coordinating medical care. It will be critical to support provider to provider collaborative relationships to assure access and coordination to both physical and mental health care.
- *Continuing Focus on Housing and Employment.* While housing opportunities have expanded some through the Permanent Supportive Housing program and other residential programs, and a centralized referral system has been instituted, finding safe, affordable housing remains a challenge. Better equipping CTTs to assist people in finding housing in the community is underway, and addressing the housing needs for people with mental illness and substance use problems will continue to be a priority. Initiatives to bring the evidence-based practice of Supported Employment to Allegheny County have also been underway, within CTTs and at a number of other programs, and will continue to receive substantial support and attention.
- *Operationalizing Recovery into All Aspects of the Service System.* The combined efforts of OBH, Community Care, and AHCI—with strong contributions from the local NAMI and Mental Health America (MHA) organizations—have made significant progress in changing the conversation around mental health and substance abuse. NAMI and MHA, as well as peer organizations like the Peer Support and Advocacy Network (PSAN), are important partners in building a recovery-oriented system.

  Symptom management and stability are no longer the goals of services, nor the expectation of consumers and families; recovery and a meaningful life are now the expectation. The expansion of peer mentors within the Mayview closure, the growth of the warmline, and the work of peers as advocates and counselors throughout the system have been critical, and these efforts must continue and expand.

The Allegheny County behavioral health HealthChoices program looks forward to meeting these challenges and achieving the hope in health, home, purpose and community for all those who experience mental illness and substance use problems.

References

Adelmann, P.K. (2003). Mental and substance use disorders among Medicaid recipients: Prevalence estimates from two national surveys. *Administration and Policy in Mental Health (31)*2: 111-129.

Centers for Disease Control and Prevention (CDC). (2009). Prevalence of Autism Spectrum Disorders Autism and Developmental Disabilities Monitoring Network, United States, 2006. *MMWR Surveillance Summaries 2009 58*(SS-10).

Coleman, M. et al. (2005). Overview of publicly funded managed behavioral health care. *Administration and Policy in Mental Health 34*(4): 321-340.

Frank, R. & Garfield, R. (2007). Managed behavioral health care carve-outs: Past performance and future prospects. *Annual Review of Public Health 28*: 303-320.

Hughes, A., Sathe, N., & Spagnola, K. (2008). *State Estimates of Substance Use from the 2005-2006 National Surveys on Drug Use and Health* (DHHS Publication No. SMA 08-4311, NSDUH Series H-33). Rockville, MD: Substance Abuse and Mental Health Services Administration, Office of Applied Studies.

Kaiser Family Foundation. (2010). *Medicaid: A Primer. Key Information on our Nations' Health Coverage Program for Low-Income People*. Accessed December 10, 2010 at http://www.kff.org/medicaid/upload/7334-04.pdf.

Kessler, R. et al.(2008). Individual and societal effects of mental disorders on earnings in the United States: Results from the National Comorbidity Survey Replication. *American Journal of Psychiatry 165*: 703-711.

Merikangas, K.R., et al. (2010). Lifetime prevalence of mental disorders in U.S. adolescents: Results from the National Comorbidity Study-Adolescent Supplement (NCS-A). *Journal of the American Academy of Child and Adolescent Psychiatry 49*(10):980-989.

National Council for Community Behavioral Health Care (n.d.). *State Spending on Untreated Mental Illnesses and Substance Use Disorders*. Accessed November 15, 2010 at http://www.thenationalcouncil.org/galleries/policy-file/ImpactofMHandSUDuninsured.pdf.

National Institute for Mental Health (n.d.). *Statistics on Mental Health*. Accessed November 15, 2010 at http://www.nimh.nih.gov/health/topics/statistics/index.shtml.

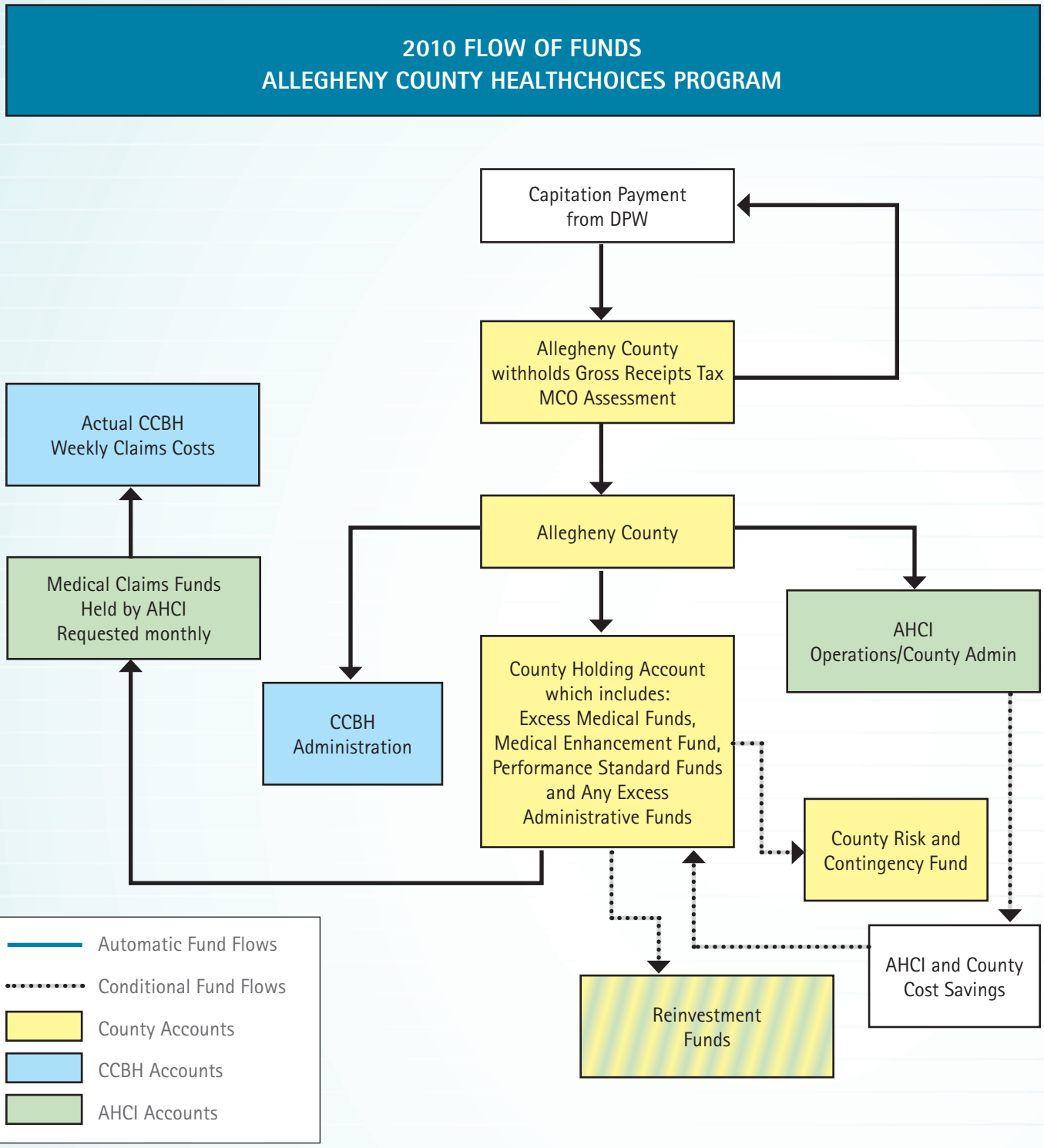
Seal et al. (2009). Trends and risk factors for mental health diagnoses among Iraq and Afghanistan veterans. *American Journal of Public Health 99*: 1651-1658.

Substance Abuse and Mental Health Services Administration. (2010). *SAMHSA's Eight Strategic Initiatives*. Accessed December 1, 2010 at http://www.samhsa.gov/about/strategy.aspx.

Technical Assistance Collaborative. (2005). *A Community-Based Comprehensive Psychiatric Crisis Response Service*. Accessed November 1, 2010 at www.tacinc.org.

World Health Organization. *The global burden of disease: 2004 update, Table A2: Burden of disease in DALYs by cause, sex and income group in WHO regions, estimates for 2004*. Geneva, Switzerland: WHO, 2008. Accessed November 1, 2010 at http://www.who.int/healthinfo/global_burden_disease/GBD_report_2004update_AnnexA.pdf.

Appendix 1:
Flow of Funds



Appendix 2: Glossary of Services

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

CART (Consumer Action Response Team)
CART is Allegheny County's consumer and family satisfaction team (CFST). People who work for CFSTs are either consumers or family members. They do interviews with consumers and families in order to report on people's satisfaction with services and quality of life as well as their needs and preferences.

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.

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).

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

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.

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.

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.

High-Fidelity Wraparound
(also called Joint Planning Teams)
In the high fidelity wraparound model, families with children who have complex needs and team members engage in a collaborative, culturally competent process to develop an integrated, community-based plan to address individualized needs.

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 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.

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 10 hours per week.

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.

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.

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.

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.

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.

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.

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.

Permanent Supportive Housing (PSH)
PSH provides affordable housing linked to supportive services that are available, but not required. PSH is safe and secure, affordable to consumers, and permanent, as long as the consumer pays the rent and follows the rules of their lease. This program also includes a Housing Support Team that assists people in maintaining their tenancy and with integrating into their home community.

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.

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.

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.

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.

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.

Warmline
The Warmline is a consumer-operated telephone service available for mental health consumers, or any other interested parties that are 18 and older, to call for support. The service provides supportive listening, problem solving, resource sharing, referral, and peer support.

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