Community Behavioral Health

2017 20th Anniversary Report
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Our Vision
A diverse, innovative, and vibrant organization in which we are empowered to support wellness, resiliency, and recovery for all Philadelphians.

Our Mission
CBH will meet the behavioral health needs of the Philadelphia community by assuring access, quality, and fiscal accountability through being a high performing, efficient, and nimble organization driven by quality, performance, and outcomes.
Foreword

A Letter From the Commissioner

Greetings Friends,

On behalf of the Board of Directors of Community Behavioral Health (CBH) and the Department of Behavioral Health and Intellectual disAbility Services (DBHIDS), we are proud to present you with this copy of Community Behavioral Health’s 20th Anniversary Report. This report highlights a pivotal journey that began over 30 years ago when key leaders of Philadelphia’s advocacy, provider, policy, and research communities made a commitment to create a system that generates hope and promotes opportunities for a life in the community for those living with mental health or substance use challenges. Their goal was to “give a voice” to those impacted by behavioral health issues and to ensure that the system was driven by the members it served rather than the profits it generated.

This report also highlights the remarkable evolution of CBH. The historical account of how CBH came to be and how it has grown over the last 20 years is impressive. The cutting-edge initiatives, cross-systems collaboration, and significant reinvestment totaling over $300 million dollars are what set CBH apart from other managed care organizations and more importantly, are what make the difference in our members’ lives.

Since CBH opened its doors 20 years ago, the behavioral health system in Philadelphia has improved access to treatment, enhanced the coordination of services, maintained cost-effectiveness, and given a voice to those impacted by behavioral health issues. Your support and contributions to the success of the organization is appreciated and have been essential to CBH’s accomplishments, ensuring we continuously focus on the three main goals of the HealthChoices program: improving access to and quality of services at stabilized costs. The 20th anniversary is a chance to celebrate the individuals and stakeholders that played a role in the creation of CBH and an opportunity to recognize the leadership of many staff over the years who have been dedicated to creating a system where our members’ health and well-being are the priority.

As we strengthen our population health approach in Philadelphia, I have no doubt the foundation built within CBH will allow us to fully realize our vision.

Sincerely,

Arthur C. Evans, Jr., Ph.D.
President, CBH Board of Directors
Commissioner, DBHIDS
History of CBH - The Early Days

Reflections on the 20th anniversary of Community Behavioral Health (CBH) would be incomplete without highlighting the creation of such an innovative model of managing care. While there are written accounts of how CBH was created, this overview attempts to bring history to life by including the testimony of some of the key stakeholders[1] who played a role in making CBH a reality. Their reflections make it clear that CBH came to be because of many people working at various levels of government in a variety of ways, with a common mission. It was a perfect storm that led to the creation of CBH.

Timeline and Overview

In the mid-1980s, a series of research articles were published on managed care in a public system, laying the foundation for future grant funding. In October of 1986, The Robert Wood Johnson Foundation and the U. S. Department of Housing and Urban Development awarded Philadelphia close to $13 million to address the needs of those with long-term mental health conditions who were not being adequately served in the community. Specifically, Philadelphia planned to close Philadelphia State Hospital at Byberry, consolidate public mental health funds into a single local authority, and develop long-term housing options and intensive case management services.

In 1996, plans were made to blend state and federal managed health care dollars for Medicaid recipients into the HealthChoices program, while mental health advocates fought to “carve out” behavioral health services. As part of the carve-out, the state gave each county the “right of first opportunity” to either contract with a private managed care organization (MCO) or to establish its own. There was great resistance at the local level, and a Blue Ribbon Commission was required to submit a report regarding the likelihood that CBH would succeed. In the end, advocates convinced City Council to approve the formation of a private, non-profit, city-run Behavioral Health MCO, and CBH opened on February 1, 1997.

Clear themes emerged as our stakeholders recounted various key events that were essential for making CBH a reality. There were numerous barriers to overcome: from competing with experienced, well-resourced and well-connected for-profit MCOs, to making the case that it was worth the risk. This was no small order: Overcoming the odds required strong leadership at all levels, a consumer system that was capable of ushering in significant change, and a unified stakeholder voice where advocates, providers, persons in recovery, administrators and family members all wanted the same thing. Lastly, the creation of CBH was about doing the right thing, about the people being served, and being mission driven so that members wouldn’t fall through the cracks.

[1] Key stakeholders and affiliations at the time CBH opened: Peter Bezrucik (Manager of Human Resources, CBH), Michael Covone (Deputy Health Commissioner, Mental Health Services), Joan Erney (Special Assistant to Deputy Secretary of the Pennsylvania Office of Mental Health and Substance Abuse Services), Trevor Hadley (Associate Professor of Psychiatry, University of Pennsylvania), Mary Hurtig (Director of Public Policy, MHASP), Wayne Lepp (Unix Administrator, CBH), Nancy Lucas (Chief Operating Officer, CBH), Estelle Richman (Commissioner of Public Health and Acting CEO of CBH), Joseph Rogers (President and CEO of MHASP), Sandy Vasko (Mental Health Administrator, Mental Health Services), and Harriet Williams (Director of Children's Mental Health Services).
History of CBH

Defying the Odds

Many believed CBH would never come to be and, if it did, that it would fail miserably in a matter of months. Charles Curie, Pennsylvania Deputy Secretary for Mental Health and Substance Abuse Services, was an outspoken proponent of the need for a behavioral health carve-out. At the local level, the battle was focused on whether or not Philadelphia should take on this risk. City Council President John Street worried about previous unfunded state mandates and thought the risk was too great for the city. There were many moving parts at the local level, which included the willingness of Mayor Rendell to trust Estelle Richman’s track record of success and give her a chance. Defying the odds took solid leadership, a united front, well-organized and empowered advocates, and a mission that was grounded in doing the right thing.

“The decision to close Byberry and the experience of [doing so] established a system and the services necessary to keep former Byberry patients in the community, giving the City confidence that we could do this.” – Mary Hurtig

Leadership

“I do think it’s about leadership. It’s leadership all up the chain where the stars align and you know you have enough influence to be able to make something happen. You have to have someone who has a commitment and fights all of those fights and can align your advocates, providers and the rest of the community.” – Joan Erney

“Where we were really lucky is everything came together. In other words, some cities have really good leadership but they have no consumer system. I couldn’t have done this without Joe [Rogers]. I needed Joe at Joe’s level. Right now, if any city wanted to do what we did, there are some things they’d have to have in place and one of them is a strong consumer system.” – Estelle Richman

“There are things that were different about Philly. It’s really a small town with a 30-plus year history of everyone knowing everyone. There have been good periods of long, sustained, quality leadership. People stay a long time in these public service jobs. That’s pretty amazing.” – Trevor Hadley

United Front

On the carve-out: “It was the only time in history where the stakeholders had one voice and wanted one thing. I mean you had family members, advocates, individuals with lived experience, providers, psychiatrists, and counties. It was a big deal.” – Joan Erney

Power of the People

“Mental health advocates, mostly consumers/recipients of services, organized and fought for change. Advocates exposed campaign contributions, got articles published, and closed down City Hall. It’s a wonderful example of the power of the people.” – Joseph Rogers

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PA Health Choices Behavioral Health Program

In 1997, the Commonwealth of Pennsylvania introduced a new integrated and coordinated health care delivery system, known as HealthChoices, to provide health services to Medical Assistance members. The HealthChoices program comprises two service components: physical health and behavioral health. Although these services are provided through separate contractors, the state requires coordination and interaction between all physical health and behavioral health managed care organizations. Each HealthChoices member is assigned a behavioral health plan based on his or her county of residence. Under the HealthChoices behavioral health component, also known as the behavioral health “carve-out,” the counties are required to ensure high quality care and timely access to appropriate mental health and substance use services and facilitate effective coordination with other needed services.
History of CBH

Doing the Right Thing

“It was never about the money; it was always about the people. People were drawn to that. That’s why people got into this work; that’s why people got into this field. When it spoke to that, it spoke to the people and that’s what aligned the advocates with the providers, with the family members and the consumers themselves. I don’t know that other systems could generate that deep a passion and commitment to why we were doing all of this.” – Sandy Vasko

“We relate to government: it’s not a big business; it’s a different animal. We’re the only ones in the country that can say we didn’t profit by this. We don’t tuck away any money. It’s a pretty remarkable structure that allows that to happen.” – Joan Erney

Reflections Then and Now

Given the expectations of failure, the commitment to succeed was palpable. CBH was ready with 89 staff in place for opening day, with some staff that were hired more than two years earlier.

“A lot of people said CBH would never last six months. The general feeling was this was an experiment. But it didn’t matter because, if we had to work 24 hours a day for a year, we were doing it.” – Estelle Richman

“I remember the computer system went down. Estelle said you can go see each other and write notes. That’s how we used to work; now, stop complaining.” – Harriet Williams

“Arthur Evans brought the recovery focus; the whole sea change is Arthur’s. Recovery wasn’t a language that was being talked about from the top to providers. Very early on after he got to Philadelphia he asked Joseph and MHASP to put on a full-day conference on recovery.” – Mary Hurtig

“I wish I could tell you today we are a seamless, unified system. We still struggle with that every day and the [disparate] cultures are probably as apparent today as the day the phones went live. So there are many lessons to be learned. I don’t know how you could have possibly changed anything as it was rolling forward. You were dealing with the big guy on the block, non-union coming into a union world. I think that getting to where we are today is a true testament of the ability to work together. We may not always be on the same page. It’s still very real that we’re very distinct entities trying to pull together right now. I think that, even in spite of that, you still have probably one of the most capable and competent systems in the country. So even in our differences—be it cultural, age or financial/economic—we’re probably stronger in spite of it because of it. And I think that’s evident across the city as well. We’re probably one of the soundest departments in the city. You can look at it as a glass half empty or a glass half full. But it sort of set a tone of how things were going to proceed. We weren’t a static system and we still aren’t. We’re always ahead of the curve on most things rolling forward. And we’re typically leading the state in terms of how it should look, how it should go, and pushing back when appropriate. I think it’s just who we are and who we’ve become out of this process.” – Sandy Vasko

The sense of pride conveyed here is quintessentially Philly. This perspective stems from a system that was designed in partnership with the members it would serve. It grew out of a history of doing the right thing, starting with the closure of Byberry, continuing to fight for an adequately funded community support system, and commitment to reinvestment each year. The road wasn’t an easy one; but, while we continue to face challenges, our mission is clear. And many of the people who fought to make CBH a reality are continuing to work to make our system better every day. This section of the report described the first wave of our system transformation, which set the foundation for a system that promotes recovery, resiliency and self-determination for all individuals, families and communities in Philadelphia. The remainder of the report highlights how our innovative thinking and population health approach is allowing us to strengthen the health and wellbeing of our communities.
What is population health?
Population health refers to the health of a community. Traditional approaches to health care center around individuals who are already experiencing a health-related condition. Population health approaches take a much broader view, seeking to improve the health status of everyone in a community, not just those who are sick. By providing excellent clinical care as well as community-level interventions and services, population health approaches help to create communities in which every member—not just those who seek health services—can thrive.

DBHIDS’ efforts over the last decade moved us from ensuring that people with behavioral health conditions and intellectual disabilities not only live in communities but are a part of their communities. As we worked with communities to help them better support people in our system, we recognized that many communities are themselves distressed, grappling with violence, poverty, inadequate housing, and other threats to health, well-being, and self-determination. We also recognized that there were many people in need of support whom we were not yet reaching or were reaching too late. In response, we launched programs to build community capacity to improve health.

The essence of our population health approach is as follows:

1. Attend to the whole population, not just to those seeking services.
3. Provide early intervention and prevention.
4. Address the social determinants of health.
5. Empower individuals and communities to keep themselves healthy.
CBH Over the Years

CBH Membership: Growth in Eligibility

- 448,171 in 1997
- 510,184 in 2007
- 649,189 in 2015

CBH Employees: Growth Over Time (Full- & Part-Time)

- 89 on opening day
- 283 in 2007
- 443 today

Number of Members Served (Unduplicated)

- 48,054 in 1997
- 87,155 in 2007
- 113,495 in 2015
Our Work

As the preceding page illustrates, CBH has seen dramatic increases in the number of members eligible for and receiving services in Philadelphia. Internally, CBH has grown not only in sheer workforce numbers but also in the breadth of each department’s responsibilities within a modest administrative cost (one of the lowest in the country). A snapshot of each department’s history and scope of work follows, reflecting both the traditional functions of an administrative services organization, as well as the unique strategies CBH has employed in partnership with other services systems in Philadelphia. Our staff is a resource for the community and our network providers are emissaries in combating stigma and ensuring safety and quality, as well as provide consultation and training to our community network of providers. Countless other aspects of the organization are not illustrated below, but are nonetheless important and support our mission.

Clinical Management

At the time of CBH’s launch in 1997, clinical care managers were called “service managers.” They were assigned to specific providers in order to perform clinical reviews and split into two teams, one of which managed services for adults and the other for children and adolescents. Back then, they had three weeks to review a packet that recommended Behavioral Health Rehabilitative Services (BHRS, previously called Wraparound) services; today they have two days. CBH did not yet have the efficiency or volume of staffing needed, so there were no actual service managers assigned to these providers. Instead, staff would wait until there was a significant pile of BHRS packets (at points the pile would literally be three feet tall), and then they would have a “packet party” where the entire child/adolescent team would spend several consecutive mornings reviewing packets. Thankfully, things are much more organized now.

After a couple of years, a new approach was piloted. Staff were assigned to specific CBH members who were having trouble connecting to and benefiting from treatment and were utilizing a high volume of services. This new team was called “care managers,” to differentiate from the service managers who were assigned to providers. While the pilot only lasted about a year, the name stuck and Service Management became Care Management. Even though the reference was that Clinical was managing clinical care, staff also liked the idea of the word “care” being in their job title, as it jived well with CBH’s mission of being “managed care with a heart”.

The Clinical division of CBH is a 24 hours a day/7 days a week/365 days a year operation. Clinical Management includes a director of Clinical Management, five clinical care coordinators, 18 care management supervisors, 98 master’s-level clinical care management staff (including team leaders, care managers, care manager trainees and care manager specialists), 17 bachelor’s level behavioral health liaisons, five administrative support staff, one clinical projects manager, and one clinical operations and training specialist. Medical Affairs consists of adult and child psychiatrists as well as psychologists and pharmacists. Clinical manages all levels of care with the exception of outpatient (which requires no prior authorization), as well as community treatment teams (CTT) and targeted case management (TCM), which are under the purview of DBHIDS and supported by clinical care managers.

Clinical Management engages in a number of activities and serves a variety of functions each day. These activities, processes and functions include but are not limited to generating and extending authorizations and completing precertifications, concurrent reviews, extending authorizations, discharge documentation, searches for treatment openings in the provider network, physician consultations, denial reviews, packet reviews, internal and external meetings (including provider meetings, interagency and family meetings, discharge planning meetings, and weekly clinical team meetings), assertive aftercare outreach, behavioral and physical care coordination with special needs and cross-systems collaboration.

I began my CBH journey on January 6, 1997. Never in my wildest dreams would I have worked in a place where wires hung from ceilings, cubicles were only partially completed, and our intercom system was to stand up and call out to the person needed (even a poodle found his way to the unit).

CBH has helped me as they help our members, with care and compassion. This company is truly family-oriented and we care for our members as we would our own family members. Thank you for the wonderful years! I’m looking forward to the next 20.

-Maria Chaves, Member Services Supervisor
Our Work

Member Services

The Member Services Department was born out of two individual units, Intake and Member Services. After a few years, the two departments were merged and retained the name Member Services. Member Services always maintained 24-hour status along with the Clinical Psychiatric Emergency Services (PES) line. Unlike a typical call center, it functioned like a travel agency, setting up appointments for outpatient substance abuse and mental health treatment and dispersing information to callers seeking other agencies performing functions outside of ours (gas, electric, etc.) To address a gap in services, Member Services Representatives were established in Family Court, DHS, and the School District.

Throughout its existence, Member Services has maintained a role in the Philadelphia community as ambassadors of CBH by attending health fairs and providing presentations to providers and members alike. Known for its ability to think outside of the box, Member Services is called upon on a regular basis to be creative in its approach to resolving an assortment of challenging member issues. This includes working closely with Clinical, Quality Management, Provider Operations, and other agencies outside of CBH.

Member Services Representatives respect the faith, values and integrity of every individual or family in need of mental health and substance use services and are committed to the treatment and recovery of our members. Member Services is committed to providing the highest quality of service to the community while focusing on recovery, resilience, and self-determination 24 hours per day, 7 days per week, making urgent or emergent services accessible to anyone in need.

Member Services specializes in all things related to our members: they are the experts in system navigation and resources for Philadelphia. They are responsible for the management of our toll free hotline, meeting with members, coordinating interpretation services for members and out-of-network services, ensuring members are connected to services after being discharged from treatment, working with members during provider closures and meeting members in the community where they are. Member Services takes pride in changing and touching lives daily, rising to challenges, and staying true to the motto: “Member Services-Always Answers the Call.”

Network Improvement & Accountability Collaborative

Philadelphia’s Behavioral Health System is engaged in an innovative collaboration with providers called the Network Improvement & Accountability Collaboration (NIAC). NIAC serves as the primary mechanism to accomplish the creation of a single, consistent approach to site reviews [monitoring] across various funding streams, resulting in fewer site visits for the provider. Prior to the inception of NIAC, site visits were conducted separately by the various units within the Behavioral Health System. Functions such as HealthChoices’ credentialing, grant monitoring, and Department of Drug and Alcohol Program (DDAP) monitoring are now accomplished through NIAC. As a way of ensuring that all aspects of a site review are scored in a standardized manner, a new scoring instrument, Network Inclusion Criteria (NIC), was developed.

The NIC allows the NIAC team to obtain both qualitative and quantitative data to critically assess an agency’s practices, allowing for a much deeper review of an agency. The practices detailed in the NIC measures alignment with the Practice Guidelines as well as health care reform as we look for alignment in context, practice and content.

In April of 2004 I went to visit a friend in Philadelphia, so I hopped on the train from New York and got off at Market East. I found myself lost and walked into 801 Market to ask for directions. One month later, I received a phone call for a job interview at CBH and was shocked to find myself at 801 again, and soon after I was hired as a senior member services representative.

I remember thinking I wouldn’t stay in Philadelphia long. Twelve years later, a marriage, a house, two babies, several promotions, a CBH family, and here I am. What started off seeming to be a coincidence turned out to be so much more. CBH has been an unexpected part of my life that I’ll always be thankful for. I don’t believe in coincidences and CBH is one of the many reasons why I never will.

-Orfelina Feliz-Payne, Director of Member Services
Provider Operations

Provider Operations comprises three branches: Provider Relations, Provider Contracting, and Network Development. Much of the early work was consumed with triage and resolution of claims issues in collaboration with the Claims Department, but over the years the department grew more distinct from Claims to increase provider support and engagement and keep up with increased state and federal requirements. Provider Contracting was created in 2016 in order to oversee the addition of any new provider or treatment service to the network and ensure proper enrollment, provider type and billing codes. Network Development has grown from just a few staff members to nearly a dozen, and has established training and technical assistance as an application rather than mandatory basis which has increased the level of provider engagement. In 2016, Network Development has more aggressively undertaken network capacity analysis, helping to identify service gaps and areas of need within the treatment continuum.

Provider Relations

Provider Relations provides customer service for the CBH provider network and comprises a group of Provider Relations representatives who are subject matter experts for each of their assigned providers. Provider Relations works closely with Claims, Clinical Management, Member Services, and other departments to ensure that the needs and in-network requirements of the providers are being met.

The Provider Relations representatives provide information to all providers as well as the DBHIDS community about covered levels of care, service locations, provider leadership, billing history, claims issues, patterns of quality concerns, provider contact information, and contract status. In addition, the Provider Relations representatives are the conduits of information for providers as they attempt to navigate the broader behavioral health system of Philadelphia. As a result, they are often called upon to answer questions raised by other departments in the system, and will research the answer if they are not immediately able to provide it. In general, providers will direct any question that falls outside their normal practice (i.e. concurrent reviews for billers, claims submissions for clinicians) to the Provider Relations representatives for assistance and resolution.

Provider Contracting

Provider Operations’ smallest unit, provider Contracting, serves as the primary point of contact for both internal and external stakeholders in relation to contract management for the CBH provider network. The team works in collaboration with other CBH departments to ensure that all the contracted services are in compliance with state standards for licensure, are aligned with proper enrollment for participation in the HealthChoices managed care program, and meet other regulatory requirements. Provider Contracting also assists agencies in developing strategies to transition grant or program-funded services into Medicaid reimbursable services via CBH.

Network Development

The primary responsibility of Network Development is to ensure that there are quality resources in the provider network to sufficiently meet the behavioral health needs of CBH members. In collaboration with other CBH departments, Network Development staff systematically identify gaps in services and develop strategies to address them. Accordingly, the Network Development unit is the single point of contact on activities related to resource development and support. All resource development and reconfiguration is completed through a procurement process. Additionally, the Network Development unit coordinates and conducts initial credentialing visits to bring providers and programs into the CBH network. Lastly, Network Development provides training, technical assistance, and evidence-based practice coordination/implementation support to providers and programs within the CBH network.

Overview of Network Development Functions

- Technical Assistance & Training
- Management of Clinical Procurements
- Evidence-Based Practice Coordination
- Technical Writing
- Network Capacity & Enhancement
Our Work

Compliance

For most of the past twenty years, the Compliance department monitored the CBH provider network with only three to four staff members. Over the past several years, Compliance has evolved significantly in the scope of the work completed by our staff. Currently, the Compliance department comprises three teams: the Special Investigations Unit (SIU), the Routine Investigations and Training Unit (RITU) and the Network Personnel Analysis Unit (NPAU). The department also includes a Compliance officer who serves a dual role as chief of staff as well as an administrative assistant who provides support for both Compliance and Network Development. Our staff comprises individuals who are not only clinically sound and diverse, but also have the strong commitment to doing and enforcing the right thing, even when the right thing is not easy.

CBH Compliance has recently assumed responsibility for the review of provider staff files as part of the delegated credentialing model. This has included the publication and regular updating of a comprehensive staff file review manual (Manual for Review of Provider Personnel Files). CBH Compliance has dramatically increased training efforts both internally and to the provider network. Externally, Compliance has re-committed to providing relevant training to our provider community around fraud, waste and abuse. Finally, CBH Compliance has piloted what may be the first effort to utilize extrapolation and statistically significant and random sampling by a Compliance unit within a PA behavioral health managed care organization (BH-MCO).

Information Services

The IS department started in August of 1994 when a consulting firm was contracted by the City of Philadelphia to develop the information technology systems for a “to be named” organization. For the first three years the two staff members titles were the “Hardware Guy” and the “Software Guy”.

When the doors opened in 1997, IS was staffed by six people. Titles did not mean much. Everyone did everything, whatever was needed. After about two years, the department grew into a proactive operation and analytical, programming and additional technical staff were added to the team. One of the early implementations was a fax system that would automatically fax out authorization letters to providers, replacing the old method of CBH mailing them. This worked well for a few years until CBH’s growth and authorization volume overwhelmed this automated faxing—how the times have changed!

Today, the IS department supports the technology-related needs of all departments within CBH. This includes applications development, systems management/administration, data management, claims processing support, encounter submission support, member eligibility support, business analysis, project management, help desk support, and network management.

Quality Management

The Quality Management Department initially started as a department of three individuals whose primary responsibility was the processing of complaints and grievances. Over the years, Quality Management (QM) has assumed responsibility of additional processes which are listed below and has grown to become a department of 22 staff who are divided into three teams: Complaints and Grievances, Provider Monitoring, and Quality Reporting.

Complaints are the mechanism by which a CBH member can file a dispute or objection regarding a participating health care provider or the coverage, operations, or management policies of CBH, while grievances are the mechanism by which a CBH member can request that CBH reconsider a denial solely concerning the medical necessity and appropriateness of a health care service. QM also participates in provider teamings, meetings of interdisciplinary groups of individuals representing CBH and, if applicable, DBHIDS, that is convened when CBH becomes aware of a significant provider-related issue(s).

QM works with Clinical Management, Network Improvement & Accountability Collaboration (NIAC), and Member Services regarding significant member incidents and member concerns when members do not want to file a formal complaint. QM also investigates whether a provider may need an action plan or quality improvement plan. Finally, QM works to evaluate CBH’s performance against the HealthChoices Program Standards & Requirements (PS&R), Independent External Review Reporting by IPRO, National Committee for Quality Assurance (NCQA) Accreditation, Certified Utilization Review Entity (CRE) Certification, and other quality improvement audits.

I have been an employee of CBH for over 17 years. Once you become a part of CBH, you become family. It is a company that provides an enriching and rewarding working experience, filled with opportunities for advancement. This company continues to evolve with each passing year, striving to place the focus on the members, and extending its outreach to the community.

-Velma Kennedy, Senior Member Services Representative
Our Work

Finance

The initial financial leadership team on day one was smaller than our current setup and consisted of a CFO, a director of Finance, and our first and current director of Claims. The Claims department consisted of only eight processors and operated at approximately 60% paper-based claims. This required that every provider check be signed by hand and resulted in thousands of pages of paper being printed and sent out twice weekly.

Finance had an eye on innovation from the very beginning. Thanks to the effort of the Claims team promoting the state’s free electronic processing software, CBH providers slowly transitioned to electronic claims processing. Today, the team of 19 claims employees processes less than 1% paper claims. The team also helped providers transition to a weekly payment setup, increasing efficiency and reducing our environmental and workload impact. Electronic claims were not the only innovative accomplishment of our Claims department. CBH also transitioned from Brahms to Xeohelth (2012-present), requiring massive manpower and a multimillion dollar vendor contract resulting in a complete revamp of the claims system and process. Claims wasn’t the only department growing as services increased, so did the need to create a reliable, high quality provider relations network. The changing financial management team had to build key relationships with the state and determine the direction to take the department to accommodate a growing organization. The financial branch of the organization had to grow and adapt as well. CBH transitioned from processing payroll for fewer than 100 employees to the over 400 we have today. Along with the 400% growth in employees, a new payroll and Human Resources system was implemented and the entire workforce successfully transitioned to electronic payroll.

The financial staff team grew to maintain the financial integrity of our records through unprecedented program growth. Administrative expenses started at $13 million the first year and were over $61 million in 2015. Medical (program) expenses grew from $224 million to $708 million. Along with increased expenses, Finance also took on a wealth of additional reporting requirements as the financial reach of the program expanded. To manage the increased reporting, the expertise of the team had to be increased. Finance currently has three certified public accountants on the team (soon to be five) and one Certified Payroll Professional (soon to be two) In addition, 12 staff have obtained a higher level of education through the tuition reimbursement program. Finance has pride in the fact that we have received positive findings, known as unqualified opinions, from our annual audits for the entirety of the program as well a positive relationship with our auditors and actuaries. This is a result of smart financial management and responsible focus on proper policies and procedures. Lastly, Finance developed the Finance Committee, which began as a high-level review group and has transformed into a powerful, information-based decision making group that reviews projections and discusses financial strategy for the organization, as well as FOCUS, a targeted decision-making group that more specifically addresses the needs of clinical and operational matters.

There were challenges, but the challenges did not paralyze us. As a matter of fact, they helped us discover who we are-by throwing off every encumbrance that so easily entangles, and allowing us to run the race that was set before us with endurance. When discouraged, we kept listening to that little voice at the end of the day that said, “I’ll try again tomorrow.”

- Emsie Bourne, Administrative Supervisor, Clinical Management

Performance Evaluation, Analytics & Research (PEAR)

The Performance Evaluation, Analytics and Research (PEAR) Department originated as the Continuous Quality Improvement (CQI) department in 2005. Using a continuous quality improvement framework, CQI initiated pay-for-performance in 2007 beginning with the development of provider profile reporting. Following a multi-year development effort, CBH inaugurated the first instance of performance pay for CBH’s providers in 2010. As the lead department on reporting of performance metrics for CBH, CQI was also responsible for the annual preparation and submission of the Program Evaluation Performance Summary (PEPS) to the Office of Mental Health and Substance Abuse Services within the Pennsylvania Department of Human Services. To delineate measurement and quality improvement efforts more clearly, state reporting responsibilities were moved to Quality Management in 2014, enabling CQI to focus on data, analysis and research. To reflect these specific responsibilities, the department was renamed Performance Evaluation, Analytics and Research.

Performance improvements rely on the use of data and measurements. Data is information about who, what, when, where, and how. Data that reflects service processes and outcomes is a major measurement area for PEAR. While every data point reflects an individual’s experience, aggregated data reflects occurrence at the program, provider, agency, or system level. By using data to inform performance improvement, we hold ourselves and our providers accountable to the population that we serve.

Currently, PEAR leads and participates in data, analytic, and research activities to support performance improvement. PEAR also collaborates with other data/analysis/research units within DBHIDS to ensure an integrated approach to inform program and policy decision-making. By providing measurement and analytical expertise, PEAR promotes data-driven decision-making to improve systems of care for CBH members and their communities. PEAR provides ongoing analytic support to multiple CBH departments, including Clinical Care Management, Member Services, Provider Operations and Quality Management Departments. Using an evaluation framework, PEAR is responsible for the following analysis activity areas that support: provider performance evaluation; program evaluation; service system evaluation; and cross-systems analytics.
Our Work

Administrative Management & Human Resources (HR)

The original staffing plan for the entire agency was 190 full-time staff (FTE), with HR operating a three-person team under the director of Administrative Management. HR’s role was initially limited to administrative functions such as benefit enrollment and recruiting. After the first director left in mid-1997, two director positions were created, with both positions reporting to the chief operating officer (COO). Shortly thereafter, assistant directors were approved for both departments, and expansion of office space dictated the expansion of staff, while the growth of the agency beyond the initial projection of 190 FTE dictated more specialized HR staff and the creation of a training director.

The office of the COO is responsible for making sure that the “wheels on the bus” don’t fall off. Several distinct functions cut across all operational departments. Emergency planning and continuity of operations are major pieces that ensure operational capacity, from making sure that IS systems are backed up and restorable in the event of a crash; migrating to a telecommuting program so that essential staff can maintain 24/7 capability during a natural disaster or national event like the Papal visit; creating and practicing evacuation plans in the event of a building emergency; and creating cloud-based infrastructure so that systems are accessible from any location. Medical record keeping and the security of protected health information are responsibilities of the Operations Support Services unit, who also create blanket authorizations for levels of care that are not actively managed by Clinical, like outpatient therapy. The COO also plays an instrumental role in the annual administrative budget development, and is responsible for the oversight of all administrative contracts.

Administrative Management is the glue that holds much of our physical infrastructure together. They ensure we have appropriate office supplies like pens and post-it notes, handle all mail operations, which range from sorting and distributing incoming mail to coordinating outgoing mail to thousands of members at a time. They work diligently to ensure that all meeting rooms are maintained, set up, scheduled accordingly, and ready for events attended by two to several hundred people. They are liaisons to building management, so that when something is broken, they know where to go to get it fixed. They handle all purchasing, manage telecommunications systems, book travel arrangements and registration for conferences, and order and set up food for various events. They play a key role in onboarding staff, distributing equipment and generating ID badges, and ensuring that work spaces are ready for new arrivals. Their work extends beyond our own staff, as they help arrange meeting locations for DBHIDS events as well.

HR plays a strategic role on many levels, starting with sourcing exceptional staff to contribute to our work. They develop and maintain performance management systems and compensation programs to ensure that our staff are recognized for achievement. Staff training, development, and benefits programs, including a dynamic wellness program, are established and maintained by HR. HR strives to balance the advocacy for employees with meeting the needs of the organization and advises executive management on best practices in employment to help create a workplace of choice.

Welfare to Work

CBH makes a good faith effort to fill 25% of non degree positions with current recipients of Temporary Assistance for Needy Families (TANF), also known as cash assistance. CBH’s commitment extends beyond the hiring process, as it does with all staff. Over the years, employees hired through this source have gone back to school through the tuition reimbursement program and taken advantage of various training programs available in their field of expertise. CBH is proud of the fact that approximately 12% of our current workforce were at one time hired through this program.

The HR team has recently reconnected with JEVS Human Services and other agencies that provide job training, and they remain committed to helping current recipients make successful transitions into our workforce. As Human Resources solidifies their departmental strategic plan they will be offering more mentoring and coaching to new hires within this group, and identifying more job development training to ensure the continued upward mobility of these valuable team members.

We were always an agency with a heart. There is always something new to learn here, be it from co-workers, providers, or members. No two days are ever alike, and no other agency can top CBH for the availability of educational opportunities in the field of behavioral health both personally and professionally.

-Hazel Carrawell, Clinical Care Management Supervisor
The Porch Light Program, a partnership between the City of Philadelphia, DBHIDS and The Mural Arts Program (MAP), shows how art can play a critical role in healing, resilience, and holistic wellness for individuals, families and our broader communities. Since 2007, MAP and DBHIDS have worked alongside behavioral health agencies and diverse communities across the city to co-create public art as an expression of community resilience. This partnership has also served as a vehicle for personal and community healing, while simultaneously transforming physical environments. Through the creation of participatory community-driven art, we offer opportunities for connection between individuals receiving behavioral health services, families, service providers, the broader community, and city government.

This process, and the connection it fosters amongst people and communities, not only increases awareness of behavioral health challenges, but it also positively influences people’s perceptions of the individuals experiencing them. For instance, over 1,000 people worked on a recent mural focused on suicide prevention. This mural united family members and friends who had lost loved ones to suicide, as well as the broader Philadelphia community. These connections are powerful forces as we all work to make our communities vibrant, healthy, and strong.

MAP has been recognized by national funders such as the Robert Wood Johnson Foundation, academic audiences, and other behavioral health leaders throughout the world who now visit us to learn how they can bring this innovative approach to their own communities.

Since 2012, Community Behavioral Health has supported Healthy Minds Philly (HMP), the Department’s public health face for behavioral health resources. HMP is an online tool and resource designed to support and improve the mental health and well-being of all Philadelphians, regardless of zip code, insurance or income status.

Intended to look and feel different than traditional government sites, HMP is a welcoming and inviting space with a full suite of wellness tools and options, including, but not limited to, an interactive community calendar, online behavioral health screenings, access to Mental Health First Aid trainings, an online cognitive behavioral self help tool, a comprehensive resources list, and more.

To date, over 90,000 people have accessed HealthyMindsPhilly.org; over 20,000 people have completed a behavioral health screening; and over 17,000 people have been trained in Mental Health First Aid, including our own employees, police officers, fire fighters, teachers, first responders, and so many others who live, work and/or study in Philadelphia.

Peer Culture and Community Inclusion Unit

As DBHIDS enters its third wave of system transformation, it is important for us to celebrate the powerful contributions made by peer support staff and people in recovery. Peer culture, support and leadership constitutes one of the ten core values of the Department’s transformation process. This element of transformation is one of the hallmarks of Philadelphia’s unique approach to population health and wellness.

DBHIDS’ Peer Culture and Community Inclusion Unit (PCCI) has the mission to lead, promote and support system transformation with the guiding principle that people with lived experiences are paramount in affecting change for others in recovery. PCCI actively models hope, wellness and empowerment throughout the behavioral health system and beyond, and promotes representation of people in recovery and family members at all levels of the system. The emphasis on the development of peer culture was and continues to be a principal driver that energizes, redefines and reinforces this new day in behavioral healthcare.
Pay-for-Performance (P4P)

Pay-for-Performance (P4P) is an initiative of CBH/DBHIDS that uses information collected from service claims and other sources to measure the quality of the services that our members receive. P4P is a payment model that rewards providers for meeting certain performance measures for quality and efficiency, rewards providers for meeting pre-established targets for delivery of healthcare services, and informs the Preferred Provider process. Service providers who achieve a certain level of quality receive a bonus payment in addition to their payment for services. CBH also uses the information collected and reported through P4P to identify areas for service improvement.

Beginning in 2007, the Performance Evaluation, Analytics and Research (PEAR) Department initiated meetings with providers to start the development of provider performance reports that include performance measures, baseline thresholds, and performance goals. Performance measures are based on national- and state-recognized standards of service quality, such as Healthcare Effectiveness Data and Information Set (HEDIS) measures, as well as CBH expectations of quality service provision.

Each of the indicators on which CBH measures the providers’ performance is aligned with the Practice Guidelines that stakeholders have identified as being essential components of a recovery- and resilience-oriented behavioral health system. P4P aligns with the tenth core value of Partnership and Transparency, and with the seventh goal, which is to promote recovery and resiliency through evaluation and quality-improvement processes. In addition, each of the P4P measures aligns with one or more of the four domains, which are: 1) Assertive Outreach and Engagement Screening, 2) Assessment, Service Planning and Delivery, 3) Continuing Support, and 4) Early Re-Engagement Community Connections and Mobilization.

Using these internal and external standards as a guide, PEAR worked with CBH clinical staff and other subject matter experts to further develop the measures for the first provider performance reports which were issued in 2009. The first incentive-based P4P awards were made in 2010 for inpatient psychiatric services, non-hospital residential rehabilitation, and residential treatment facilities for children. Each subsequent year, additional levels of care were added incrementally.

Throughout the development process, PEAR consistently asked for provider input, posting discussions, meeting summaries, presentations & baseline results on our website.

Providers’ input includes:
- Suggested measures
- Participation in focus groups
- Review & vetting of operational definitions
- Recommended differential weighting of P4P measure scores

As of 2016, PEAR evaluates provider performance for 90% of CBH services. PEAR is working with other departments throughout CBH and DBHIDS to increase the use of indicators of service quality from sources other than claims, such as the Integrated Care Program initiative. PEAR is also working with the EPIC department to develop a process for rewarding providers who use evidence-based practices. In 2017 and beyond, PEAR will continue to work with both internal and external stakeholders to CBH to redefine the P4P process in an effort to ensure quality services for our members.

Evidence-Based Practice and Innovation Center (EPIC)

EPIC was established in 2013 in order to advance system-wide efforts supporting the implementation, sustainability, and accessibility of behavioral health evidence-based practices (EBPs) in Philadelphia.

The DBHIDS Practice Guidelines assert that “a core value of The Department of Behavioral Health and Intellectual disAbility Services is that a recovery-oriented and resilience-oriented system of care is one that provides the highest quality and most effective behavioral health services to consumers and persons in recovery. As such, DBHIDS is committed to developing a system of care that is grounded in evidence-based practices.”

EPIC activities include: providing education and resources, supporting DBHIDS EBP initiatives, identifying key strategies for successful community implementation, and aligning fiscal and operational policies to optimize practice impact.

Several DBHIDS-supported EBP training and implementation initiatives have resulted in over 500 therapists from 60 programs receiving intensive EBP training. In addition, over the last three years, EPIC’s strong communications infrastructure has allowed the department to reach thousands of individuals throughout Philadelphia with information, resources and training opportunities related to EBP implementation. Looking toward the future, EPIC will focus attention on supporting the expansion and sustainability of EBPs through further alignment with referral, tracking, monitoring and financing processes within the system.
Cross-Systems Collaboration

Autism Services

In 2012, CBH designated specialized providers as Autism Centers of Excellence (COE) to address the rapidly increasing prevalence of autism spectrum disorders (ASD). The COEs are providers within the CBH network who offer a comprehensive service array, ensuring that top quality services are available for children up to 21 years old. Services include: diagnostic and assessment services, Behavioral Health Rehabilitation Services (BHRS), case management, outpatient therapy, medication management, social skills groups, summer therapeutic activities programs, and after school programs.

CBH’s commitment to offering evidence-based services is evident by the recent release of the Applied Behavior Analysis (ABA) Performance Standards. The ABA Performance Standards provide a blueprint for providers who serve children with ASD to provide high quality ABA, the gold standard in treatment for ASD. The requirements for treatment in CBH’s ABA Performance Standards exceed the State’s minimum requirements and will help to ensure the best quality of care is available for our members. CBH will be working with the provider community in 2017 to help ensure the necessary supports are in place for provision of high quality ABA services.

More recently, CBH has had significant involvement with the Philadelphia Autism Project (PAP). This project, under the leadership of former Councilman Dennis M. O’Brien, created a citywide task force to examine the quality of, and access to, services and supports for individuals and families in Philadelphia who are living with ASD. The partnership between City Council and DBHIDS on PAP continues with support from Councilman Derek Green, an original PAP stakeholder and father of a son with ASD. With several key PAP members now at CBH, our role in PAP implementation has increased, including leadership of both the Finance and Zero to Five work groups. Some of the exciting initiatives being targeted by these groups include: improving coordination of care for families with children ages birth to five, the creation of a pilot for certified peer specialists in autism, the expansion of services for adults with ASD and much more. For more information about PAP projects and events check out the website: www.phillyautismproject.org

Behavioral Health/Intellectual Disabilities Community Treatment Team (BHID CTT)

BHID CTT is designed to provide diverse services and supports to address the complex needs of individuals with mental health and intellectual disability challenges. Typical areas of need requiring BHID CTT expertise or consultation include: assessment of mental illness and intellectual disability, ruling out medical conditions, psychotherapy, psychopharmacology, positive behavior supports, effective environment, and communication challenges.

BHID CTT will also provide guidance to providers and their direct support professionals (DSPs) to enhance practical skills and supports, including coaching or modeling skills for DSPs related to assessment and observation, recovery and behavior support, crisis intervention, understanding and managing triggers, health and wellness, and community collaboration and teamwork. These are all strategies identified as best practices for individuals with co-occurring ID/DD and mental illness. CBH, the Office of Mental Health, Office of Intellectual Disabilities, and Philadelphia Coordinated Health Care meet weekly to review cases that are assigned to the team. This team will monitor and evaluate the implementation and readiness of the CTT model including providing clinical oversight and technical assistance where needed.
Cross-Systems Collaboration

Tobacco Recovery and Wellness Initiative (TRWI)

TRWI is a partnership between the Philadelphia Department of Public Health Tobacco Policy and Control Program, University of Pennsylvania’s Comprehensive Smoking Treatment Program, and the Department of Behavioral Health and Intellectual disAbilities (DBHIDS). The purpose of TRWI is to engage behavioral health providers to incorporate evidence-based tobacco dependence treatment into their clinical and community practice.

Smoking is the leading cause of death and disability for those with behavioral health issues, and smoking rates are significantly higher for this population than those of the general population. For example, 41% of Philadelphia residents with mental health conditions are smokers; nationally, persons with serious mental illnesses such as schizophrenia and bipolar disorder have lifetime smoking prevalence rates as high as 82%. We believe that people with behavioral health conditions have a right to wellness and recovery. Tobacco-free environment and cessation treatments are effective means of reducing rates of tobacco use among persons in acute inpatient psychiatric (AIP) and extended acute inpatient (EAC) settings. Therefore, we have worked with these providers to successfully implement a tobacco-free environment beginning in December 2015. By January 1, 2018, we expect that all CBH-contracted residential drug and alcohol treatment facilities will have implemented tobacco-free policies.

Community Supports Services

CBH’s Community Supports Services (CSS) Team oversees and manages service coordination for individuals who are referred to Permanent Supportive Housing (PSH). PSH is nationally recognized as the best practice for providing affordable housing and community-based services to those transitioning from residential mental health treatment settings and formerly chronic homeless individuals with disabilities. This concept is centered on the idea that an individual can live in his or her choice of permanent, quality and affordable housing, while being linked with voluntary, flexible and individualized services focused on obtaining and maintaining housing. The target populations are individuals who are referred from extended acute units, mental health residential/congregate care settings, shelters funded by the City of Philadelphia, Safe Havens, Journey of Hope and transitional programs.

The CSS Team is responsible for monitoring the ongoing delivery of behavioral health services for individuals in PSH and works collaboratively with other departments in CBH, DBHIDS, Targeted Case Management, Office of Homeless Services, and the Behavioral Health Training Unit to meet members’ needs. As of September 30, 2016, 1,347 participants have been leased in an apartment and authorized to CSS core services. Eighty-four percent are currently clinically stable, paying rent, and working towards improving their quality of life. An evaluation of service utilization and cost for a sample of individuals leased-up between CY 2012 and 2013 indicate a reduction in use of high acuity services over time, an increase in community-based service use, and a reduction in total cost of service use.

Forensic Intensive Recovery & Justice Addiction Treatment Initiatives

For over twenty years, the Office of Addiction Services (OAS) has worked in partnership with criminal justice agencies including the First Judicial District, Adult Probation and Parole, the District Attorney’s Office, Philadelphia Prison System and numerous addiction treatment providers to develop a network of justice and behavioral health projects. These projects work to divert non-violent individuals with substance use challenges from jail, as well as promote community reentry activities to link individuals to services when they return to the community.

One example of a project is Forensic Intensive Recovery (FIR), a prison deferment initiative that offers eligible participants substance abuse treatment in lieu of incarceration. The Forensic Services team works with CBH to refer participants to community-based providers for residential, intensive outpatient and regular outpatient treatment services.

Behavioral Health and Justice Related Services (BHJRS) Division, DBHIDS

BHJRS seeks to address behavioral health and justice-related issues by connecting justice-involved individuals to appropriate behavioral treatment and recovery interventions while balancing priorities of justice and public safety, as well as decreasing recidivism and improving behavioral health functioning.

BHJRS leads multiple initiatives, such as: Crisis Intervention Team (CIT) Training, Post-Arrest Crisis Screening, and expansion of the Accelerated Misdemeanor Community Court Program (AMP) capacity, a neighborhood-focused court program designed to divert lower level offenders from a standard trial track into appropriate community service and substance abuse treatment. They also enhance coordination between hospitals, courts, correctional systems, and the community through the Forensic Support Team, First Judicial District Mental Health Court (FJDMHC) Behavioral Health and Criminogenic Risk/Needs Screening, and partner with CBH’s Network Development to increase residential treatment facility slots.
Public Systems Partners

**Wellbeing**

21 staff co-located in the family and adult courts

**Education**

Programs in over 100 Philadelphia schools
3 school-based liaisons

**Family**

10 staff co-located at the CUAs and DHS

**Community**

2 CCMs co-located at Prevention Point
1 CCM co-located at Einstein’s child & adolescent Crisis Response Center

**Physical Health**

2 certified peer specialists & 2 CCMs partnered with physical health plans
6 health insurance counselors in health centers

CBH is dedicated to supporting Philadelphia’s children and families within the communities where they live, learn, work, and gather. It is not uncommon for youth and families with behavioral health needs to have the involvement of multiple systems and supports. For this reason, CBH works with a multitude of public system partners including Community Umbrella Agencies (CUAs), the School District of Philadelphia, physical health managed care organizations (PH-MCOs), Office of Homeless Services, the Courts, and the Philadelphia Department of Human Services (DHS).

**Education**: Schools are a natural community for children and families. By both co-locating therapeutic programs within schools, and enhancing relationships with providers in close proximity to schools, we are increasing opportunities for youth to access developmentally and diagnostically appropriate services. CBH has a school-based team where Clinical Care Managers (CCMs) ensure quality services and help coordinate School Crisis Postvention Responses, Interagency Service Planning Teams (ISPTs), and leadership groups around the implementation of Positive Behavioral Interventions and Supports (PBIS), Decreasing School Discipline Disparities, and the School Arrest Diversion Program.

**Wellbeing & Family**: CBH understands that youth involved in the child welfare system, on both the dependent and delinquent side, have unique treatment needs based on their experiences that have brought them to this system involvement. CBH has staff co-located at Family Court to support youth and families’ access to assessment and treatment services. They are also available to offer information on the children’s treatment continuum to the judges and advocates to help direct individuals to the most developmentally and diagnostically appropriate treatment. When DHS embarked on their Improving Outcomes for Children (IOC) initiative, CBH responded by creating a specialized Clinical Care Management Team to offer consultation and to facilitate connections for behavioral health services including evidence-based practices.

**Community**: In addition to the work that the Community Supports Services (CSS) Team conducts on housing, CBH also assists individuals who are struggling with acute behavioral health crises in the community. Two care managers visit Prevention Point, a multi-service public health organization serving vulnerable populations affected by substance use and other psychosocial issues, to help individuals gain information about and access to services. This partnership was developed in order to help address the opioid epidemic affecting Philadelphia and the nation. Additionally, one CCM visits the Einstein Crisis Response Center (CRC), the only CRC designated by the city of Philadelphia to serve children and adolescents as young as age three. The CCM conducts pre-certifications, assists with searches for treatment openings, and provides a clinical history of CBH members who present for admission. In some cases, they are able to recommend a community-based service, preventing an unwarranted inpatient admission.

**Physical Health**: CBH Health Center Insurance Counselors evaluate the eligibility of patients seeking treatment in health centers. They also help them enroll in the appropriate program and conduct follow up if needed. The Community Based Care Management (CBCM) team coordinates with Primary Care Practice (PCP) teams and provides consultation services to help improve recognition, treatment, and management of psychosocial/behavioral problems that impact medical conditions. Additional information is included on the following page.
Complex Care Management

The goal of DBHIDS’ population health approach is to enhance the well-being of our members and bring us closer to reducing health inequities in our communities. Population health addresses all determinants of health, including biological, psychological, social, environmental, and political. Initiatives such as integrated physical and behavioral health care services are considered promising steps to increasing quality of care and improving health outcomes. Integration of care is the coordination of inter-professional teams of primary and behavioral health care for a defined population in order to provide patient-centered care in a systematic and cost-effective approach. Underpinning these transformative efforts is the collection of data to evaluate performance and identify areas of clinical quality and cost improvement. In addition to partaking in numerous DBHIDS and community-led care integration initiatives, CBH has direct involvement in multiple large integrated care initiatives described below.

**Physical & Behavioral Health (PHBH) Integration**

**Integrated Care Program (ICP):** The ICP is a collaborative effort between the HealthChoices behavioral and physical health managed care organizations in Pennsylvania to improve outcomes for individuals with serious and persistent mental illness (SPMI) through enhanced care coordination between physical and behavioral health providers. Specifically, the ICP seeks to reduce emergency room utilization, reduce inpatient physical and psychiatric admission and readmission, increase the percentage of members who stay adherent to an anti-psychotic medication regimen for at least 80% of their treatment period, and increase initiation and engagement rates of alcohol and other drug dependence treatment.

**Behavioral Health Consultants (BHCs) in Federally Qualified Health Centers (FQHCs):** CBH funds and supports the model of embedding licensed BHCs in FQHC primary care settings, which serve more than 10,000 individuals per year. In this model, the BHC is available for same day consultations to assess behavioral health challenges that may impede physical health outcomes. The BHC provides brief, solution-focused, evidence-based interventions to help improve physical and behavioral health outcomes of individuals, as well as provides support and education to the primary care teams. In 2017, CBH will collect enhanced tracking of health outcomes and satisfaction of CBH members receiving services from BHCs.

**Community-Based Care Management (CBCM):** CBCM is a partnership with Health Partners (HPP) that seeks to help integrate physical and behavioral health interventions in HPP’s primary care practices for high cost utilizers. CBCM addresses both the health needs and socioeconomic barriers that physical health high-utilizing populations often face. The aim is to improve members’ quality of health, thereby reducing both the utilization of high cost health care services and the overall healthcare cost per member per year. Community health workers and a nurse care navigator were trained and placed at 10 primary care practices in North Philadelphia. CBH staff, including three care managers and two certified peer specialists, offer behavioral health care management and direct support to over 4,000 eligible enrollees.

**Special Needs Team:** Within the Clinical Management Department, the Special Needs Team works directly with PH-MCOs and high-risk members with co-occurring mental health and physical healthcare needs to ensure seamless coordination of care across both systems for over 2000 members annually.

**Care Management Transformation (CMT)**

CMT represents a fundamental shift in the way we work with members, providers, and within our own agency to impact the health of our community. CBH aims to improve the health and wellness of our members by providing the best care for the whole population at the lowest cost.

Historically, we have managed the behavioral health treatment of our members by level of care or by treatment episodes. We have re-evaluated our care management strategies, including eliciting feedback from members and providers, in order to better understand what has worked well and how we can improve our approach. Our vision is to create an efficient, data-driven system that utilizes evidence-informed practices to manage both individuals and populations and coordinate member care.

We are developing new strategies that allow us to manage cohorts of individuals with complex conditions, create streamlined efficiencies for individuals who require limited interventions, track member outcomes, and meet the needs of our members as quickly and appropriately as possible. Over the last year we have utilized pilots and made incremental changes in order to evaluate the impact of transformation efforts as they are made. Clinical care managers have been increasingly present in the community, interacting with members and collaborating with providers and other systems. Through Care Management Transformation we are: "Creating Healthy Tomorrows, Today."
A Look Back

In CBH’s first year, most of our funding went to inpatient psychiatric providers. Over the years, we have successfully changed the distribution of payments so that “Other Specialized Services” are now the largest piece of the pie. Since 1997, we have added many additional offerings in the community that have enabled this switch, including intensive outpatient treatment (IOP), specialized and targeted case management services, community integrated recovery centers (CIRCS), and many others.

Abbreviations: D&A = Drug & Alcohol, RTF = Residential Treatment Facility. "Other Specialized Services" includes Inpatient D&A, Intensive Outpatient Treatment, Community Integrated Recovery Centers (CIRCS), Assertive Community Treatment (ACT), Other Case Management, Crisis Residence, Lab Services, Adolescent Psychosis Education, Assessment, Care, and Empowerment (PEACE), and certain other specialized services.
Our commitment to investing in community infrastructure is reflected not only in the many initiatives we have described, but also in the numbers. Each year, we seek to replicate this trend, as we remain committed to providing treatment to our members in the least restrictive environment possible.
# 2015: Members Served

<table>
<thead>
<tr>
<th>Level of Care</th>
<th>Unique Members Served</th>
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<tbody>
<tr>
<td>Inpatient Psychiatric</td>
<td>12,634</td>
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<tr>
<td>Inpatient Drug &amp; Alcohol</td>
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<tr>
<td>Intensive Outpatient Drug &amp; Alcohol</td>
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<tr>
<td>Non-Hospital Drug &amp; Alcohol</td>
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<tr>
<td>Outpatient Psychiatric</td>
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<td>Other</td>
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<th>SMI Diagnosis</th>
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<td><strong>55,457</strong></td>
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DHS Address indicates member under care of Department of Human Services (undercount); SMI = Serious Mental illness defined as primary or secondary diagnosis of Schizophrenia, Schizoaffective Disorder, Bipolar Depression, Major Depression, Psychotic Disorder, or Borderline Personality Disorder.
2015: Levels of Care

CBH has an extensive network of providers that provide a multitude of services, most of which are listed below. We are especially proud to have outpatient services available at over 180 sites. Over the years, CBH has created Requests-for-Proposals (RFPs), Requests-for-Qualifications (RFQs), and Requests-for-Applications (RFAs) in order to bolster Philadelphia’s capacity to serve as many specialized needs as possible. Examples include enhancing services for: children with autism, individuals who are deaf and hard-of-hearing, survivors of traumatic events, non-English speaking individuals, and youth who are aging out of the child welfare system. Additionally, CBH monitors network distribution and increases services as needed in geographically under-served areas.

CBH, led by the Evidence-Based Practice and Innovation Center (EPIC), also seeks to increase evidence-based practice (EBP) capacity by supporting DBHIDS-sponsored initiatives including but not limited to Cognitive Behavior Therapy (CBT), Prolonged Exposure (PE), Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), Parent-Child Interaction Therapy (PCIT), and Dialectical Behavior Therapy (DBT).

- Inpatient Psychiatric Hospitals
- Extended Acute Inpatient Psychiatric Hospitals
- 23-hour Bed
- Inpatient Detoxification
- Non-hospital Detoxification
- Inpatient Rehabilitation
- Non-hospital Residential Rehabilitation
- Halfway House
- Outpatient Mental Health
- Federally Qualified Health Center (FQHC) Clinic Visit
- Partial Hospitalization
- Outpatient Alcohol and Other Drug Treatment
- Medication Assisted Treatment
- Intensive Outpatient
- Behavioral Health Rehabilitation Services (BHRS)
- School Therapeutic Services (STS)
- Community and School Support Team (CASST)
- Behavioral Health/Intellectual Disability Non-Fidelity ACT
- Laboratory Tests
- Residential Treatment Facility Accredited (RTF)
- Residential Treatment Facility Non-Accredited (RTF)
- Community Integrated Recovery Centers
- Family Services
- Blended Adult Targeted Case Management (TCM)
- Blended Child (TCM)
- Blended Enhanced (TCM)
- Assertive Community Treatment (ACT)
- Intensive Case Management (ICM)
- Resource Coordination (RC)
- Alcohol and Other Drug Intensive Case Management
- Alcohol and Other Drug Forensic Case Management
- Certified Peer Specialist (CPS)
- Crisis Residence
- RTF for Adults
- Long Term Structured Residences (LTSR)
- Residential Intensive Non-hospital Treatment
- Mobile Psychiatric Rehabilitation
- Host Homes
Looking Ahead

What Does the Future Hold?

I want to first thank the City of Philadelphia, the Community Behavioral Health Board of Directors, those who came before me, and all of the CBH staff for the opportunity to be a part of this innovative company for the past four years. When the HealthChoices behavioral health program kicked off in 1997, many of us wondered how Philadelphia’s small fledgling start-up would fare given the complexity and rigor of the program’s state and federal requirements. Twenty years later, not only is the administrative infrastructure sound and capable, CBH has become an integral part of the Philadelphia human services system, providing support to major city priorities that impact the health and wellness of all Philadelphians.

HealthChoices was able to generate reinvestment funding of over $300 million since inception of the program. Key initiatives funded by reinvestment were allocated as follows: Drug & Alcohol Services ($84m), Homeless & Housing Services ($80m), Co-Occurring Services ($11m), Sidewalk Ordinance (SWORD) ($10m), Community Development ($33m), Compact, a citywide initiative designed to improve children’s social and emotional health ($6m), School-Based Services ($10m) and most recently, Early Intervention Sustained Recovery ($15m) and Community Integration and Transitional Supports for Criminal Justice ($10m).

As our vision reflects, we aspire to be a diverse, innovative, and vibrant organization in which we are empowered to support wellness, resiliency, and recovery for all Philadelphians. As the Department’s (DBHIDS) vision suggests, we believe that every individual can achieve health, well being, and self-determination. At CBH, we believe we have a role to play in achieving that.

As such, we have identified several key strategic priorities as areas of focus over the next three to five years. The first is to diminish the impact of trauma and poverty through the provision of behavioral health screenings, early intervention, and access to an array of evidenced-based behavioral health practices and interventions for children and their families. Second, we will provide routine early identification and treatment for individuals with serious mental illness and promote recovery and wellness for individuals with addiction, autism, and mental health challenges. Collectively, our efforts will promote community tenure and family wellness. We will strive to accomplish these priorities through a robust quality management framework, data-driven decision making, accountability to our members, and an emphasis on outcomes as evidence of the impact of our interventions. This will require a committed and competent workforce, innovative financing and performance practices, and the ongoing support of our community partners.

Although the future may appear somewhat uncertain today, we will continue to work tirelessly to make a difference in Philadelphia! Happy 20th Anniversary Community Behavioral Health- here’s to 20 more!!

Joan Erney, JD
Chief Executive Officer, CBH