



A Roadmap to an Essential, Comprehensive System of Behavioral Health Care for Maryland

A Study and Recommendations by Hospital Leaders

INTRODUCTION

There is a crisis in our state, faced by an estimated one in five Marylanders: mental health and substance use disorders. Those with these chronic conditions are senior citizens, adults, adolescents, and children. They are rich, poor and middle class. Behavioral health conditions – mental health and substance use disorders – know no barriers, and they represent perhaps our greatest collective health challenge as a state and as a nation. How Maryland’s health and policy leaders respond to this challenge will determine the health care system’s ability to efficiently and effectively deliver high quality care.

In June 2015, recognizing the need for a comprehensive approach to the state’s behavioral health crisis, the Maryland Hospital Association called for the creation of a Behavioral Health Task Force, composed of hospital executives and experts in mental health and substance use disorders. This group was charged with identifying and addressing key behavioral health issues affecting Maryland’s hospitals and the communities they serve. Since inception, task force members have identified myriad complex factors that impede the effective delivery of behavioral health care. They include statutory, regulatory, practice, workforce, and budgetary barriers.

In September 2016, the task force released its first report, an assessment of the behavioral health care services provided in Maryland’s hospitals. This report, the second analysis from the task force, outlines essential features of a sustainable behavioral health care delivery system that puts patients first and is guided by evidence-based treatment practices, seamless linkages to care, and a highly-skilled, adequate workforce. This report seeks to strike a balance between universal evidence-based treatment and the innovation needed to tailor strategies based on the unique needs of Maryland’s different communities. The report, which is being shared with Maryland policymakers, behavioral health providers and stakeholders, articulates only one perspective, that of Maryland’s hospitals. There is widespread recognition that the experience, ideas and recommendations of all stakeholders – providers, payers, government, consumers, and community organizations must come together to deliver an effective, essential behavioral health treatment system for Maryland.

MARYLAND’S FRAGMENTED BEHAVIORAL HEALTH CARE SYSTEM

Maryland’s behavioral health care system is fragile, fragmented and underfunded, a crisis that did not occur overnight. Policymakers and health care providers widely agree that a coordinated and sustained effort from all stakeholders will be necessary to develop a supportive, recovery-oriented statewide system for Marylanders who have a serious mental illness or substance use

disorder. Mental health and substance use disorders are long-term and chronic – but treatable – health conditions and deserve the same attention as any medical condition. Unfortunately, when patients seek care they are faced with a shortage of qualified behavioral health practitioners and limited community-based resources. The result: they are often left in the shadows, crowding streets, jails and prisons, and hospital emergency departments, largely going without effective treatment and social services to help them to live healthier, more productive lives.

Behavioral Health Services: Needs

Maryland’s opioid crisis has been deemed a state of emergency. The number of people who died in Maryland from drug and alcohol related overdoses surged 66 percent in 2016 compared to 2015,¹ exposing the magnitude of the growing opioid epidemic and the inadequacy of available resources to stem the number of deaths. While this epidemic is challenging in and of itself, we know that Maryland also faces challenges in treating people with mental health diagnoses. Specifically, a third of the primary diagnoses driving behavioral health-related emergency department (ED) utilization are mood disorders and schizophrenia and other psychotic disorders, and another third are alcohol and drug-related disorders. An increase in ED utilization is often a proxy for lack of community-based resources and long-term care options.

What is often underestimated, or at times ignored, is behavioral health’s impact on chronic disease. More than one-quarter of adults in the U.S. experience some type of behavioral health disorder in a given year.² While 29 percent of adults with a medical condition also have some type of mental health disorder, close to 70 percent of adults with a mental health disorder have at least one medical co-morbidity.³ Both conditions often act as a driver for one another, heightening the risk that a person with a chronic disease will develop a mental health disorder and vice-versa. The presence of both mental and chronic health conditions in a patient often increases their health care costs. Patients with untreated depression and a chronic illness have monthly health care costs that average \$560 higher than those with just a chronic disease.⁴ It costs 80 percent more to treat common chronic conditions when depression or anxiety are also present.⁵ Further, this comorbidity increases impairment in functioning and decreases adherence to prescribed regimens for treatment of medical conditions.⁶ For example, depressed patients are three times more likely to be non-compliant with their medical care treatment plan.⁷

Until state and federal regulations were recently changed, health care insurers, including Medicaid, were not required to cover behavioral health services. This left patients with behavioral health conditions functionally uninsured, even as research has shown that people who are insured have better health outcomes.⁸ While health care providers, policymakers, and

¹ Maryland Department of Health and Mental Hygiene. Drug and Alcohol-Related Intoxication Deaths in Maryland 2016. Available June 12, 2017 at https://bha.health.maryland.gov/OVERDOSE_PREVENTION/Documents/Maryland%202016%20Overdose%20Annual%20report.pdf

² Johnson, S. R. (n.d.). Addressing Behavioral Health To Improve All Health. Available: <http://www.modernhealthcare.com/assets/interactive/behavioral-health#!/>

³ Walker, E. R., & Druss, B. G. (2011). Mental disorders and medical comorbidity (21). Available: https://www.integration.samhsa.gov/workforce/mental_disorders_and_medical_comorbidity.pdf

⁴ American Hospital Association. (2012). Bringing Behavioral Health into the Care Continuum: Opportunities to Improve Quality, Costs and Outcomes. Available: <http://www.aha.org/research/reports/tw/12jan-tw-behavhealth.pdf>

⁵ The Robert Wood Johnson Foundation. Mental Disorders and Medical Comorbidity. Available: <http://us.milliman.com/insight/research/health/pdfs/Chronic-conditions-and-comorbid-psychological-disorders>

⁶ Kane JM, Kishimoto T, Correll CU. Non-adherence to medication in patients with psychotic disorders: epidemiology, contributing factors and management strategies. *World Psychiatry*. Available: 2013;12(3):216-226. doi:10.1002/wps.20060.

⁷ DiMatteo, M. R., Lepper, H. S., & Croghan, T. W. (2000). Depression is a risk factor for noncompliance with medical treatment: Meta-analysis of the effects of anxiety and depression on patient adherence. *Archives of Internal Medicine*, 160, 2101-2107.

⁸ Centers for Disease Control and Prevention (2011). Fact Sheet – CDC Health Disparities and Inequalities Report – U.S., 2011. Available: <https://www.cdc.gov/minorityhealth/chdir/2011/factsheet.pdf>

government regulators^{9, 10, 11, 12} have begun to recognize that behavioral health conditions should be treated as chronic conditions with a full continuum of evidence-based, culturally-effective services, significant gaps remain.

In 2016, Medicaid patients comprised almost half of all inpatients with a behavioral health primary diagnosis.¹³ This is up from 2013 when Medicaid patients comprised 32 percent of all patients with a behavioral health primary diagnosis.¹⁴ For comparison, Medicaid covers 20 percent of all Marylanders,¹⁵ suggesting that there is a greater prevalence of behavioral health needs within the Medicaid population. Behavioral health emergency department visits reflect a similar trend, as Medicaid patients account for more than 44 percent of all emergency department visits with a primary diagnosis of behavioral health in 2016, up from 35 percent in 2013.¹⁶

Heightening the hospital crisis is a lack of placement options for children. One hospital leader recently attributed “an alarming increase” in the lengths of stay for young behavioral health patients to an inability to transfer them to more appropriate settings of care, in turn causing longer wait times in the emergency department. Some hospitals report children being hospitalized more than 100 days beyond what is medically necessary; others have experienced their entire pediatric unit being filled with behavioral health patients. Many hospitals report that when transfers of pediatric and adolescent patients do take place, they are increasingly being sent to an out-of-state facility.

In addition to pediatric and adolescent patients, hospitals are seeing patients with higher acuity and patients requiring specialized and fully integrated programs to address their needs, including: pregnant women who use substances, trauma survivors with mental health and substance use concerns, those with developmental disabilities, and the geriatric-psychiatric population.

The complexity of these patients is reflected in rising lengths of stay across Maryland’s hospitals. The average length of stay for inpatients with a behavioral health primary diagnosis is significantly higher than that of non-behavioral health patients, and the length of stay for behavioral health patients is on the rise, increasing by more than 10 percent from 2013 to 2016 for inpatients with a behavioral health primary diagnosis.¹⁷

Scarce post-discharge treatment options and social supports leave many patients in a vicious cycle where hospitals serve as the safety net, often at significant cost. However, there are costs beyond direct medical care including disability payments and lost productivity. These high costs place a heavy burden on Medicare, Medicaid, and other public insurance programs; on employers, which help pay for the health coverage of workers and their families; and on

⁹ U.S. Department of Health & Human Services (2016). Facing Addiction in America: The Surgeon General’s Report on Alcohol, Drugs, and Health. Available: <https://addiction.surgeongeneral.gov/>

¹⁰ National Institute on Drug Abuse (October 2016). The Science of Drug Abuse and Addiction: The Basics. Available: <https://www.drugabuse.gov/publications/media-guide/science-drug-abuse-addiction-basics>

¹¹ American Psychiatric Association (2013). Diagnostic and statistical manual of mental disorders (DSM- 5) (5th ed.). Arlington, VA: American Psychiatric Publishing

¹² Department of Health and Human Services, U.S. Public Health Service, National Institute of Mental Health (1999). Mental Health: A Report of the Surgeon General. Available: <https://profiles.nlm.nih.gov/ps/access/NNBBHS.pdf>

¹³ Maryland Hospital Association analysis of Health Service Cost Review Commission inpatient claims data

¹⁴ Ibid.

¹⁵ Roughly eighty-five percent of Medicaid patients receive somatic services under a managed care model, while behavioral health services are delivered fee-for-service under a “carve-out.”

¹⁶ Maryland Hospital Association analysis of Health Service Cost Review Commission outpatient claims data

¹⁷ Ibid.

households, through higher taxes and reduced wages.¹⁸ Lack of treatment amplifies these outcomes and increases the likelihood that individuals will end up homeless or incarcerated.¹⁹ These social impacts, in conjunction with treatment costs, present a significant and growing economic burden. In fact, every aspect of our health care system and every business, school and community support service is more strained today because of unmet behavioral health care needs.

Behavioral Health Services: Capacity

The few dedicated behavioral health facilities in Maryland routinely operate near or above capacity. Community-based resources like clinics and individual mental health providers are stretched to the limit (in 2014, just 14 percent of the psychiatrists listed on Maryland's health exchange were accepting new patients and were available for an appointment within 45 days).²⁰ Behavioral health patients unable to get the ongoing care they need often end up in crisis in emergency departments. From 2013 to 2016, emergency department visits by people with behavioral health needs jumped by 18.5 percent, while all other emergency department visits dropped by more than 8 percent.²¹ Patients can remain for days or weeks in hospitals, waiting for space in more appropriate settings to become available. And when space does open, it is often many miles from their homes and support systems. This problem is pronounced for psychiatric patients who, based on their age, need to be transferred to an appropriate facility but are delayed due to a dearth of appropriate capacity, such as residential treatment beds for juvenile patients and skilled nursing facility beds for geriatric patients.

The closing of state-operated psychiatric beds (state beds decreased from 4,390²² in 1982 to 950²³ in 2016) has not been offset by greater access to community-based services. Three state facilities have closed in the past decade and the remaining five state hospitals primarily serve forensic patients from the court system. This gulf between need and capacity, noted in a 2012 report²⁴ commissioned by the state, has resulted in a care delivery system with severe deficiencies. That report recommended that the state would need anywhere from 216 to 482 additional state hospital beds, depending on the level of investment made in community-based treatment. While the state has recently budgeted²⁵ for a limited increase in bed capacity, the significant pressure on acute care general and private freestanding inpatient psychiatric hospitals²⁶ to fill this gap persists.

¹⁸ The Commonwealth Fund (November 2013). *Better Care at Lower Cost: Is It Possible?* Available: <http://www.commonwealthfund.org/publications/health-reform-and-you/better-care-at-lower-cost>

¹⁹ Hogg Foundation for Mental Health/Methodist Healthcare Ministries (March 2011). *Crisis Point: Mental Health Workforce Shortages in Texas*. Available: http://www.hogg.utexas.edu/uploads/documents/Mental_Health_Crisis_final_032111.pdf.

²⁰ Mental Health Association of Maryland. (January 2015). *Access to Psychiatrists in 2014 Qualified Health Plans*. Available: <https://www.mhamd.org/wp-content/uploads/2014/01/2014-QHP-Psychiatric-Network-Adequacy-Report.pdf>

²¹ Maryland Hospital Association analysis of Health Service Cost Review Commission outpatient claims data

²² Maryland Health Care Commission White Paper: *Roles of State and Private Hospitals in the Provision of Inpatient Psychiatric Treatment* (May 24, 2017). Available: http://s3.amazonaws.com/zanran_storage/mhcc.maryland.gov/ContentPages/19187225.pdf

²³ Treatment Advocacy Center (June 2016). *Going, Going, Gone: Trends and Consequences of Eliminating State Psychiatric Beds, 2016*. Available: <http://www.treatmentadvocacycenter.org/storage/documents/going-going-gone.pdf>

²⁴ Maryland Department of Health and Mental Hygiene (May 24, 2017). *Independent Study on Future Demand for State-Operated Psychiatric Hospital Capacity*. Available: http://dlslibrary.state.md.us/publications/JCR/2011/2011_72.pdf

²⁵ To meet the requirements of the 2016 Justice Reinvestment Act the Governor provided an additional allocation of \$1.5 million to support 60 new 8-507 residential placements for individuals awaiting a court date. A.F. Whitsitt Center, a 24/7 residential treatment center for adults in Kent County was appropriated an additional \$800,000 in FY16 to restore capacity (from budget cuts in FY12) to 40 beds (up from 26). A 16-bed stepdown unit was opened at Springfield Hospital Center in 2016. Finally, a 20-bed step down unit was opened at Clifton T. Perkins in April 2017. The unit is intended for patients that are about to be released from Perkins and will not accept patients admitted directly from the community.

²⁶ Maryland's three inpatient psychiatric hospitals, known as Institutions for Mental Disease (IMDs) are Sheppard Pratt Health System, Adventist Behavioral Health and Brook Lane.

As a result, mental health and substance use disorder admissions are more likely to be readmitted, (rehospitalized within 30 days of discharge) than other types of patients. In 2016, there were 6,530 readmissions for patients who were previously hospitalized with a primary behavioral health diagnosis. The readmissions rate for these patients in 2016 was 15 percent; the readmissions rate for non-behavioral health patients was 11 percent.²⁷

The emergency departments of Maryland's hospitals are often the first to be affected when policies fail to facilitate access to necessary services. This is because a lack of adequate behavioral health services in the community leaves patients with just two options for treatment: emergency departments and jails – neither of which is a clinically appropriate setting for patients with chronic behavioral health conditions. As an example, one hospital CEO reported that on a single day, 75 percent of their facility's ED bed capacity was filled with behavioral health patients. Another hospital experienced a record 41-hour average length of stay for behavioral health patients. The ED chair at yet another hospital reported an average length of stay of 36 hours for psychiatric patients requiring transfer, nine times the average length of stay for non-psychiatric patients. This impact carries over into the length of stay for inpatient admissions, as the vast majority of these admissions, almost 70 percent, are admitted through the emergency department. The average inpatient length of stay for behavioral health patients is between five and six days, much higher than the typical length of stay for other patients.²⁸

Due to the increased lengths of stays (resulting from increased patient acuity and limited number of community providers to discharge the patient to) and an overall rise in Medicaid behavioral health admissions, available inpatient psychiatric bed capacity in Maryland's acute care hospitals has shrunk. Studies show that hospitals with bed occupancy rates exceeding 85 percent can expect regular bed shortages, periodic bed crises, and difficulty in providing timely access to care.²⁹ In 2016, the average acute care occupancy rate for staffed psychiatric beds for individuals with a behavioral health primary diagnosis was 99.9 percent, a 4 percent increase from 2013 to 2016.³⁰

This problem impacts the state budget and, more importantly, patients. First, the state often pays well beyond what it would need to if patients could be directed to appropriate community-based behavioral health providers, with inpatient services costing more than \$2,000 a day; for a child hospitalized 100 days or longer, total costs can approach a quarter of a million dollars. Second, hospital care for non-behavioral health patients can be compromised without efficient and appropriate transfers of behavioral health patients. In short, failure to support adequate capacity for this specific patient population has a ripple effect across all Maryland communities.

THE PROCESS

In December 2016, the task force began work to: identify essential components of a robust behavioral health treatment system; explore and evaluate gaps and vulnerabilities in the continuum of care; and develop concrete proposals to improve the delivery of behavioral health services.

²⁷ Maryland Hospital Association analysis of Health Service Cost Review Commission inpatient claims data

²⁸ Ibid.

²⁹ GE Healthcare. Capacity Strategy: The Science of Improving Future Performance. Available: http://partners.gehealthcare.com/12-03-12-Capacity_Strategy_The_Science_Of_-WP-1012_r3.pdf

³⁰ Maryland Hospital Association analysis of Health Service Cost Review Commission inpatient claims data and data presented in the Maryland Health Care Commission's *Annual Report on Selected Maryland General and Special Hospital Services, Fiscal Year 2017*

To support this effort, members, relying on evidence and data, wholly reimagined Maryland's continuum of care and explored solutions, while recognizing current workforce challenges. Members examined ways to leverage the scattered pockets of innovation already underway. This work was performed understanding that the development of the next phase of Maryland's All-Payer Model demonstration is rapidly progressing and the next version of the demonstration is expected to hold Maryland's hospitals accountable for controlling the total cost of care within Maryland's communities.

The recommendations in this report are meant to identify core elements of an essential treatment system for patients in need. The concept of an essential treatment system is an evidence-based, high-quality, integrated behavioral health care delivery model for Maryland. It is supported by an abundance of research and aligns with recent recommendations of federal agencies³¹ and the plurality of medical professional organizations.

This work has been guided by the following consensus statement and guiding principles:

Consensus Statement

An essential treatment system for those with behavioral health concerns provides a full range of culturally-effective and evidence-informed or evidence-producing services. Behavioral health care provision is addressed in a holistic manner that achieves the Triple Aim: healthier communities, better experiences for patients, and lower costs. The system is consistent with other chronic disease models and the expectation is that health-based services will be provided and paid for across a continuum of community-based primary and secondary care, including social services.

Guiding Principles:

- Behavioral health services seek to improve overall well-being by preventing mental illness or substance use disorders (alcohol or drug abuse) and/or caring for patients with these conditions
- An innovative system will provide integrated, coordinated and outcome-based care
- All care will be informed by the dynamics affecting the greater health care system
- High quality providers recognize and fulfill their unique role in the continuum of care and are not expected to devise strategies to support the entire continuum
- Every patient will utilize hospital services when necessary and have access to care in the community that improves physical and behavioral health outcomes
- A spectrum of interventions will be utilized to engage patients based on population, geography, access to social supports and other appropriate factors
- Improved patient outcome measures will be achieved by supporting various treatment services and supports
- Care will improve patient engagement and satisfaction and be delivered in a system that is effective and efficient

³¹ U.S. Department of Health & Human Services (2016). Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health. Available: <https://addiction.surgeongeneral.gov/>

AN ESSENTIAL TREATMENT SYSTEM FOR BEHAVIORAL HEALTH

An ideal treatment system for all health concerns employs processes, programs and engagement tools to prevent chronic disease. When prevention is not successful, the system identifies and addresses the disease or condition as early as possible to generate better health outcomes, decrease secondary sequelae, and reduce utilization of more invasive and expensive services. In this context, an essential behavioral health treatment system provides a continuum of high-quality health and social support services, all of which promote physical and behavioral health.

An individual who touches any part of this health care system should receive or be transferred to appropriate prevention, early intervention, secondary prevention, formal and informal treatment, and acute and post-acute care services. All services should be geared toward achieving the Triple Aim. As with all other health conditions, geography, race, ethnicity, class, financial resources, transportation, literacy, and other important factors play vital roles in access to care and in outcomes for patients.

An essential behavioral health treatment system will have several indispensable components; still others should be tested, researched and, if proven effective, added to the system. It is natural that the way systems innovate and evolve to provide these services will vary based on available resources, geography, patient demographics, the type and severity of behavioral health concerns, community capacity for primary and behavioral health services, and other factors.

This paper offers the following recommendations for an essential treatment system for behavioral health, recognizing that jurisdictions will tailor their efforts to meet the resource realities and unique needs of their local communities:

- 1. Provide all patients with behavioral health screenings and, if necessary, referrals, as part of their routine care, regardless of setting.**
- 2. Create the infrastructure needed to provide immediate access to care for those experiencing a behavioral health crisis.**
- 3. Integrate and coordinate behavioral health care so it is delivered in the appropriate setting.**
- 4. Invest in the highly skilled workforce and physical capacity needed to proactively manage behavioral health conditions.**
- 5. Invest in and make available prevention and harm reduction services like syringe exchanges and mental health first aid.**

Ideally, all systems should adhere to evidence-informed, consensus-driven guiding principles, be developed within the context of existing regulations, and leverage existing innovations. Each recommendation is summarized in the following section.

RECOMMENDATIONS TO SUPPORT DEVELOPMENT OF MARYLAND'S ESSENTIAL TREATMENT SYSTEM

RECOMMENDATION 1

Provide all patients with behavioral health screenings and, if necessary, referrals, as part of their routine care, regardless of setting.

Immediate Steps

- Protocols should be adopted to implement behavioral health screenings and subsequent referrals to community-based providers
- State agencies should be funded to support widespread adoption of screening models
- Statewide and local training, education and forums should be developed to share best practices and policies
- State and local health departments should identify and make available to local providers community-specific referral resources
- MHA should convene stakeholder partners to explore opportunities to support a modernized approach to appropriate and timely patient transfer and referral

Roadmap

All patients who present in the health care system should be screened; ideally screening also occurs in schools and senior living facilities, to ensure appropriate referral to treatment before an emergent health care event. Different screening tools could be used depending on a patient's clinical context. Diagnostic tools such as medical history, exams, and laboratory results could be used for patients who present more overtly. Maryland has experience with Screening Brief Intervention and Referral to Treatment (SBIRT) under a five-year Substance Abuse and Mental Health Services Administration (SAMHSA) grant to integrate SBIRT in community clinics and hospital emergency rooms. The tool aims to identify moderate or high-risk patients who do not present overtly. Screenings could be conducted by hospital staff or by community-based providers under contract with hospitals. Hospitals that have experience with universal screening using SBIRT or other tools can share best practices with other hospitals. It should be noted, that depending on hospital and community capacity, the ability to refer patients can be a significant challenge. Therefore, MHA will work with stakeholder partners to identify regional and/or statewide approaches to provide an "air traffic controller" -like system that can support appropriate and timely patient placement, which could include real-time bed inventory tracking and scheduling capabilities.³²

Rationale

Early screening for mental health and substance use disorders allows for earlier diagnosis, limiting more expensive sequelae of untreated diseases. As such, universal screening should be at the core of an essential treatment system. Advocate Health Care, based in Chicago, has been conducting mental health screenings within its primary care physician practices as well as screening all emergency department and hospital inpatients. In 2012 they found that 26 percent

³² A modernized system is ideally based on electronic interconnectedness in the form of secure HIPAA-compliant, easy-to-navigate, web-based interfaces and community partner portals to support communication between providers and support agencies.

of their medical inpatients had a behavioral health issue, which amounted to approximately \$26 million a year in excess health care costs and added to their length of stay by an average of 1.07 days. SAMHSA reports that people who received screening and brief intervention in an emergency department, hospital or primary care office experienced 20 percent fewer emergency department visits, 33 percent fewer nonfatal injuries, 37 percent fewer hospitalizations, 46 percent fewer arrests and 50 percent fewer motor vehicle crashes.³³ Multiple studies have shown that investing in SBIRT can result in health care cost savings that range from \$3.81 to \$5.60 for each \$1 spent.³⁴

RECOMMENDATION 2

Create the infrastructure needed to provide immediate access to care for those experiencing a behavioral health crisis.

Immediate Steps

- Recommendations from state and local work groups to address gaps in Maryland’s crisis response systems should be implemented and evaluated
- Development of additional models, such as regional dedicated emergency psychiatric facilities should be explored
- Explore the need to clarify or revise regulatory and statutory provisions that prevent individuals from bypassing the ED and going directly to appropriate care sites

Roadmap

Crisis services are an essential component of any comprehensive system of behavioral health care. They significantly reduce behavioral health crisis and offer earlier intervention to stabilize crisis more quickly and at the lowest level of care appropriate. However, Maryland’s system is a fragmented patchwork of unfunded and underfunded services, where the hospital ED often becomes the default point of access. Systematic reform of crisis care has been or is being implemented in a number of states including California, Colorado, Georgia, and Washington. These states were driven to new approaches for different reasons, yet their approaches share common elements including: regional or statewide crisis call centers,³⁵ centrally deployed mobile crisis available 24/7, and crisis stabilization.³⁶ In Maryland, crisis service models that contain these core components will be developed and tested at local³⁷ and regional levels where there is shared ownership and accountability across local government, providers, law enforcement and other community stakeholders.

³³ SAMHSA-HRSA Center for Integrated Health Solutions. SBIRT: Screening, Brief Intervention, and Referral to Treatment: Opportunities for Implementation and Points for Consideration. Available: https://www.integration.samhsa.gov/SBIRT_Issue_Brief.pdf

³⁴ Ibid.

³⁵ In model programs, call centers serve as the “front door” for crisis services and use technology for real-time coordination across a system of care.

³⁶ Crisis stabilization programs offer short term “sub-acute” care for individuals who need support and observation, but not ED holds or a hospital inpatient stay.

³⁷ For example, Behavioral Health System Baltimore, Inc. has begun a crisis system planning process for Baltimore City and has reached out to MHA for participation. This plan is anticipated to address the full range of crisis service needs for adults and youth and will include centralized coordination, mobile crisis team expansion, urgent care services, and police and EMS diversion.

Maryland's Heroin & Opioid Prevention Effort (HOPE) and Treatment Act of 2017 requires the establishment of at least one crisis treatment center by June 1, 2018.³⁸ The center is required to provide individuals who are in a mental health or substance use disorder crisis access to clinical staff to perform assessments and determine the appropriate level of care 24 hours a day, seven days a week, and then immediately connect the individual to that care. Additionally, the Act requires the state to create a 24-hour hotline for patients, family, and/or providers to obtain information on where to access crisis care. Further, the Behavioral Health Advisory Council was charged with developing a strategic plan, submitted to the General Assembly in November 2017, which ensures that clinical crisis walk-in services and mobile crisis teams are available statewide and operating 24 hours a day and seven days a week. That report outlined eight recommendations to address gaps in Maryland's behavioral health crisis services. MHA will support efforts to develop *additional* and strengthen *existing* crisis services with the goal of a comprehensive and connected statewide system. In addition to participating in of the work of the aforementioned groups, MHA will prioritize exploration of additional structures, such as regional dedicated emergency psychiatric facilities and regulatory and statutory changes that may be necessary to fortify Maryland's crisis infrastructure.

Any model must address the Maryland Institute for Emergency Medical Services Systems requirements that EMS providers take all patients to the ED as well as current interpretation of requirements regarding the location at which an individual must be psychiatrically evaluated when detained on Emergency Evaluation Petition.³⁹ Additionally, there is a need to create a more robust community provider network as crisis centers will become overcrowded with long lengths of stay (just like EDs) if there is nowhere to send patients after stabilization. Community providers must be incentivized to take patients quickly and during non-traditional hours. For full implementation, payers must establish rates and reimburse for crisis services at the appropriate level.

Rationale

Crisis services are a spectrum of services provided to individuals experiencing a behavioral health emergency. There is evidence that crisis stabilization, community-based residential crisis care, and mobile crisis services can divert individuals from unnecessary hospitalizations and enable patients to receive treatment in less restrictive settings.⁴⁰ The specific crisis response will depend on the patient and the specifics of the crisis episode. There are different models across the country that provide timely assessment and transitions for those in a behavioral health crisis. For example, the Alameda County (California) Psychiatric Emergency Services model offers a stand-alone psychiatric hospital with a crisis stabilization unit that accepts referrals from emergency departments, as well as directly from EMS providers. Over a 30-day period in 2015, a study demonstrated that emergency department boarding times decreased by 80 percent and the dedicated psychiatric ED admitted 24 percent of the patients seen while discharging 75.2

³⁸ HOPE Act of 2017, Chapter 572, http://mgaleg.maryland.gov/2017RS/chapters_noln/Ch_572_sb0967E.pdf

³⁹ Maryland Code, Health-General Article §10-624 requires that individuals subject to a petition for an emergency mental health evaluation (aka EP) be taken to the closest emergency facility. Currently the only facilities that have been interpreted as meeting the definition of "emergency facility" under the Health General §10-620 are hospitals with emergency rooms.

⁴⁰ SAMHSA, 2014. Crisis Services: Effectiveness, Cost-Effectiveness, and Funding Strategies. Available: <https://store.samhsa.gov/shin/content/SMA14-4848/SMA14-4848.pdf>

percent.⁴¹ SAMHSA has identified evidence-based and cost-effective services that should be considered in a crisis service model: 23-hour crisis stabilization/observation beds, short-term crisis residential stabilization services, mobile crisis services, 24/7 crisis hotlines, peer crisis services, and warm (peer-run) lines.⁴² Additional services that should be considered are withdrawal management programs, a laboratory, pharmacy, and radiology.

RECOMMENDATION 3

Integrate and coordinate behavioral health care so it is delivered in the appropriate setting.

Immediate Steps

- Community providers and hospitals should work together to create strategic partnerships initiated by the understanding of local providers' quality and service capabilities
- Standard hospital discharge protocols and uniform treatment plans should be developed in consultation with clinical leaders and experts
- Public and private payers should support the expansion of needed behavioral health services, including telehealth services
- The state should address disparities in billable services and reimbursement rates for mental health and substance use disorder services
- The state should support the sharing of data on Medicaid patients who are receiving behavioral health services

Roadmap

Integrating behavioral and physical health care services across the care continuum helps create a seamless system of care that offers patients the services they need, when they need them, whatever setting they are in. Achieving integration requires networks or partnerships with community stakeholders — other hospitals or health systems, clinics, social service agencies, and local and state organizations — to coordinate care and the implementation of alternative payment models to sustain needed services. Partnerships will feature clearly-stated goals and desired outcomes, along with data collection to assess progress. Each health care organization has to develop its own plan for integrating behavioral health, driven by community needs and available resources. MHA will work with community provider groups to identify standard data elements that should be collected and shared to inform these strategic decisions. The decision to be a direct provider of behavioral health services or to provide these services via collaborative partnerships, joint ventures or contractual arrangements will be driven by community needs and available resources. Workforce shortages make programs difficult to scale, therefore investments in provider capacity must be prioritized and existing infrastructure and availability of high quality community providers must be leveraged.

Case management will be an integral part of the health care system, ensuring patients can navigate the complex system and receive the care they need. There are existing programs in the state that hold promise and could be expanded. One example is Maryland Medicaid Health

⁴¹ Zeller, S., Calma, N., & Stone, A., *Western Journal of Emergency Medicine* (2014). Effects of a Dedicated Regional Psychiatric Emergency Service on Boarding of Psychiatric Patients in Area Emergency Departments, 15(1), 1–6. <http://doi.org/10.5811/westjem.2013.6.17848>

⁴² SAMHSA, 2014. Crisis Services: Effectiveness, Cost-Effectiveness, and Funding Strategies. Available: <https://store.samhsa.gov/shin/content/SMA14-4848/SMA14-4848.pdf>

Homes, which targets populations with behavioral health needs at high risk for additional chronic conditions. Through this program, patients are offered enhanced care management services from their regular providers, including psychiatric rehabilitation programs, mobile treatment, and opioid treatment programs.⁴³

Statewide, hospital and community case management and care coordination providers will need to collaborate with local social support services to provide the services necessary to stabilize patients' lives and improve health outcomes upon discharge. MHA will work with hospitals to develop evidence-informed recommendations for core components of a standard discharge protocol for patients treated for a drug overdose or identified as having a substance use disorder. These will be shared with all hospitals for adoption.⁴⁴ Services included in a discharge protocol and treatment plan will need to be covered by payers and the state for activities to be sustainable and successful.^{45, 46} The lack of parity across mental health and substance use disorder benefits undermines the integration of behavioral health services and care to individuals with co-occurring disorders who enter treatment through the substance use disorder door. Disparities between services that may be billed for substance use disorders and mental health services and the reimbursement rate for comparable services must be remedied.

Strategic partnerships and state purchasing contracts should include real-time information sharing across systems to ensure that relevant information is available to all members of the care team. Therefore, hospitals and community providers will utilize CRISP, the state health information exchange, to upload and share patient care coordination information, including longitudinal treatment plans. Payers, including Medicaid, will facilitate data-sharing and encourage care coordination, including more accountability for these functions and subsequent health outcomes from the state's managed care organizations and behavioral health administrative services organization. All payers should ensure competent provider networks and mechanisms for assessing and rewarding high-quality care.

Rationale

Integrating physical and behavioral health services throughout and across the continuum of care, while partnering with community stakeholders to expand access to appropriate behavioral health services in the least restrictive setting, can help hospitals and health systems achieve Triple Aim goals. There is widespread agreement that hospitals cannot and should not be the primary providers for patients with chronic diseases; however, for patients presenting in hospital emergency departments with behavioral health concerns, this is often the case. The preferred approach when a patient presents in an acute care hospital is that hospitals work with community-based partners to ensure patients continue behavioral health treatment plans and are

⁴³ Maryland Medicaid Health Homes. Available: <https://mmcp.health.maryland.gov/SiteAssets/SitePages/Healthy%20Homes/Maryland%20Medicaid%20Health%20Homes-%201%20pager%2011.13.15.pdf>

⁴⁴ As part of the Heroin & Opioid Prevention Effort (HOPE) and Treatment Act of 2017, by January 1, 2018, hospitals are required to create and share discharge protocols for patients treated for a drug overdose or identified as having a substance use disorder. HOPE Act of 2017, Chapter 572, http://mgaleg.maryland.gov/2017RS/chapters_noln/Ch_572_sb0967E.pdf

⁴⁵ Beginning January 1, 2017, Medicare will make separate payments to physicians and non-physician practitioners for behavioral health integration services they furnish to beneficiaries over a calendar month service period, using four new Medicare Part B billing codes.

⁴⁶ Behavioral Health Integration Services. (May 2017) Medicare Learning Network. Centers for Medicare and Medicaid Services. Available: <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/BehavioralHealthIntegrationPrint-Friendly.pdf>

discharged back to community settings. A 2007 study of the Blue Shield of California Case Management Program targeting those with complex or advanced illness showed that care coordination and support led to a 38 percent reduction in hospital admissions. Further, using an integrated care approach will allow for better patient outcomes as observed in the Hennepin County Medical Center's Coordinated Care Center in Minneapolis, Minnesota. This integrated onsite primary care clinic utilizes an Accountable Care Organization shared savings model to provide primary care, behavioral health services, care management, medical treatment management, and assistance to address social needs for patients with complex health profiles at risk of frequent hospitalizations.⁴⁷ The program led to a 38 percent decrease in ED visits, a 25 percent decrease in hospitalizations and a per patient cost savings ranging from \$3,100-\$24,170.⁴⁸

RECOMMENDATION 4

Invest in the highly skilled workforce and physical capacity needed to proactively manage behavioral health conditions.

Immediate Steps

- The state should conduct a study on the necessary supply of physicians and other behavioral health providers and physical capacity necessary to address the crisis, including mapping by jurisdiction where resources exist and recommendations to address deficiencies; recommendations should include opportunities to streamline licensure and credentialing processes, increase interest in joining the behavioral health field, and enhance education and training to promote integrated care
- The Certificate of Need process should be modernized to address the lack of available hospital and community capacity for behavioral health services

Roadmap

A multi-stakeholder group including state officials, providers, behavioral health patients and families, payers, and others will be convened to determine Maryland's behavioral health workforce needs (both clinical and non-clinical). The effort will take into account prevalence of different conditions, an understanding of how many current providers exist and accept insurance, current reimbursement, an outline of how long it takes to develop new practitioners and staff extenders, and opportunities to streamline and expedite the licensure and credentialing processes at relevant health care boards. Efforts to identify training requirements for certified behavioral health peer workers as well as opportunities to expand the use of telehealth can also alleviate a strained workforce. MHA will convene members to consider ways to modernize the state planning process to expedite the development of additional behavioral health treatment capacity in the state and share recommendations with the Maryland Health Care Commission, the Health Services Cost Review Commission and legislative leadership.

⁴⁷ Hostetter, M., Klein, S. & McCarthy, D., The Commonwealth Fund (October 7, 2016). Hennepin Health: A Care Delivery Paradigm for New Medicaid Beneficiaries. Available: <http://www.commonwealthfund.org/publications/case-studies/2016/oct/hennepin-health>

⁴⁸ Henkel, A. & McCarthy, N., ECG Management Consultants (January 4, 2016). Rethinking Care for Emergency Department Super Utilizers in a Value-Based World. Available: <http://www.ecgmc.com/thought-leadership/articles/rethinking-care-for-emergency-department-super-utilizers-in-a-value-based-world>

Rationale

Maryland has an inadequate supply of behavioral health practitioners to meet the growing demand. The existing workforce is aging, and care conditions and low reimbursement cause many to leave the field or stop accepting insurance, limiting access to those who need it most. The scarcity of psychiatrists, addiction medicine doctors, nurse practitioners, therapists, counselors, social workers, and physician assistant prescribers limit both hospitals' and community providers' ability to offer some forms of evidence-based care. In addition to a significant increase in the clinical workforce, non-clinical workers such as peer recovery specialists can be helpful to manage the needs of this population. Building a workforce that includes all levels of practitioners and paraprofessionals will take time and is the responsibility of the state, with input from a diverse group of stakeholders.

Workforce development must be coupled with an examination of what physical hospital capacity is needed (both inpatient and outpatient), as well as the capacity of community clinics and other ambulatory support services. Closures of state and community facilities leave those with behavioral health conditions with only two places to receive care: emergency departments and jails. Hospitals are responsible for patients not only during a hospital stay, but beyond, as hospitals work to reduce readmissions and manage the total cost of care. If there was adequate community support, there would be less need to expand hospital services in a global budget environment. The need to modernize the state planning process, taking into account current views on capacity and need in light of an evolving care delivery system, has never been as pressing as it is now.

RECOMMENDATION 5

Invest in and make available prevention and harm reduction services like syringe exchanges and mental health first aid.

Immediate Steps

- State or local health departments should create a local directory of prevention services such as syringe exchange programs, housing sites for the homeless, naloxone distributors, and mental health first aid training
- Federal and state funding should support local harm reduction and prevention services, including naloxone for distribution in hospitals
- Providers should enhance access to naloxone for high-risk patients via specific prescribing and distribution policies

Roadmap

Even though patients are not in treatment, it is important to meet patients where they are, to educate them, their family members, and/or their caregivers about behavioral health illnesses, when to seek care, what emergencies look like, and how they should be treated. Providers should be aware of the existing services in their community and partner as appropriate to ensure referral procedures are effective in decreasing potentially avoidable utilization. It should be noted that initial investments are necessary to develop new harm reduction/secondary prevention services or expand current programs, therefore state funding will be needed to ensure sustainability.

Maryland's hospitals will implement protocols to ensure patients who present with an overdose receive a prescription for naloxone.

Rationale

In behavioral health care, the purpose of secondary prevention is to keep patients healthy even if they are not in formal behavioral health treatment. Without secondary prevention services, patients may experience dangerous sequelae from their untreated mental health or substance use disorders, including but not limited to criminal justice issues, sexually transmitted illnesses, estrangement from family and community, job interruptions or job loss, homelessness, suicide, or trauma.⁴⁹ One harm reduction activity, syringe exchange, has been shown in research and practice to significantly reduce the spread of HIV, to engage people in social services, and to engage them in treatment without encouraging an increase in drug use.⁵⁰ Relying on data from existing naloxone distribution programs, researchers found that for every 20 percent of people who use heroin in a population treated with the drug, about 6.5 percent of overdose deaths could be prevented.⁵¹ Similarly, the Maryland Early Intervention Program offers integrated and specialized programs with expertise in the early identification, evaluation, and comprehensive psychiatric treatment of adolescents and young adults at risk for, or in the early stages of, a mental illness with psychosis. Collection of information about Adverse Childhood Experiences (ACEs) through Maryland's Youth Risk Behavior Survey would inform efforts to mitigate the serious, long-term impacts on a child's health including the risk for alcoholism, depression, and dozens of other illnesses and unhealthy behaviors.⁵² Further, Mental Health First Aid training, recognized by SAMHSA as an evidence-based program and practice, was found to increase participant recognition of mental illnesses, concordance with primary care physicians about treatments, confidence in providing first aid, actual help provided to others, and a reduction in stigmatizing attitudes.⁵³

⁴⁹ Young, J.L., Psychology Today (December 30, 2015). Untreated Mental Illness: Understanding the effects. Available: <https://www.psychologytoday.com/blog/when-your-adult-child-breaks-your-heart/201512/untreated-mental-illness>

⁵⁰ World Health Organization (2004). Evidence for Action Technical Papers: Effectiveness of Sterile Needle and Syringe Programming in Reducing HIV/AIDS Among Injecting Drug Users. Available: http://www.who.int/hiv/pub/prev_care/effectivenesssterileneedle.pdf

⁵¹ Szalavitz, M., Time.com (January 2, 2013). Study Supports Benefits of Naloxone in Treating Drug Overdoses: Study shows naloxone effective for treating overdose. Available: <http://healthland.time.com/2013/01/02/study-supports-benefits-of-naloxone-in-treating-drug-overdoses/> and National Institute on Drug Abuse (revised September 2016). Opioid Overdose Reversal with Naloxone (Narcan, Evzio). Available: <https://www.drugabuse.gov/related-topics/opioid-overdose-reversal-naloxone-narcan-evzio>

⁵² Anda RF, Whitfield CL, Felitti VJ, Chapman D, Edwards VJ, Dube SR, Williamson DF. Adverse childhood experiences, alcoholic parents, and later risk of alcoholism and depression. *Psychiatr Serv.* 2002;53(8):1001–1009 and Dube SR, Felitti VJ, Dong M, Chapman DP, Giles WH, Anda RF. Childhood abuse, neglect and household dysfunction and the risk of illicit drug use: The Adverse Childhood Experience Study. *Pediatrics.* 2003;111(3):564–572.

⁵³ National Council for Behavioral Health. Mental Health First Aid Efficacy: A Compilation of Research Efforts. Available: <https://www.mentalhealthfirstaid.org/cs/wp-content/uploads/2013/10/MHFA-Research-Summary-UPDATED.pdf>

A LOOK AHEAD

To improve Maryland's fragmented behavioral health care infrastructure, policies and practices that address inadequate community behavioral health infrastructure and capacity must be developed. Effective solutions depend on the development of new high-quality providers and community networks, as well as the support of current quality providers so they can thrive in this challenging environment and play a role in ongoing innovation. To achieve this, significant barriers must be overcome. Among them: low reimbursement for behavioral health services; a dearth of providers, especially those that take insurance; and a certificate of need process that can inhibit adding appropriate capacity in a timely manner.

Also, there are many unknown factors that will affect the health care landscape in the months and years ahead. First, Maryland's budget is precarious. Though the governor has pledged additional funding to address substance use disorders, this money is to be used specifically for the opioid crisis and does not address the broad care delivery infrastructure to meet all behavioral health needs.

Second, unknown but expected federal policy changes may further impact coverage and affordability of care. This uncertainty comes at a time when Maryland's hospitals, state regulators, and political leaders are coordinating with federal agencies to develop the next phase of our All-Payer Model demonstration, where the focus on financial targets will shift from hospital-only savings to "total cost of care" savings, which captures spending for all health care providers in Maryland.

These factors necessitate immediate action by state government, clinical providers, community partners, payers and consumers to come together in support of the investments needed to create a comprehensive system for behavioral health care and recovery. This work is a long-term proposition, one that requires a sustained focus to ensure the infrastructure is able to adjust to support the needs of this population.