



Healthy Montgomery Behavioral Health Task Force

Recommendations Presented to the Healthy Montgomery Steering Committee

Executive Summary

March 2016

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Healthy Montgomery is Montgomery County's community health improvement process, an ongoing effort that brings together County government agencies, County hospital systems, minority health programs/initiatives, advocacy groups, academic institutions, community-based service providers, the health insurance community, and other stakeholders to improve the health and well-being of all Montgomery County residents. It includes data collection, needs assessment, priority-setting, strategic action planning, and the implementation and evaluation of collaborative efforts.

One of the current Healthy Montgomery priority issue areas is behavioral health. The Behavioral Health Task Force (BHTF) was launched in November 2014 following the release of the [Healthy Montgomery Behavioral Health Action Plan](#). BHTF membership includes public and private behavioral health service providers (including mental health and substance abuse) from throughout Montgomery County who treat adults and children in institutional and community settings. Also represented are the County's minority health initiatives and programs, the four County hospital systems, County councils and commissions, academia, family and consumer advocates, and Montgomery County emergency services, police, and corrections. The BHTF is co-chaired by Thom Harr (CEO Emeritus, Family Services, Inc.) and Kevin Young (President, Adventist HealthCare Behavioral Health & Wellness Services).

The purpose of the BHTF is to carry out the strategies defined in the Healthy Montgomery Behavioral Health Action Plan. That is, to:

1. Consider ways in which *info*MONTGOMERY can be enhanced to create an accessible Web-based basic information, communications, and linkage system through which consumers, their families, providers and other social service agency or referral source personnel can easily gain clear, basic information about treatment options, the full range of available services, payment mechanisms, and how to access services;
2. Establish protocols to facilitate safe and appropriate transfer of clients from institutional settings (e.g., hospitals, emergency rooms, correctional facilities, schools, universities) to community behavioral health organizations, primary care organizations and crisis centers;
3. Initiate a process to explore the creation of a coordinated system of care or other formal partnership-based business agreement to meet the needs of individuals with more serious behavioral health conditions who live in Montgomery County.

The BHTF works within the larger framework of the Healthy Montgomery overarching goals which include: improving access to health and social services; achieving health equity for all residents; and enhancing the physical and social environment to support optimal health and well-being and reduce unhealthful behaviors.

Three BHTF Subcommittees worked on the recommendations addressing the three strategies above. The *info*MONTGOMERY Subcommittee addressed the first strategy; the Policies and Protocols Subcommittee focused on the second strategy; and the Coordinated Care Subcommittee addressed the third. Each BHTF Subcommittee worked over the course of the past year, discussing and drafting the recommendations. Throughout the year, the BHTF also met, in its entirety, several times to discuss the progress of the Subcommittees and to provide feedback on and discuss the recommendations.

Context

Work on the recommendations of the BHTF has occurred in the midst of many parallel efforts in Montgomery County as well as at the state and national levels. The work also comes at a time when there is a national focus on improving the care of people with behavioral health issues, reducing the costs of incarceration and hospitalization, and improving outcomes for people with behavioral health issues.

At the federal level, legislation has been introduced in both the House and Senate to provide additional resources. The Substance Abuse and Mental Health Services Administration (SAMHSA) recently awarded \$22.9 million in planning grants to 25 states, including Maryland, to develop models for Certified Community Behavioral Health Centers. However, only eight states will be funded for implementation. Also, for the past several years SAMHSA has been supporting primary care integration into behavioral health centers, addressing the disturbing fact that people with mental illness have a greatly reduced life span primarily due to untreated chronic diseases such as chronic obstructive pulmonary disease (COPD) and diabetes.

One of the most significant developments occurred shortly before the creation of the BHTF. This development involves Maryland's implementation of the latest Centers for Medicare and Medicaid Services (CMS) waiver funding with a group of local hospitals. This created a cap on "total patient revenues" for hospitals and set a maximum escalation of cost at 3.58% per year for five years with financial sanctions for failure to meet the goals. Behavioral health patients are a significant part of the pool of "high risk, high utilizers" identified by hospitals. To comply with the terms of the waiver, hospitals not only must control costs but reduce re-admissions; creating a move to the development of community-based services (i.e. urgent care clinics) and utilization of existing, lower cost, community services. As a result, the County's six general hospitals have joined together to submit a request for a rate increase, in part to address behavioral health patient disposition and cost through improved services.

Similar efforts are underway for jails as well as hospitals. Incarceration is a high cost, low efficacy alternative for many people with mental health and/or substance abuse problems. As a result, local efforts have focused on this issue. Most recently, Montgomery County appointed a Planning and Implementation Committee for establishment of a mental health court. For those who are eligible, this will allow diversion from jail into treatment. Efforts have also been underway to create a local version of "the Restoration Center," a highly acclaimed project in San Antonio, Texas that provides an alternative to both incarceration and hospitalization for persons with mental illness and/or substance abuse problems.

These local efforts have been greatly enhanced by the comprehensive review of Montgomery County's behavioral health system (*Behavioral Health in Montgomery County* – Report No. 2015-13, July 28, 2015), carried out by the Montgomery County Office of Legislative Oversight (OLO). By assembling an extensive assessment of the current situation, OLO provided not only a starting point for planning an enhanced system but also highlighted the complexities involved not only for consumers but for providers and policy makers.

The complicating factors of substance abuse and unstable housing are recognized in all local systems. An important effort is underway to identify local resources and improve utilization. Housing options are critically needed if other efforts are to succeed. These issues appear in nearly every effort to improve the system and often stand as a barrier to full implementation of alternatives like hospital or criminal justice diversion.

As all of the systems options are explored one additional element is intriguing, the rapid development of technology that might support new approaches. For example, with a shortage of behavioral health prescribers, telehealth may be an approach to extending scarce resources. Smart cards, smart phone apps for consumers, electronic health records, and automated care management systems may all play a role.

Behavioral Health in Montgomery County

Healthy Montgomery and the BHTF use several behavioral health measures to focus Healthy Montgomery's behavioral health work and monitor progress. The measures include emergency department visits for behavioral health conditions, suicide rates, adolescent/adult illicit drug use in the past month, and adults with any mental illness in the past year. Data for Montgomery County reveal the following:

- The rate of emergency department (ED) visits for behavioral health conditions has increased 17% for all ages from 804.4 (per 100,000 population) in 2008-10 to 944.9 (per 100,000) in 2011-13; residents ages 18-34 are almost 4x more likely to visit the ED for behavioral health conditions; while the rate is lower for children (1-17 years) (686.1 in 2011-2013), children ED visits increased the most among age groups from 2008-2010 to 2011-2013 (542.4 to 686.1), a 26% increase.
- Males are 22% more likely than females to visit the ED for behavioral health conditions, but the gap is narrowing slightly. Black/African American residents are 5x times more likely than Asians/Pacific Islander residents, White residents are 3x more likely than Asian/Pacific Islander residents, and Hispanic residents are 2.5x more likely than Asian/Pacific Islanders to visit the ED for behavioral health conditions. Black disparity gap is narrowing slightly. While experiencing the lowest rate, the rate for Asian/Pacific Islanders has increased the most from 200.2 to 237.4 (per 100,000), a 19% increase.
- The suicide rate in Montgomery County has increased 12% for all ages from 6.5 (per 100,000) in 2006-08 to 7.3 (per 100,000) in 2011-13. Older residents (65 years and older) have the highest suicide rate. Also, the suicide rate for White residents is double that for Black/African American residents and Asian residents. The rate for Black/African American residents worsened by 29% (the rate worsened for White residents by 16% and improved by 26% for Asian/Pacific Islander residents; Hispanic suicides were too few to compile rates).
- Adolescent/adult (12 years and older) illicit drug use in the past month increased by 15.2% from 6.1 (per 100,000) in 2006-08 to 7.03 (per 100,000) in 2010-12.
- Adolescents 12-17 years old are twice as likely as adults (26 and older) to have used illicit drugs in the past month.
- Adults (18 years and older) with at least one major depressive episode in the past year increased by 10% from 5.83 (per 100,000) in 2006-08 to 6.39 (per 100,000) in 2010-12. With this rate moving away from the Healthy People 2020 target of 5.8 per 100,000 (Mental Health & Mental Disorders 4.2), a 10% improvement is needed to meet the national target.¹

In addition to the immense costs to individuals with behavioral health problems and their families that are represented by these data, there are additional social and financial costs. National data reveal that total spending for behavioral health in 2009 was \$172 billion, including 61% (\$105 billion) from public

¹ Healthy Montgomery Community Health Needs Assessment 2015 (in preparation).

sources (Medicare, Medicaid and other federal, state, and local funding; with Medicaid the largest public source) and 39% from private sources (largely, private insurance and out-of-pocket spending).²

The BHTF offers its recommendations in the context of the individual, family, social, and financial costs these data represent in Montgomery County.

Summary Recommendations

*info*MONTGOMERY Subcommittee Recommendations:

1. **Create an accurate, relevant, and updated inventory of behavioral health services in the County through *info*MONTGOMERY.** Specifically, create a network of behavioral health resource specialists to manage the effort to build the data base and create a structure to ensure sustainability.
2. **Enhance *info*MONTGOMERY to improve the usability and accessibility of the information provided and its accessibility to vulnerable populations including people with disabilities, youth, seniors and people of diverse ethnicities, cultures and languages.** Specifically, employ user surveys, convene an advisory group, engage members from the County's diverse communities for guidance in ensuring website is logistically and linguistically accessible and that resources are culturally appropriate, and research best practices to implement changes to the present database including migration to a new platform.
3. **Inform consumers and professionals (e.g., consumers, caregivers, case managers, social workers, school counselors, therapists, physicians, hospitals, and other service providers) about *info*MONTGOMERY, as the gateway to behavioral health resources, using a deliberate, coordinated, and long-term outreach campaign, including targeted outreach to culturally and linguistically diverse populations in the County.**

Policies and Protocols Subcommittee Recommendations:

1. **Establish and fund an Integrated Care Consortium.** The Integrated Care Consortium (ICC) will continue the work started by the Healthy Montgomery BHTF (subsequently taking the place of the BHTF), allowing Healthy Montgomery to focus on other tasks to which it is committed. The ICC will create an infrastructure and leadership structure to move the specific recommendations of the BHTF forward both in the short- and long-term.
2. **Establish a process and assign a high priority to the identification of specific measures that will alleviate the problem of insufficient and inadequate housing for persons with behavioral health problems.** Inadequate supply of short and long-term housing for individuals with behavioral health challenges impacts the cost of care, drives disproportionate use of hospital resources, and ultimately has a negative impact on the behavioral health and physical health and life expectancy of this population.
3. **Identify and implement specific measures that will reduce the barrier that transportation presents in access to care, housing, and supportive services for persons with behavioral health problems.** Barriers such as transportation often have a negative impact on the behavioral

² N. Carrizosa, S. Richards. *Behavioral Health in Montgomery County*. July 28th, 2015. Montgomery County Office of Legislative Oversight. Report Number 2015-13. Accessed at: http://www.montgomerycountymd.gov/OLO/Resources/Files/2015_Reports/OLO%20Report%202015-13%20Behavioral%20Health%20in%20Montgomery%20County.pdf

health, physical health, and life expectancy of persons with mental health and/or substance abuse disorders and often lead to increased costs of care in the long run.

Coordinated Care Subcommittee Recommendations:

- 1. Identify funding for a study to create guidelines for a County-wide care coordination system (the study would be overseen by the Integrated Care Consortium, if formed).** The County-wide care coordination system to be studied would: 1- focus on the specific needs of individual consumers for their care coordination (a model broader in scope than the hospitals' efforts to coordinate care for those transitioning out of the hospital and to prevent re-hospitalization); 2- be designed based on a model that adopts SAMSHA's guiding principles of recovery³ and supports SAMSHA's working definition of recovery from mental disorders and/or substance use disorders - that is, a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential; and 3- align with the County hospital systems and existing efforts in the non-profit sector.
- 2. Create and implement a pilot for a formalized, coordinated system of care addressing behavioral health (substance abuse and mental health), medical and social needs of 300 adult consumers (18 years and older) who have a mental health diagnosis and one of the following – chronic homelessness as defined by the federal Department of Housing and Urban Development (HUD), minimal or no supports, multiple acute hospitalizations and/or emergency department (ED) visits; and/or multiple incarcerations.** According to the Agency for Healthcare Research and Quality (AHRQ), "care coordination is the deliberate organization of patient care activities between two or more participants (including the patient) involved in a consumer's care to facilitate the appropriate delivery of health care services. Organizing care involves the marshalling of personnel and other resources needed to carry out all required patient care activities and is often managed by the exchange of information among participants responsible for different aspects of care."⁴
- 3. Implement a Hub and Pathways Model for Care Management of Behavioral Health consumers.** Specifically, the Hub and Pathways Model is recommended because of its ability to effectively bring together the efforts of various stakeholders in a more collaborative and less duplicative effort than is now possible. The model is particularly effective in incorporating the social determinants of health (i.e., housing, education, income, employment, food sufficiency) with medical care. With research indicating 80% of a person's health status relates to the former it is critically important for persons with mental health and/or substance abuse problems to have these issues addressed as they are often dominant factors.

A critical element in the recommendations of the Coordinated Care Subcommittee is strong support for a shared base of principles and values based on SAMSHA's working definition of recovery from mental disorders and/or substance abuse disorders. Inclusive in this is the use of "peer bridgers" as a part of the system that includes not just professional services but involvement of patients/consumers and, where possible, families. The presence of supportive individuals in the life of a person experiencing

³ SAMSHA's Working Definition of Recovery: 10 Guiding Principles of Recovery can be accessed at: <https://store.samhsa.gov/shin/content/PEP12-RECDEF/PEP12-RECDEF.pdf>

⁴ Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services. Closing the Quality Gap: A Critical Analysis of Quality Improvement Strategies. Volume 7- Care Coordination. Accessed at: <http://www.ahrq.gov/research/findings/evidence-based-reports/caregaptp.html>

these issues has a potentially marked influence on disease management and outcomes. The SAMHSA principles include:

- Recovery emerges from hope.
- Recovery is person-driven.
- Recovery occurs via many pathways.
- Recovery is holistic.
- Recovery is supported by peers and allies.
- Recovery is supported through relationships and social networks.
- Recovery is culturally-based and influenced.
- Recovery is supported by addressing trauma.
- Recovery involves individual, family and community strengths and responsibility.
- Recovery is based on respect.⁵

For more information about Healthy Montgomery or the work of the BHTF, please visit www.HealthyMontgomery.org

⁵ SAMHSA's Working Definition of Recovery: 10 Guiding Principles of Recovery can be accessed at: <https://store.samhsa.gov/shin/content/PEP12-RECDEF/PEP12-RECDEF.pdf>