An Overview of the Philadelphia HealthChoices Program
Agenda

Welcome & Introductions

Philadelphia HealthChoices Program

Community Behavioral Health
- Provider Network Overview, including Entry and Procurements
- Quality Management and Compliance
- Priority Initiatives
  - Children’s Services
  - Response to the Opioid Epidemic

Questions / Closing Remarks
Vision
We envision a Philadelphia where every individual can achieve health, well-being, and self-determination.

Mission
The mission of the Department of Behavioral Health and Intellectual disAbility Services is to educate, strengthen, and serve individuals and communities so that all Philadelphians can thrive.
Philadelphia Landscape

Population: 1,547,607 (5th Largest City in the USA)

In CY 2017- **714,247** individuals were eligible for Medicaid

In any given month, 606,853 individuals are eligible and enrolled in the HealthChoices MA program.

118,458 individuals received services in CY 2017.

The City of Philadelphia assumes full risk for the HealthChoices behavioral health Medicaid managed care program, maintaining reserves and risk protections; DBHIDS manages the Philadelphia HealthChoices program.

Philadelphia created CBH in 1997 to provide administrative services for the HealthChoices Behavioral Health Program.

CBH retains no excess revenue, thereby allowing all savings to be available for reinvestment.
Philadelphia DBHIDS

$1.5B single-payer system operated by the City of Philadelphia

Within DBHIDS there are six divisions, that oversee services for children, adults, and families:

Intellectual disAbility Services (IDS) division served 14,500 in FY 2017

Division of Behavioral Health managed services for 36,444 uninsured individuals in FY 2017

Community Behavioral Health (CBH) managed mental health and substance use services for Medicaid and had 714,000 members in CY 2017 and served 118,216 members in CY 2017.
Philadelphia DBHIDS

$1.5 B FY 19 budget; less than 1% city revenue (0.09%)  
$1 dollar of city matching dollars results in an additional $9 dollars of state and federal dollars

Multiple state and federal funding streams with required program, financial and reporting requirements

**IDS:** Early Intervention Medicaid Funding; State Base Funding

**BH:** Federal Block Grant Funding (mental health & substance use)  
**Substance Use:** State Base funding; BHSI (uninsured); Act 152; Special Initiative State Grants (gambling, opioid)  
**Mental Health:** State Base funding; CHIPP funding (for state hospital discharges)

**CBH:** Medicaid Funding (no city matching funds)
HealthChoices Program Goals

To **improve access** to health care services for Medical Assistance recipients

To **improve the quality** of health care available to Medical Assistance recipients

To **stabilize** Pennsylvania’s Medical Assistance **spending**
### Guiding Authority & Program Standards

<table>
<thead>
<tr>
<th>Authority</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>US Health and Human Services (CMS) 1915 (b) Federal Waiver</strong></td>
<td></td>
</tr>
<tr>
<td><strong>PA DHS (MA Authority)</strong></td>
<td></td>
</tr>
<tr>
<td>Program Standards and Requirements (PS&amp;R) and Appendices</td>
<td></td>
</tr>
<tr>
<td>- Must follow general MA regulations/licensing regulations</td>
<td></td>
</tr>
<tr>
<td><strong>PA DHS contract with Philadelphia (annual)</strong></td>
<td></td>
</tr>
<tr>
<td>OMHSAS monitors contract</td>
<td>PEPs (annual reporting requirements- program and quality)</td>
</tr>
<tr>
<td><strong>Philadelphia County</strong></td>
<td></td>
</tr>
<tr>
<td>Philadelphia Contract with Community Behavioral Health (annual)</td>
<td></td>
</tr>
</tbody>
</table>
HealthChoices Program Requirements Demand State and Federal Oversight through Routine Monitoring, Reporting and Auditing

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quarterly monitoring meetings with Office of Mental Health &amp; Substance Abuse Services (OMHSAS)</td>
<td></td>
</tr>
<tr>
<td>HealthChoices (HC) policies are reviewed and approved through OMHSAS</td>
<td></td>
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<tr>
<td>Routine submission of complaints, grievances, and an array of quality metrics (PEPS)</td>
<td></td>
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<tr>
<td>Monthly encounter data submission</td>
<td></td>
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<tr>
<td>Triennial program review</td>
<td></td>
</tr>
<tr>
<td>Monthly financial reporting, Annual Audit</td>
<td></td>
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<tr>
<td>Reinvestment submission reviewed and approved by OMHSAS</td>
<td></td>
</tr>
</tbody>
</table>
Financial Overview
HealthChoices
Behavioral Health Program Funding Stream

- Federal (45%)
- State (54%)
## HealthChoices Program: Financial Overview

<table>
<thead>
<tr>
<th>Description</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capitation: Per Member Per Month (PMPM), at risk for overages, able to keep up to 3% (savings) for reinvestment (shared risk arrangement in 2016 for MA expansion population).</td>
<td></td>
</tr>
<tr>
<td>Capitation payments are required to be actuarially sound, based on an “efficient” and “well operated” managed care organization.</td>
<td></td>
</tr>
<tr>
<td>Providers are predominantly paid on Fee-for-Service (FFS) basis.</td>
<td></td>
</tr>
<tr>
<td>Alternative Payment Arrangements (APA) must be approved by the state and shown to be cost effective.</td>
<td></td>
</tr>
<tr>
<td>CBH is quickly moving provider payments to value-based.</td>
<td></td>
</tr>
</tbody>
</table>
HealthChoices Program: Financial Overview

Rates are established on an annual basis

Capitated Rate (PMPM) \times \text{Enrollment} \Rightarrow \text{Revenue}
The total economic impact of spending by DBHIDS on the Philadelphia economy is nearly $4 billion. Although there are additional positive impacts on the broader regional economy, 100% of this $4 billion impact occurs within the county.

Of this $4 billion, $1.12 billion is from direct spending (DBHIDS and its contractors), $1.28 billion is from indirect spending (e.g. spending by the vendors and businesses patronized by DBHIDS and its contractors) and $1.5 billion is from induced spending (additional spending by the employees of DBHIDS and its contractors).
2017: Our Members at a Glance

Over 714,000 eligible members

Over 118,000 used services

Eligible members: 46% Male 54% Female

Used services: 52% Male 48% Female

[Diagram showing statistics on eligible members and services used]
Medicaid Data: FY 2017
Total Population Based on U.S. Census Decennial Data, 2010

What share (%) of all people eligible for Medicaid are in my district? (685,596)

- District 1 (8%)
- District 2 (9%)
- District 3 (11%)
- District 4 (8%)
- District 5 (10%)
- District 6 (9%)
- District 7 (18%)
- District 8 (11%)
- District 9 (11%)
- District 10 (6%)

What share (%) of people who use behavioral health services are in my district? (111,528)

- District 1 (9%)
- District 2 (8%)
- District 3 (10%)
- District 4 (6%)
- District 5 (12%)
- District 6 (8%)
- District 7 (23%)
- District 8 (11%)
- District 9 (8%)
- District 10 (5%)
Providers by District

Categories
Most to Least
- Multi
- MH Outpatient
- Residential
- D&A Outpatient
- Rehabilitation
- Case Management
- Inpatient

Created by: IT Department, Community Behavioral Health
Projection: Lambert Conformal Conic
Datum: North American 1983
Data Source: City GIS_PLANNING.Council_Districts_2016, CBH, BHSI, OMH data warehouses
Any provider agency that provides more than one service category at the same site (address) is counted once.

For example, NPHS at 801 Girard Avenue provides inpatient, rehab, and outpatient but counts as one site and one agency. If two distinct provider agencies and/or individual psychiatrists are colocated at the same address they are counted as one site but separate agencies.
Community Behavioral Health
HealthChoices Behavioral Health Program was phased in 10+ years. County Government was offered right of first opportunity and could contract with the Commonwealth using several models:

- Develop own BHO (Behavioral Health Organization)
- Contract with ASO (Administrative Services Organization)
- Contract with MCO (Managed Care Organization) and download majority of risk

County government remains at risk for any of these options

Reinvestment becomes available - limited to usage to behavioral health

Program is statewide first phase has reached 21 years; Medicaid savings estimates range up to $10B over the life of the program to date.

Five Current Contractors/Subcontractors:

- Community Care Behavioral Health Organization
- Magellan Behavioral Health
- Beacon/Value Behavioral Health of Pennsylvania
- Perform Care
- Community Behavioral Health (Philadelphia)
CBH History

The Behavioral Health HealthChoices Program, started in 1997 through a 1915 (b) federal waiver, was created in response to the underutilization of behavioral health services during the initial design of the program, which carved-in behavioral health to the physical health insurers.

Pennsylvania opted to create a “county right of first opportunity” model. This meant that counties could opt to either create a risk-bearing entity to directly manage the program, or could contract with a licensed managed care organization (MCO) to manage on their behalf.

Philadelphia was the only county that opted to create its own entity, Community Behavioral Health (CBH), as a 501 (c)3 nonprofit organization in response to this with broad stakeholder support.

Philadelphia’s unique model was recognized with an Innovations in Government Award (1999).
## Pennsylvania Behavioral HealthChoices
### Managed Care Organization (MCO) Comparison

<table>
<thead>
<tr>
<th>MCO Name</th>
<th>CBH</th>
<th>CCBHO</th>
<th>MBH</th>
<th>PerformCare</th>
<th>VBH of PA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organizational Status</td>
<td>Non-Profit</td>
<td>Non-Profit</td>
<td>For-Profit</td>
<td>For-Profit</td>
<td>For-Profit</td>
</tr>
<tr>
<td>Corporate Affiliation</td>
<td>None</td>
<td>UPMC</td>
<td>Magellan</td>
<td>AmeriChoice</td>
<td>Beacon</td>
</tr>
<tr>
<td>County Administrative Oversight Structure</td>
<td>Division of DBHIDS</td>
<td>County Oversight Entity in some counties*</td>
<td>None</td>
<td>County Oversight Entity</td>
<td>County Oversight Entity</td>
</tr>
<tr>
<td>Board of Directors</td>
<td>County Officials &amp; Stakeholders</td>
<td>UPMC &amp; Community Members</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Percent Profit</td>
<td>None</td>
<td>1.5-2%, performance-based contract</td>
<td>1.5-2%</td>
<td>1.5-2%</td>
<td>1.5-2%</td>
</tr>
</tbody>
</table>

As a non-profit organization contracted by the City of Philadelphia’s Department of Behavioral Health and Intellectual disability Services (DBHIDS), CBH returns all administrative and medical savings to the City for reinvestment. Additionally, CBH has no spend on corporate overhead, additional county oversight, or marketing costs.

The remaining four MCOs retain their administrative savings and spend additional resources to varying degrees on corporate overhead, county administrative oversight costs, and county administration costs.

*County oversight entity incorporated and receiving Healthchoices administrative dollars*
### CBH Quick Facts

- Located at 801 Market Street on the 7th, 10th, and 11th floors
- 480 CBH employees made up of administrative and clinical staff, as well as individuals with lived experience. A site for supported employment and hires recent TANF recipients.
- Staff are co-located at Philadelphia Department of Human Services (DHS), the Philadelphia School District, Family Court, Prevention Point, Health Centers and a local mission. Additionally staff are deployed in collaboration with physical health partners, and a team created with DHS to provide support to youth adjudicated dependent with no current family support system.
- Contracts with approx. 175 in-network providers, with approx. 700 locations
- Administrative budget is less than 8%, and medical spending exceeds national benchmark
## CBH Key Functions

- **24/7 capability**

- Performs utilization review, complex care management, quality management, provider network management, and fiscal oversight and accountability for the individuals enrolled in the Medical Assistance program

- Administers a broad array of support, treatment, and intervention programs for children, adults, and families impacted by mental health and substance use issues

- Functions as single payer for Medicaid (MA is a combination of State and Federal)

- Engage providers, host technical assistance sessions and learning collaboratives, and quality reviews
CBH Key Functions

- Outreach to members through Members Services and clinical teams- Gurney Street, Prevention Point, community meetings
- Clinical Procurements to expand access to services
- Conduct compliance audits to assure financial accountability
- Manages the full range of mental health and substance use services for Medicaid recipients and had 714,000 eligible members in CY 2017 and served 118,216 members in CY 17
- Manages a network of approximately 175 providers with approx. 700 sites offering a full continuum of services
How Providers Enter the CBH Network

CBH utilizes a procurement process to bring new providers and programs into the network. For profit entities may only enter the network through a procurement process, which aligns with the City’s procurement policy.

Providers must be enrolled in the Medicaid program and licensed by the Pennsylvania Department of Human Services (PA DHS) or the Pennsylvania Department of Health (DOH).

The CBH/provider contractual relationship is governed by the Provider Agreement, which delineates the roles, responsibility, and authority of both parties.

Our work is governed by the HealthChoices Behavioral Health Program Standards and Requirements.
How CBH Shares Information with Providers

- Weekly email blasts, to include the posting of Bulletins and Notices
- DBHIDS Executive Director’s Meetings
- Provider Advisory Committee (PAC) Meetings
  - Feedback is received from this committee prior to CBH issuing Bulletin/Notice
- Pay-for-Performance Advisory Committee Meetings
- Compliance Newsletters
- DBHIDS website
How CBH Assists Providers

CBH routinely meets with providers at CBH and on site at providers locations.

CBH provides opportunities to enhance knowledge and competency through lunch and learns, technical assistance, and clinical and other training opportunities at no charge.

A recent example of a CBH sponsored provider training is *Building Bridges*, a best practice for psychiatric residential treatment.

CBH Provider Relations staff serve as single point of contact with provider agencies to assist with trouble shooting, problem resolution, and navigation of resources.
Oversight & Monitoring
Oversight and Monitoring: Credentialing

All new programs or program expansions undergo an initial credentialing process to include: a review of staff files, facility tour, review of written policies, review of clinical records, and collection of the required business documents for entering the CBH Network.

Existing providers undergo re-credentialing reviews, conducted by the DBHIDS Network Improvement and Accountability Collaborative (NIAC), to remain in the CBH network.

Components of the NIAC site review process: Agency Self-Appraisal; focus groups with agency staff members; focus groups with individuals receiving services; parent satisfaction surveys; an executive level interview; facility tours; clinical chart reviews; staff file reviews to evaluate training and supervision practices; and a review of the agency’s written policies.

All CBH funded agencies are presented to the CBH Credentialing Committee for review and approval of initial and re-credentialing statuses.
Oversight and Monitoring: Quality Management

| The Quality Management (QM) Department of CBH serves as the hub for assessing significant incidents, quality of care concerns, and complaints and grievances. |
| QM manages the complaint and grievance processes, and reports incidents. |
| QM routinely conducts provider site visits, monitors Quality Improvement Plans (QIP), facilitates provider meetings and Quality Response Teams (QRT). |
| QM reviews trending of quality indicators and metrics to inform both provider and CBH quality improvement activities. |
| All of these activities are conducted in consultation and collaboration with other units across the DBHIDS. |
## Oversight and Monitoring: Compliance

<table>
<thead>
<tr>
<th>Assists in facilitating adherence to applicable federal and state regulations governing the Medicaid program as well as CBH policies and procedures.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Auditing and monitoring activities are designed to address compliance with laws governing Medicaid behavioral health program operations and billing.</td>
</tr>
<tr>
<td>Required to report suspected Fraud, Waste, and Abuse (FWA) to the PA DHS Bureau of Integrity and state Office of the Attorney General; and participates in quarterly meetings with the state and other BH-MCO's.</td>
</tr>
<tr>
<td>Works with the Department of Justice and the Philadelphia Office of Inspector General.</td>
</tr>
<tr>
<td>The state OAG has highlighted the comprehensiveness of CBH’s referrals and efforts to assist with the investigation processes.</td>
</tr>
</tbody>
</table>

**Compliance hotline for suspected FWA: 1-800-229-3050**
Oversight and Monitoring: Consumer Satisfaction Team (CST)

CST serves as a critical partner in the monitoring of the provider network by ensuring quality assurance from the member’s perspective.

Staffed entirely by recipients of behavioral health services and family members.

CST’s goal is to ascertain whether members and/or family members are satisfied with their services.

CST meets regularly with DBHIDS leadership and plays an important role in system-wide policy and program decisions.
Community Behavioral Health

Children’s Services Overview
Philadelphia System of Care

A system of care for children is a coordinated community-based array of services and supports that is:

- Family Driven
- Youth Driven
- Culturally and linguistically competent
- Trauma-informed
- Individualized to the unique needs of families
- Integrated across systems
- Strengths-based
Philadelphia Alliance for Child Trauma Services (PACTS)
What is a trauma-informed system?

- Understanding trauma and its impact
- Promoting safety
- Supporting consumer control, choice, and autonomy
- Sharing power and governance
- Ensuring cultural competence
- Integrating care
- Understanding that recovery is possible

Guarino, Soares, Konnath, Clervil, & Bassuk, 2009
Child Trauma Experiences

- Sexual abuse
- Physical abuse
- Emotional abuse/psychological maltreatment
- Neglect
- Domestic violence

- Death or bereavement
- Forced displacement

- War/Terrorism/Political violence (in US)
- War/Terrorism/Political violence (outside of US)
- Community violence
- School violence

- Impaired caregiver defined as:
  - Substance abuse
  - Parental mental illness

- Illness/Medical Trauma
  - Serious injury/accident
  - Natural disaster
  - Kidnapping

- Extreme interpersonal violence
  - other trauma
  - Separation from family member
  - Bullying
1. Develop an integrated system of child trauma providers

2. Build capacity for trauma screening and assessment

3. Build partnerships between PACTS providers and other child serving systems (schools; child welfare; juvenile justice; physical health; CAC; homeless shelter, etc.)

4. Increase delivery of TF-CBT, PRI-CARE and CFTSI

Beidas, Adams, Kratz et al., 2016
Developing a Coordinated System

PACTS Provider Map
Trauma-Focused Cognitive-Behavioral Therapy Before PACTS

Pre-PACTS

3 agencies specializing in pediatric trauma
A City-Wide Child Trauma Initiative

**Post-PACTS**
16 agencies specializing in pediatric trauma
Children’s Crisis Services
Background

- Multi-year effort to look at national and local models of acute care systems of care for children
- 2017 City (DBHIDS) Procurement for Mobile Children’s Crisis Services and Site Based Crisis Center for Children
- Germantown (Einstein) Children’s Crisis Response Center (CRC) stopped evaluating children under the age of 18 on September 4, 2017.
- Behavioral health emergencies involving a child or adolescent were encouraged to contact the Philadelphia Crisis Line, go to an Urgent Care Center, or go to the nearest child-serving emergency room to be evaluated.
- During the interim crisis planning period, the following services began: Urgent Care Center; Children’s Mobile Crisis Teams (CMCTs); and the Children’s Mobile Intervention Services (CMIS).
- On January 5, 2018, the new Children’s CRC opened.
Children’s Crisis Continuum

- Urgent Care Center (UCC) - went into effect September 2017
- Children’s Mobile Crisis Teams (CMCT) - went into effect November 2017
- Children’s Mobile Intervention Services (CMIS) - went into effect December 2017
- New Children’s Crisis Response Center (CRC) - went into effect January 2018
- Children’s Stabilization Beds - went into effect January 2018
# Overview of Services

<table>
<thead>
<tr>
<th>Urgent Care Center (UCC)</th>
<th>Children’s Mobile Crisis Teams (CMCT)</th>
<th>Children’s Mobile Intervention Services (CMIS)</th>
<th>Children’s Stabilization Unit (CSU)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Effective, efficient, and resolution-focused alternative to a Crisis Response Center (CRC)</td>
<td>• Mobile, on-site, face-to-face therapeutic response to a child or youth and his/her family experiencing a behavioral health crisis.</td>
<td>• Mobile, face-to-face, in-home, community, school or other locations where the family feels most comfortable receiving services.</td>
<td>• Designed for young people showing acute distress from mental health challenges, social factors and/or the effects of substance use.</td>
</tr>
<tr>
<td>• Children and family meet with master’s level clinician for a comprehensive assessment with the hope of ameliorating the crisis at hand.</td>
<td>• Provided in the home, school, or community 24 hours/7 days a week.</td>
<td>• Provides brief, intensive interventions, psychiatric assessment, case management, and medication management as needed for up to eight weeks.</td>
<td>• The goal is to stabilize a crisis situation so young people can quickly return to a home or community setting.</td>
</tr>
<tr>
<td>• Hours of Operation: 11:00am to 6:00pm, Monday – Friday</td>
<td>• Includes a crisis assessment; crisis planning; up to 72 hours of crisis intervention and stabilization services including referral and linkages to all necessary behavioral health services and supports.</td>
<td>• CMIS is resolution-focused, addresses social determinants of health, delivered with an end-service mindset, and concludes sooner than six weeks when clinically appropriate.</td>
<td>• Rapid resolution focused treatment is provided through a comprehensive assessment, stabilization of the individual in crisis through psychosocial and psychopharmacological interventions, and restoration of the individual to a level of functioning requiring a less intensive treatment setting, while preventing an unnecessary hospital admission.</td>
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</tbody>
</table>
Psychiatric Residential Treatment
Grounding Values

Community treatment is preferred over residential treatment

Placement in RTF disrupts:

- Family Bonds
- Peer Relationships
- School/Community Ties (including jobs in community)
- Limited role models
contracts with **18 Pennsylvania PRTFs** and 13 out-of-state programs.

spent approximately **$36 million for PRTF** services.

69% were DHS youth (2017)

Approximately $22 million (or 63%) of the total PRTF spent on children and youth identified as DHS-involved through dependency or delinquency.
Youth in Residential Treatment: 2006-2017

* 8 of these youth are at a highly specialized program in NJ which is actually closer to Philadelphia than some of the in state placements.
Support Team for Education Partnership (STEP) Project
The Goals of STEP

The STEP Project is a partnership: School District, the City, and the DBHIDS.

To improve the continuum of behavioral health services ranging from prevention and at-risk services to intensive treatment options for all public schools to best serve all students.

Ensure wellness for all youth and families by identifying drivers of behavioral issues early and connecting children and families to appropriate resources to result in reduced missed instructional time and prevent children going into crisis.

A behavioral health support team will be phased into 21 District schools and 1 charter school; the team consists of:

A **Social Worker**, **School Behavioral Consultant**, **Case Manager**, and **Family Peer Specialist**.
<table>
<thead>
<tr>
<th>School</th>
<th>Grades</th>
<th>Zip</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cassidy, Lewis C.</td>
<td>K-6</td>
<td>19151</td>
</tr>
<tr>
<td>Cramp, William Elementary</td>
<td>K-6</td>
<td>19140</td>
</tr>
<tr>
<td>Edmonds, Franklin S.</td>
<td>K-7</td>
<td>19150</td>
</tr>
<tr>
<td>Elkins, Lewis Elementary</td>
<td>K-4</td>
<td>19134</td>
</tr>
<tr>
<td>Frankford High</td>
<td>HS</td>
<td>19124</td>
</tr>
<tr>
<td>Gideon, Edward</td>
<td>K-8</td>
<td>19121</td>
</tr>
<tr>
<td>Locke, Alain</td>
<td>K-8</td>
<td>19139</td>
</tr>
<tr>
<td>Logan, James Elementary</td>
<td>K-5</td>
<td>19141</td>
</tr>
<tr>
<td>McMichael, Morton</td>
<td>K-8</td>
<td>19104</td>
</tr>
<tr>
<td>Meade, General George C.</td>
<td>K-8</td>
<td>19121</td>
</tr>
<tr>
<td>Penrose *</td>
<td>K-8</td>
<td>19153</td>
</tr>
<tr>
<td>Powel, Samuel Elementary</td>
<td>K-4</td>
<td>19104</td>
</tr>
<tr>
<td>Science Leadership Academy</td>
<td>5-8</td>
<td>19104</td>
</tr>
<tr>
<td>Sheridan, Philip Elementary</td>
<td>K-4</td>
<td>19134</td>
</tr>
<tr>
<td>South Philadelphia High</td>
<td>HS</td>
<td>19148</td>
</tr>
<tr>
<td>Southwark</td>
<td>K-8</td>
<td>19148</td>
</tr>
<tr>
<td>Stearns, Allen M.</td>
<td>K-8</td>
<td>19124</td>
</tr>
<tr>
<td>Steel, Edward T.</td>
<td>K-8</td>
<td>19140</td>
</tr>
<tr>
<td>Tilden, William Middle</td>
<td>5-8</td>
<td>19142</td>
</tr>
<tr>
<td>Washington, Martha</td>
<td>K-8</td>
<td>19104</td>
</tr>
<tr>
<td>West Philadelphia High</td>
<td>HS</td>
<td>19139</td>
</tr>
<tr>
<td>Belmont Charter School</td>
<td>1-8</td>
<td>19104</td>
</tr>
</tbody>
</table>

*These schools are also West Philadelphia Promise Neighborhood Schools
*These schools are also Mayor’s Office of Education Community Schools
*A School Behavior Consultant will be placed at the beginning of Phase I implementation High School
STEP Updates

- In Academic Year 17-18 a Social Worker has been added to all 21 District schools. In the high schools, the team will primarily focus on 9th graders.

- In Academic Year 18-19 the remaining staffing complement is being hired beginning with the School Behavior Consultants.

- These positions are School District of Philadelphia (SDP) employees, hired by the District. They will be supported in professional development by both School District Central Office and CBH.

- STEP staff are being trained to be able to bill Medicaid for Medicaid reimbursable services provided while braided funding sources are also being identified.

- SDP Staff are partnered with DBHIDS/CBH and the University of Pennsylvania to monitor implementation and outcomes.
Response to the Opioid Epidemic
The Opioid Emergency
Dramatic Increase in Fatal Overdoses

Figure 4. Age-adjusted drug overdose death rates, by opioid category: United States, 1999–2016

Unintentional Drug Related Deaths by Year, 2003-2017

Notes:
1. Deaths involving more than one opioid category (e.g., a death involving both methadone and a natural or semisynthetic opioid) are counted in both categories.
2. Deaths involving cause-of-death codes X40-X44, X60-X64, X65, and Y10-Y14. Drug overdose deaths involving selected drug categories are identified by specific multiple-cause-of-death codes: heroin, T40.1; natural and semisynthetic opioids, T40.2; methadone, T40.3; and synthetic opioids other than methadone, T40.4.

A Chronic Disease Becomes Acute

- Addiction has long been a fatal disease, albeit typically in chronicity.
- While virtually every other medical condition is trending towards becoming a chronic illness, OUD has rapidly trended towards an acutely fatal disease.
- The emergence of inexpensive fentanyl has driven this dramatic shift.
How much of an Emergency

Unstable OUD

Perception of how OUD is handled

Chest Pain

Dangerous
Our Charge

Expand access and capacity for Medication Assisted Treatment (MAT)

Reduce barriers to treatment

Identify unhelpful regulation and practices, while promoting care connection, coordination and engagement

Fighting stigma and providing education
Mayor’s Taskforce Recommendations

- Increase the provision of medication-assisted treatment
- Expand treatment access and capacity
- Embed withdrawal management into all levels of care, with an emphasis on recovery initiation
- Implement “warm handoffs” to treatment after overdose
Medication-Assisted Treatment is Evidence-Based Treatment

“Access to medication-assisted treatment can mean the difference between life or death.”
Michael Botticelli, Director, White House Office of National Drug Control Policy

“The safety and efficacy of MAT has been unequivocally established.”
Dr. Nora Volkow, Director, National Institute on Drug Abuse
MAT Benefits

- Improves patient survival
- Reduces drug use
  - Total amount used
  - Number of days/month used
  - Number of weeks with any drug use
- Protects against overdoses (buprenorphine and naltrexone)
- Protects against HIV/HCV
- Reduces criminal behavior
- Increases retention in treatment
- Improves postnatal outcomes

Source: The National Council & SAMSHA
Medication Assisted Treatment Works

<table>
<thead>
<tr>
<th>Medication</th>
<th>Abstinence %</th>
<th>Medication free or Placebo %</th>
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<tbody>
<tr>
<td>Naltrexone ER</td>
<td>36</td>
<td>23</td>
</tr>
<tr>
<td>Buprenorphine/naloxone</td>
<td>60</td>
<td>20</td>
</tr>
<tr>
<td>Methadone</td>
<td>60</td>
<td>30</td>
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</table>

*Connery HS, 2015*
Medication Assisted Treatment Works

Rhode Island Department of Corrections initiated an MAT program behind the walls

- 60% reduction in 6-month death rate
- Large and clinically significant reduction in post incarceration deaths

Service Expansions

- Expanded capacity for MAT in outpatient
- Expansion of the Temple Crisis Response Center
- Creation of Pathways to Recovery Partial Program
- Creation of 24-hour access center
- Bed expansion – anticipating an additional 150 beds over the course of the next year.
NET Centers introduces **new**
23-Hour Observation and Ambulatory Detox for Opioid Use

NET is currently offering
Buprenorphine and Vivitrol Treatment Services in addition to its Intensive Outpatient Treatment Programs.

**Available now at our**
**Spring Garden location:**
499 N. 5th Street, Suite B
Philadelphia, PA 19123
Policy / Procedural Changes
Expanding Capacity for Medication Management

- **Residential Drug and Alcohol (D & A) Levels of Care** required to provide MAT-compatible services by January 1, 2020.

- **Crisis Response Centers (CRCs) and D&A Providers Offering Detox** can elect to provide buprenorphine stabilization.

- **All D&A Providers** incorporate MAT options into treatment planning for members.
  - Discussing Opioid Use Disorder treatment options, including MAT
  - Informed consent—risks, benefits and alternatives
  - Formal agreements where necessary
Barriers to Treatment

Hours/Availability - “We aren’t open during that time”

Messaging
- “There are no beds”
- “You are going to be denied anyway”

Exclusionary Criteria
- “We don’t treat members with polysubstance abuse”
- “We don’t do x or y (MAT)”
- “You must be free of suicidal thoughts for 72 hours”

Delays
- Urine Drug Screens
- Doctor Availability for inductions
System Goal = Treatment on Demand

Rapidly assess and link those with Opioid Use Disorder to an evidence-based treatment.
Increasing Access

- **Outpatient levels of care** – *time to induction*

- **Residential levels of care** – *night and weekend hours*

- **Crisis Response Centers (CRCs)** - *aftercare linkage* for members with substance use disorders who are not authorized for residential level of care
Prior Authorization Changes

Prior Authorizations for Residential Rehab (3B)

- Majority of denials come from 3B
- Ease of access
- Increased ownership and accountability for providers
Policy Clarifications

1. Urine Drug Screens
2. Vitals
3. Verification of Identity
4. Prescriber Letters
5. Insurance Status
Verifying Identification

**Non-Narcotic Treatment Programs** no requirement for photo ID

**Narcotic Treatment Programs** photographic identification is not required but the verification of identity is required before treatment
Implementing “Warm Handoffs” to Treatment After Overdose

The Recovery Overdose Survivor Engagement (ROSE) Project through PRO-ACT employs Certified Recovery Specialists to connect individuals who are at risk of or have survived an opioid overdose to treatment.

In January, **125 individuals were engaged from which 78 referrals to treatment were coordinated.**
Innovative Programming
Opioid Use Disorder Performance Incentive: $50,000 Pay-for-Performance

1. Provision of MAT
2. Access and Staffing
3. Customer Service and Cultural Responsiveness
4. Marketing
Medicaid Prescriber Dashboard

Number of your MA patients who received an opioid or benzodiazepine prescription from you, who also received substance abuse or addictive disorder treatment in the past two years:

- Opioid: 4
- Benzodiazepine: 0

Number of your MA patients who received a combination of opioid and benzodiazepine prescriptions with at least one from you:

- Opioid: 12
- Benzodiazepine: 19

July 1, 2016 – June 30, 2017
Preliminary Outcomes

- A steep decline in Opioid prescriptions
- A persisting increase in naloxone prescribing to at-risk members
- Pharmacy Detailing Project to cover all pharmacies in Philadelphia, addressing barriers to accessing Narcan, etc.
- PDMP initiating state wide dashboard
- CBH Hosted a PDMP Training on 8/14 and 8/15
SUD Services in Philadelphia

Where We Were

- MA: Hospital based detox; D&A OP (State Plan)
- Expenditures in BH; less than 5%

Where We Are

- MA: Expanded MA benefits via supplemental services
- Expenditures in BH; close to 25%
Treatment Continuum

Within DBHIDS, Community Behavioral Health (CBH) manages the behavioral health services for Medicaid beneficiaries while the Division of Behavioral Health (DBH) manages care for uninsured individuals and various recovery support services.

*Coordinated Response to Addiction by Facilitating Treatment (CRAFT)*
Vastness of CBH Network

- 900 residential beds with a 30-day average stay
- Thousands of outpatient slots across partial and intensive outpatient tailored to members needs
- 4,000 unique members with OUD served every year in residential settings, 10,000 in outpatient
### Overview of CBH Utilization

#### Overall Utilization for 2017
- Approximately: 27,000 people utilized SU service.
- 14,000 had an OUD diagnosis (52%).
- $170 million spent across 5 LOCs

#### Point in Time – June 1, 2018
- On any given day 5,500 people are receiving services.
- Approximately: 4,600 in Outpatient
  1,000 in Residential
Who to call for help:

If one of your constituents is in need of assistance, please direct them to Community Behavioral Health Member Services at 1-888-545-2600.
## CBH’s Response Summarized

<table>
<thead>
<tr>
<th>More people receiving MAT and more services available</th>
<th>Fewer overall prescription opioids since 2015</th>
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<tbody>
<tr>
<td>Partial program</td>
<td>Medicaid specific numbers are trending down</td>
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<tr>
<td>24/7 Stabilization Center</td>
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<tr>
<td>Planned Temple and residential beds</td>
<td><strong>Issued guidelines for opioids and benzodiazepines</strong> in collaboration with the Philadelphia Department of Public Health.</td>
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<td><strong>Increased efforts to improve access</strong></td>
<td><strong>Cross system partnerships</strong> around encampments and the Kensington emergency efforts.</td>
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<td>Reducing time to induction</td>
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<td>Including night and weekend hours</td>
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<td>CRC aftercare linkages</td>
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<tr>
<td>Waiving pre-authorization</td>
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<tr>
<td><strong>Helped eliminate prior authorization for MAT medications</strong></td>
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- Fewer overall prescription opioids since 2015
- Medicaid specific numbers are trending down
- **Issued guidelines for opioids and benzodiazepines** in collaboration with the Philadelphia Department of Public Health.
- **Cross system partnerships** around encampments and the Kensington emergency efforts.
- **Innovative programming and incentives**
Closing Remarks

- The Philadelphia Health Choices program is unique and has become an integral part of the city’s infrastructure.

- CBH has demonstrated its competence in meeting the HealthChoices objectives of increasing access; enhancing quality and being good stewards of public money.

- CBH brings only value to the city, requiring no city dollars to support the infrastructure.
Questions
Resources

www.DBHIDS.org

www.HealthyMindsPhilly.org

Acute Services **215-686-4420** (Emergency and Crisis Services)

CBH Member Services **1-888-545-2600** (available 24/7)