COMMUNITY BEHAVIORAL HEALTH

CBH

ASSOCIATION OF MARYLAND

March 2, 2015

Donna Kinzer, Executive Director
Maryland Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Ms. Kinzer:

CBH is the professional association for Maryland's network of community-based programs serving the great majority of the 160,000 children and adults who use the public mental health system. Our member agencies operate outpatient clinics, case management services, rehabilitation programs, and a variety of housing, vocational, crisis, and related support services that help people stay out of hospitals and participate in community life as productively as possible.

Data from the Health Services Cost Review Commission (HSCRC), the Department of Health and Mental Hygiene, and the Agency for Healthcare Research and Quality (AHRQ), among other sources, support the fact that behavioral health conditions contribute to longer hospital stays, more frequent readmissions, higher healthcare costs and worse health outcomes. This holds true to varying degrees across all payers. Given the critical role behavioral health will play in the success of the new Medicare waiver, our member organizations thought it important to share our thoughts on care coordination with the Commission.

Individuals with behavioral health conditions present distinct challenges in terms of care coordination. They often receive substandard primary care from practitioners who are not well trained in behavioral health or who are uneasy around individuals with behavioral health diagnoses. Unfortunately, it is not unusual to have serious somatic conditions overlooked or attributed to delusional thinking. Further, individuals with behavioral health conditions often mistrust the medical profession and refuse to visit a primary care practitioner, even if they have access through Medicare or Medicaid coverage. And finally, those with behavioral health conditions are often dealing with other challenges, such as homelessness and poverty, that make it more difficult to adhere to medication and other treatment regimens.

This population is not likely to benefit from telephonic or infrequent care management interventions. Many require daily visits – sometimes two or more times per day - for med management and other necessary interventions. This is not a group that can be easily managed from a primary care practitioner's office or through hospital-based outreach. A strong, trusting relationship must be established in order to impact health outcomes and alter utilization of the

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health care system. Fortunately there is a comprehensive continuum of community-based behavioral health services that exists in Maryland that can serve this population and positively impact their health outcomes. The challenge is in educating hospital staff of the array of services available and implementing engagement, tracking, and evaluation systems to ensure that interventions are timely and effective.

There are currently some partnerships between hospitals and CBH members that are showing very promising results, particularly in reducing 30-day readmissions for both somatic and psychiatric reasons. These partnerships utilize behavioral health services, such as intensive case management and assertive community treatment (ACT), that use a team approach and engage individuals who historically have not been well served in traditional facility-based settings. At least one of the partnerships focuses on diverting children and adolescents from emergency departments (EDs) and inpatient stays. These partnerships should be identified and assessed, and if shown to be effective and cost-efficient, expanded and replicated.

In addition, CBH offers the following suggestions to the HSCRC to assist in meeting the waiver requirements and to promote better health outcomes for individuals with behavioral health needs:

- **Allow for hospital in-reach by behavioral health staff prior to discharge.**
  Outpatient mental health clinics indicate that between 50% and 80% of referrals from hospitals fail to make or keep their initial appointments. Without medication or needed treatment, these individuals have a high risk of readmission into the hospital. One way to increase the likelihood of client follow up is to allow behavioral health staff to establish a relationship with the individual prior to discharge from the hospital. An evaluation and other engagement activities could be conducted face-to-face or via telemedicine by a licensed therapist and/or case management staff. It should be noted that there may be same-day billing prohibitions that currently preclude this practice. There may also be limitations on the use of telemedicine by certain payers.

- **Expand the availability of residential crisis beds.**
  Residential crisis beds serve individuals who are in or at imminent risk of psychiatric crisis. They serve as an alternative to an ED visit or inpatient stay. They also function as step downs from inpatient care for individuals no longer needing an inpatient level of care but who are not ready to return to their former environment (or perhaps have no housing to return to). Hospitals – and in particular, EDs - have been increasingly using this service. However, the demand for crisis beds far outweighs capacity. Additional crisis beds should be made available through public sector funding or via private contracts with hospitals.

- **Expand the use of health homes.**
  The Affordable Care Act allowed state Medicaid programs to create chronic health homes for individuals with serious mental illnesses. Maryland's program began in

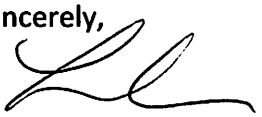
October of 2013, with the majority of programs coming on board in the first few months of 2014. Eligibility for the program is restricted to individuals served by psychiatric rehabilitation programs (PRPs), ACT teams, or methadone maintenance programs. While data is still being collected by DHMH, the program is showing great promise in terms of improvements in health indicators, such as lowered blood pressure and cholesterol level, as well as decreases in emergency department and inpatient utilization. Although the health home program is open to dual eligibles, those with Medicare-only are not eligible. In addition, individuals served by outpatient mental health clinics are not eligible unless they are also enrolled in a psychiatric rehabilitation or ACT program.

- **Expand the use of the Chesapeake Regional Information System for our Patients (CRISP) to allow hospital staff to identify and communicate with the community-based behavioral health provider.**
  The CRISP Encounter Notification System (ENS) is very helpful in providing treating psychiatrists with information regarding the ED and inpatient utilization of their clients. However, care management rarely happens at the psychiatrist level; it is the registered nurse (RN) care managers and community outreach workers who develop and implement the plans that allow individuals to successfully transition from hospital care back into the community. If hospital staff could access CRISP to identify the behavioral health provider on record, our RN care managers could be included in transition planning earlier in the process, thereby increasing the chances for a successful transition.

- **Allow for gain sharing with community behavioral health organizations.**
  Community behavioral health organizations play a crucial role in keeping those with mental illnesses and addiction disorders out of hospitals and functioning successfully in the community. However, years of underfunding and budget neglect are challenging our ability to sustain, much less expand, these critical services. Gain sharing arrangements would reward organizations that meet identified goals and allow them to reinvest in their services.

Thank you for your consideration of our suggestions. We are committed to working with you and our hospital partners to achieve the goals of the new Medicare waiver.

Sincerely,



Lori Doyle
Public Policy Director