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A Call for Change: 15 Years of Progress in HealthChoices Behavioral Health

Commonwealth of Pennsylvania
Office of Mental Health and Substance Abuse Services
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Introduction

A Call for Change: 15 Years of Progress in HealthChoices Behavioral Health (HC-BH) documents the accomplishments in transforming the system. The impetus and blueprint for this transformation, *A Call for Change: Toward a Recovery-Oriented Mental Health Service System for Adults (A Call for Change)*, was published 15 years ago.

This Introduction has two sections. The first section provides the background that traces the development of the vision of transformation developed in collaboration between the Office of Mental Health and Substance Abuse Services (OMHSAS), the Mental Health Planning Council (MHPC), members, Primary Contractors (PCs) and their contracted Behavioral Health Managed Care Organizations (BH-MCOs), and provider stakeholder groups. The second section describes the structure and specific goals of this 15-year review of the HC-BH system transformation.

Background

In addition to *A Call for Change* released in 2005, OMHSAS issued *Strategies for Promoting Recovery and Resilience and Implementing Evidence-Based Practices* in 2006. *A Support Document for the Call for Change: Transformation of the Children's Behavioral Health System in Pennsylvania* was developed in 2010. *A Call for Change* and the two subsequent documents became the blueprint for HC-BH service delivery transformation. *Strategies for Promoting Recovery and Resilience and Implementing Evidence-Based Practices* provided research on national best practices and recommendations to support the work of advisory committees and OMHSAS leadership in pursuing system transformation. The third draft document, *A Support Document for the Call for Change: Transformation of the Children's Behavioral Health System in Pennsylvania* provided both research and a strategic plan for transforming the children's HC-BH system into one that is youth-guided and family-driven. A detailed summary of each document is outlined below.

A Call for Change: Toward a Recovery-Oriented Mental Health Service System for Adults (2005)

In November 2005, under the leadership of then Deputy Secretary Joan Erney, *A Call for Change* was released. Its aim was to establish a firm foundation for the Commonwealth of Pennsylvania's (Commonwealth's or Pennsylvania's) transformation to a recovery oriented system. It described 11

challenges and barriers to be addressed and the need to engage in open, honest discussion and debate about those issues. The 11 challenges are summarized below and include the following.[1]

1. **Power**: Rebalance power so that the expertise and contributions of the consumer[2] and the provider are respected and have equal weight in decisions about treatment.

2. **Relationships**: With an equalized balance of power between consumers and professionals, traditional professional/client roles and rules also change. Although professional guilds have begun to work on updating codes of ethics and practice guidelines to address these changes, these new standards are still emerging.

3. **Coordination and Community**: Fragmentation and conflicting care can be experienced by consumers, their family members, and providers results from involvement with a fragmented system of care (SOC). Treatment strategies should integrate care from multiple entities (e.g., primary health care, schools, child welfare, and juvenile justice) particularly in the areas of co-occurring disorders and lifespan screening. Mental Health (MH) services should be designed to help individuals meet their personal needs through access to effective MH treatment and a wide array of community resources.

4. **Peer Support and Consumer-Run Services**: Peer services are an emerging and promising practice that is aligned with the values of a recovery and resilient health care delivery system. Actions steps are needed to identify standards for Peer Support and sources of funding.

5. **Workforce Issues**: Attitudes that may not engender recovery are enmeshed into standards, policies, and practices in the education, training and practice of BH professions. There is a need to develop recovery-based competencies as a core standard of practice in professional standards and guidelines.

6. **Evaluation and Quality Assurance**: Currently, evaluation and quality assurance approaches do not involve consumers and family member in the construction of instruments, evaluation methods or conducting the evaluation. To promote Recovery and Resilience (R/R) principles in evaluation and quality assurance, consumers and family members should be involved in every stage of the evaluation and quality assurance process. For example, the Recovery Oriented System Indicator (ROSI) Measure holds promise as an assessment tool.

7. **Medical Necessity and Evidence-Based Practices (EBPs)**: R/R oriented health care systems incorporate individual, environmental, and social and spiritual factors into treatment and support.

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[1] Pennsylvania Department of Public Welfare OMHSAS. (November 2005). *A Call for Change Toward A Recovery-Oriented Mental Health Service System for Adults*. Pages 52-61. Pennsylvania Department of Human Services. https://www.dhs.pa.gov/Services/Mental-Health-In-PA/Documents/CallForChange.pdf

[2] The term “consumer” is used when quoted from other sources. For purposes of this report, the term individual or member is used.

The meanings of both "medical necessity" and "evidence-based practices" should be expanded to address the needs of the individual's whole self.

8. **Financing**: In addition to providing funding for basic care, explore innovative financing approaches such as capitation; managed care financing; separate funding streams for clinical and recovery service bundles; Individual Recovery Accounts for Self-Directed Care (SDC); and Personal Assistance Services/Personal Care Services through Medicaid.

9. **Recovery Dialogues between Mental Health and Substance Abuse Services**: Increase dialogue between MH and substance abuse systems to further understanding and development of consensus on the meaning of recovery, and the integration of recovery into the respective delivery systems.

10. **Recovery Education**: Develop a set of competencies for recovery-oriented staff, and incorporate into every academic curriculum for professional training. Provide organizational support for staff to obtain R/R education.

11. **Review of Licensing, Regulations and Policy**: Conduct a review of policies to identify and resolve potential barriers to R/R.

Recognizing that transformation to a system of services that fosters R/R requires a significant philosophical change, OMHSAS charged all stakeholders to look at ways they could impact these 11 areas.[3] Communities came together with new energy to transform the system and began to identify actions to address the eleven challenges, leading to *Strategies for Promoting Recovery and Resilience*.

Strategies for Promoting Recovery and Resilience and Implementing Evidence-Based Practices (2006)

In October 2006, OMHSAS published the *Strategies for Promoting Recovery and Resilience and Implementing Evidence-Based Practices*[4] report. In an effort to support the Commonwealth in achieving the transformation described in *A Call for Change*, this report operationalized the goals outlined in *A Call for Change* and address the barriers and challenges to achieving those goals. The report includes information on national best practices and strategies being used in other states to directly and indirectly enhance R/R.

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[3] Pennsylvania Department of Public Welfare OMHSAS. (November 2005). *A Call for Change Toward A Recovery-Oriented Mental Health Service System for Adults*. Pennsylvania Department of Human Services. https://www.dhs.pa.gov/Services/Mental-Health-In-PA/Documents/CallForChange.pdf

[4] Mercer Government Human Services Consulting. (October 2006). *Strategies for Promoting Recovery and Resilience and Implementing Evidence-Based Practices*.

The report focuses on five broad goals, summarized below in which strategies are developed to support R/R-oriented health delivery system.

1. **Facilitating R/R in managed care** — strategies for using managed care tools and practices to incorporate the philosophy of R/R.

2. **Implementing EBPs that enhance R/R** — strategies to address the iterative process of change, promote readiness to change, incorporate consumer involvement to infuse R/R principles into the health delivery system, and offer guidance on how to create change.

3. **Reducing reliance on state hospitals and improving community integration for adults, older adults, and people with co-occurring mental illness and substance abuse disorders** — identifying a minimum service array that enhances R/R and promotes community integration to reduce reliance on state hospitals.

4. **Researching evidence-based strategies for Family-Based Mental Health (FBMH) Services** — identifying a minimum service array and FBMH strategies that enhances resilience.

5. **Reviewing the emerging practice of Early Childhood MH Consulting** — researching available outcome literature and interviewing key informants about this service.

Draft A Support Document for the Call for Change: Transformation of the Children's Behavioral Health System in Pennsylvania (2010)

Building upon achievements to transform the children's BH system, in November 2010, OMHSAS drafted a follow-up report titled *A Support Document for the Call for Change: Transformation of the Children's Behavioral Health System in Pennsylvania.*[5] This report reviews the history of BH services for children and youth, evaluates the progress on advancing the children/youth HC-BH service delivery system, and recommends 10 "next steps", summarized below, in the development of an ideal array of BH services for youth and families.[6]

1. **Develop a public health approach to children's BH**: The public health model emphasizes promotion of mental wellness, as well as the prevention of MH problems.

2. **Develop Early Childhood Mental Health (ECMH) services**: Initiatives that build on knowledge of infant and young child development, such as workforce development and MH consultation to early care and learning centers should be enhanced and expanded.

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[5] Although *A Support Document for the Call for Change: Transformation of the Children's Behavioral Health System in Pennsylvania* remains as a Draft document, the document serves as a strategic plan to transform the children's behavioral health system.

[6] Mercer Government Human Services Consulting. (November 2010). *A Support Document for the Call for Change: Transformation of the Children's Behavioral Health System in Pennsylvania*.

3. **Develop a service system that is family-driven and youth-guided**: The Systems of Care initiative and the development of High Fidelity Wraparound (HFW) are two key constructs to the future of children's BH services. Both support children with multi system and complex needs, use family and natural supports, build on strengths and the resiliency of children, and utilize peers for transition age youth.

4. **Improve and expand the EBPs that comprise the ideal service array**: The public system can provide incentives for the implementation prevention, screening and assessment, and EBPs of community-based services, including monitoring and improving access to existing EBPs and expanding as appropriate.

5. **Expand school-based BH**: Expand initiatives such as School Wide Positive Behavioral Supports, as well as school-based BH services.

6. **Restructure residential treatment**: Residential treatment should be provided less frequently, with a goal of a 50% reduction from baseline trends. The residential treatment that is provided should be more intensive, short-term, clinically effective, and community-based. Supportive efforts, such as trauma-informed care (TIC), alternatives to coercive techniques and reduction of out-of-state placement are essential components.

7. **Expand services to youth with substance use conditions and co-occurring issues**. Address the systemic issues that inhibit early identification, coordination of treatment and follow-up for youth with substance use conditions and co-occurring issues.

8. **Assist transition age youth and young adults to develop the skills and assets necessary to be successful in adulthood**. Specific action includes:

    A. Development of a system of BH services for transition age youth and young adults in every county.

    B. Psychiatric rehabilitation specific to the transition-age population.

    C. Options to address the housing needs, vocational needs and social development of transition age youth and young adults.

9. **Coordinate and braid services across agencies**. To reduce the overuse of residential treatment, OMHSAS, the Office of Children, Youth, and Families, the juvenile justice system and schools will need to work together to accomplish the following:

    A. Increase the use of an expanding the array of community-based EBPs.

    B. Increase the use of short-term, non-institutional out-of-home placements.

    C. Increase the focus on trauma-informed interventions within all services and levels of care, as it has become increasingly evident that traumatic stress plays a role in the lives of many children who are served by all of these agencies.

D. Support data collection, training and fidelity to promising and emerging practices that show Commonwealth- or community-specific success.

E. Support the availability of flexible funding and family support services to facilitate individualized, family-driven and youth-guided planning processes that are grounded in natural supports.

F. Increase recruitment and/or retention of 1) child/adolescent psychiatrists, 2) providers well-versed in EBPs, 3) youth and family peer advocates, 4) providers with specialized expertise in working with diverse cultural and linguistic populations, and 5) youth and families committed to offering their knowledge, guidance, support and strong voices to all aspects of Department of Public Welfare (DPW) that will affect Pennsylvania's youth.

10. **Incorporate the changes emanating from health care reform**. Over time, the Patient Protection and Affordable Care Act of 2010 (ACA) will extend health insurance coverage to the uninsured, allow young adults to remain on family insurance plans until age 26 and require that insurance companies no longer reject individuals with pre-existing medical problems, including MH problems. It will also expand the reach of the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), which requires that insurance companies impose no greater restriction, in terms of cost or limitation on access to treatment, for MH conditions and substance use disorders (SUDs) than for all other medical/surgical procedures. There is the potential in these reforms for additional community-based prevention and wellness services, funding for early childhood home visitation and funds for school-based health clinics, all of which would have significant implications for children's BH.

Structure and Purpose of A Call for Change: 15 Years of Progress in HC-BH

In 2018, the OMHSAS MHPC[7,8] requested OMHSAS revisit *A Call for Change* to assess the level of progress made over the past 15 years and to identify recommendations to support continued transformation of the HC-BH system. The Technical Assistance Collaborative, Inc. (TAC) initiated this effort by conducting regional listening sessions across the Commonwealth and gathered survey responses from stakeholders.

[7] MHPC consists of three committees: Children's Advisory Committee, Adult Advisory Committee, and Older Adult Advisory Committee. MHPC advices on a broad BH mandate to include but not limited to mental health, substance abuse, BH disorders, and cross-system disability. At least 51% of the members are current or former BH consumers and family members. Members are appointed by the deputy secretary of OMHSAS.

[8] Commonwealth of Pennsylvania Department of Human Services. *Mental Health Planning Council*. https://www.dhs.pa.gov/Services/Mental-Health-In-PA/Pages/Mental-Health-Planning-Council.aspx

OMHSAS engaged Mercer Government Human Services Consulting (Mercer) to build upon and broaden the analysis to include progress on addressing the recommendations in the 2006 and 2010 Strategies documents as well as ensuring future recommendations consider current national trends.

Structure of A Call for Change: 15 Years of Progress in HC-BH

Prioritized by OMHSAS, the following six areas of focus and associated strategies were selected for review and analysis.

- Four areas of focus from the *Strategies for Promoting Recovery and Resilience and Implementing Evidence-Based Practices* report include:
  - Strategies for the Implementation of R/R through Managed Care
  - Implementation strategies for EBPs that support the goal of transforming the HC-BH delivery system
  - Strategies to reduce reliance on Commonwealth Psychiatric Hospitals and increase community integration
  - Development of a FBMH service array that supports system transformation
- A children's delivery system area that reflects both the *Strategies for Promoting Recovery and Resilience and Implementing Evidence-Based Practices* report as well as the *A Support Document for the Call for Change: Transformation of the Children's Behavioral Health System in Pennsylvania* report:
  - Strategies for the development of Early Childhood Services and Transformation of the Children's BH System
- A newly defined area by OMHSAS:
  - Enhancing Integrated Health Care

At the request of OMHSAS, Mercer also included a supplementary section on Pennsylvania's BH crisis system.

Purpose of A Call for Change: 15 Years of Progress in HC-BH

The purpose of this document is to review the developments within the Commonwealth of the HC-BH delivery system, describe the goals accomplished within the past 15 years, and a high-level overview of national trends. This review is intended to provide a foundation for the future development of a strategic plan for building on these accomplishments, based upon recommendations from members, providers, PCs and their contracted BH-MCOs, MHPC, OMHSAS and other stakeholders. It is important to recognize this report does not capture all accomplishments and initiatives within the past 15 years.

A Call for Change: 15 Years of Progress in HC-BH includes the following components:

- Reflections on the transformation of the HC-BH health delivery system by OMHSAS leadership.
- A multi-faceted description of accomplishments in the transformation of the HC-BH service delivery system for the past 15 years for each of the six areas of focus and associated strategies through interviews with members, providers, the PCs and BH-MCOs, and HC-BH service utilization trends.[9]
- A high-level national scan of developments in the six focus areas used by other states.
- A high-level summary of areas of recommendations the Commonwealth might consider for continued pursuit.

[9] Accomplishments span across many of the six focus areas.

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Methodology

OMHSAS Leadership Review and Assessment

Mercer facilitated an interview with OMHSAS leadership to discuss the accomplishments in transforming the HC-BH service delivery system over the past 15 years and recommendations for further transformation. Additionally, Mercer conducted a similar interview with former Deputy Secretary, Joan Erney. Staff were asked to identify of the 11 original challenges/barriers described in *A Call for Change,* what areas OMHSAS has made the most progress and areas that continue to present the greatest challenges. Refer to Appendix A for a listing of current and former OMHSAS leadership staff interviewed.

PC and BH-MCO Interviews

These interviews address particularly effective initiatives designed to implement the strategies in each of the six areas of focus. PCs in collaboration with their contracted BH-MCOs were asked to identify the two most successful initiatives in each area of focus, understanding that many initiatives have occurred over 15 years. Funding and data/monitoring strategies are included, as available. Refer to Appendix B for a current list of counties, PC's, and BH-MCOs.

Stakeholder Groups

Listening Sessions

At the start of the initiative, Technical Assistance Collaborative (TAC) facilitated a series of in-person listening sessions to discuss system transformation, gaining input from a range of stakeholders including counties, BH-MCOs, advocates, members, and families of the HC-BH system across the age span in all regions of the Commonwealth. Listening sessions included feedback on system progress, keys to progress, challenges/barriers to transformation, needs and recommended priorities for future transformation. TAC also conducted interviews with specific key informants who were not able to attend listening sessions, including OMHSAS executive staff, Commonwealth hospital leadership, Central Region Child and Adolescent Service System Program (CASSP) Coordinators, and Central Region County MH and intellectual and developmental disabilities (IDDs) administrators. Two hundred and ninety stakeholders participated in the listening sessions. Key results from the listening sessions are summarized within this report, in Section 4.

Interviews

Mercer leveraged and expanded upon the listening sessions, including provider and HC-BH member groups, to provide perspective on the six areas of focus. Due to COVID-19, Mercer facilitated a total of nine separate virtual interviews with the following stakeholders:

Members:

1. Adults, natural supports, and family members
2. Children, youth, natural supports, and family members

Providers:

3. Acute Psychiatric Hospitals and Facility-Based Services
4. Community Mental Health Care Centers and Clinics
5. Crisis
6. Consumer Owned
7. Integrated Care Clinics and Integrated Community Wellness Centers (ICWCs)
8. Community-Based Providers for Adults
9. School- and Community-Based Providers for Children and Youth

While addressing the areas of focus for the report, stakeholders shared information and experiences including notable improvements and challenges relative to the transformation effort since *A Call for Change*. In addition, stakeholders shared next steps in the continued transformation of the HC-BH delivery system.

A Call for Change Online Stakeholder Survey

TAC coordinated with OMHSAS to develop an online survey that mirrored the domains/indicators[10] of recovery transformation described in *A Call for Change.* The survey was issued in March 13, 2019 through June 3, 2019 and in total, 440 individuals participated in the survey. Providers, county staff and BH-MCOs represented 61.59% of all respondents, while members, family members, and advocates represented 28.63% of all respondents. Many respondents did not complete every question

[10] Pennsylvania Department of Public Welfare OMHSAS. (November 2005). *A Call for Change Toward A Recovery-Oriented Mental Health Service System for Adults*. Pages 36–48. Pennsylvania Department of Human Services. https://www.dhs.pa.gov/Services/Mental-Health-In-PA/Documents/CallForChange.pdf

and OMHSAS calculated the responses among stakeholder groups to identify differences. Key survey results are summarized in Section 4.

Utilization Trend Analysis

A utilization trend analysis was conducted for members that was broken out by adults and youth as well as for selected services of interest. The data utilized for this analysis was obtained from HC-BH claims and HC eligibility data. Because the final counties to implement managed care and capitated payments took place in 2007, 2010 was selected as the earliest year for the trend analysis in order to insure the data is both comprehensive and accurate. Data from 2018 is the most recently validated data set with sufficient runout; therefore 2018 was used as the final year in the trend analysis.

A descriptive time series analytic approach was used to analyze the trend in HC-BH eligible members between 2010 and 2018. In 2015, the Commonwealth expanded Medicaid to cover childless adults between 21 and 64 years of age, in addition to the historical groups of Medicaid recipients. This expansion impacted both raw and normalized utilization data for adults, making comparisons pre- and post-expansion difficult to interpret. Shifts in raw utilization numbers could either be a function of the larger number of members, or an increase in penetration of the pre-expansion population. Changes in normalized measures (e.g., penetration, per member per month [PMPM]) are harder to interpret as they reflect a larger denominator (population). Consequently, the comparison of adult utilization was not a time series, but a simple comparison between 2010 and 2014, and 2014 and 2018.

Literature Review

Mercer conducted a high-level review of other state approaches to strategies outlined in each of the previously identified six areas of focus. The publication dates for the resources, reports, and literature span over the past fifteen years. Mercer searched for available information in the public domain specific to the six areas of focus. Search words included, but were not limited to: Recovery and Resilience; Recovery Oriented Services; Peer Support; SDC; TIC; Telehealth; Housing First; Employment First; Wraparound; Infant and Early Childhood Mental Health (IECMH) Service Array; System of Care; School-Based Mental Health Services (SBMHS); and Integrated Healthcare Services. In collaboration with TriWest Group (TriWest), TriWest performed the literature review in Sections 7 and 8.

3

Overview: OMHSAS Leadership Review

Background of HC-BH Program

The HC-BH program was first implemented in 1997 in southeast Pennsylvania with the vision of increasing access to services, improving quality of care, and containing costs. A decade later, in 2007, OMHSAS achieved its mission of creating a unified BH[11] system and increasing access to care for children, youth, adults, and older adults in all 67 counties.

The success of the HC-BH program has been built in partnership with county government, which is legally responsible for providing and managing MH services under the Mental Health and Intellectual Disability Act of 1966.[12] County government is given the "right of first opportunity" to bid on the HC-BH program to manage risk based contracts. The HC-BH program unifies service development and financial resources at the local level closest to the individuals served. Medicaid eligible individuals are automatically enrolled in the BH program in the county of their residence. A risk-based contract allows flexibility to make decisions that meet the unique needs of the county and, if savings are created, the county reinvests the money back into recovery-oriented services and supports, such as supportive housing, drop-in centers, crisis and diversion supports, and respite.

Since the program's inception, OMHSAS has remained committed to evolving the HC-BH program beyond this original vision to also achieve system transformation in accordance with the following goals and principals[13]:

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[11] BH includes MH and substance abuse services.

[12] Pennsylvania General Assembly. (January 1967). *Mental Health and Intellectual Disability Act of 1966*. https://www.legis.state.pa.us/WU01/LI/LI/US/PDF/1966/3/0006..PDF

[13] Commonwealth of Pennsylvania Department of Human Services. *OMHSAS Mission/Vision/Guiding Principles*. https://www.dhs.pa.gov/Services/Mental-Health-In-PA/Pages/OMHSAS-MissionVision.aspx#:%7E:text=The%20goals%20of%20OMHSAS%20are%20to%3A&text=Implement%20services%20and%20policies%20to,unique%20needs%20of%20older%20adults

OMHSAS Goals:

- Transform the children's BH system to a system that is family-driven and youth-guided.
- BH services and policies in the adult system are grounded in R/R principles.
- BH services and supports recognize and accommodate the unique needs of older adults.

Every individual served by the HC-BH system will have the opportunity for growth, recovery and inclusion in their community, have access to culturally competent services and supports of their choices, and enjoy a quality of life that includes family members and friends.

Guiding Principles:

- Focus on prevention and early intervention.
- Facilitate recovery for adults and resiliency for children.
- Respond to individuals' unique strengths and needs throughout their lives.
- Recognize, respect, and accommodate differences as they relate to culture/ethnicity/race, religion, gender identity, and sexual orientation.
- Ensure individual human rights and eliminate discrimination and stigma.
- Provide a comprehensive array of programs and funding that build on natural and community supports unique to each individual and family.
- Develop, monitor, and evaluate programs and services in partnership with consumers, families, and advocates.
- Collaborate with other agencies and service systems.

OMHSAS Leadership Interview

Mercer conducted a structured interview of OMHSAS leadership staff including the OMHSAS Deputy Secretary, Chief of Staff, all Bureau Directors, and the Medical Director. In considering the accomplishments and progress of *A Call for Change* over the last 15 years, OMHSAS' current and former leadership identified the following themes.

"I believe quite a bit of change has occurred since 2005 because a lot of individuals were willing to work together to effect change. This required a willingness to listen, learn, accept, and grow; however, there is much more work to do. I am reminded of the George Bernard Shaw quote: 'Progress is impossible without change, and those who cannot change their minds, cannot change anything.' Let's continue to grow together."

"We've come a long way working together. Working hand in hand with individuals, families, providers, counties and the advocacy community, we have been effective in changing minds, beliefs and practices, transforming the service delivery system and reducing stigma along the way. While we have a lot of work ahead of us, I am proud of how far we have come."

Peer Support

Leadership agreed that one of the marquee accomplishments since *A Call for Change* has been the development and continued enhancement of Certified Peer Specialists (CPS) and Certified Recovery Specialists (CRS) into a core service. While still a nascent service option at the outset of *A Call for Change* initiative, it is now a fundamental component of promoting R/R. OMHSAS recognized peers are now included in management meetings, committees and compliance reviews to ensure their voice is considered. There are opportunities for continued improvement of the service including integration into a wider array of services and further development of standards and training for specialty peer professionals like youth, family, and crisis specialists.

Member and Family Choice

The *A Call for Change* initiative has widened the array of MH/SUD services and emphasized the member's voice and choice in support planning. Over time, children and youth services in particular have seen an improvement in choice. Members now have more choice in how and where services are provided, including access to telehealth. Leadership noted that *A Call for Change* has rebalanced the approach to support planning in general so that members, families, and providers alike are partners in decision-making.

"I believe our behavioral health system has made immense strides since 2005, but we have further to go as we all work together to transform the system. Families, Individuals, Counties, Primary Contractors, BH-MCOs, Providers, and advocates have all worked, and continue to work, to move our system forward."

Over the last 15 years, OMHSAS has supported the expansion of member, family, and youth advocacy groups. Stakeholder workgroups have been created to include and promote the voice of members and family members with lived experience. Leadership recognizes that it has an opportunity to help member organizations develop more coordinated advocacy leadership efforts to respond to legislative demands. In addition, there is an opportunity to improve outreach and inclusion from diverse communities to promote representative leadership.

MH/SUD Services Coordination

Leadership has observed an improvement in the coordination and dialogue specifically between MH/SUD. *A Call for Change* has promoted integrated language and messaging focused on R/R, supported by peers. There is continued opportunity to strengthen provider skillsets to look beyond a primary diagnosis and consider person-centered care more holistically. In addition, there are opportunities to develop the provider workforce to address the dual needs of individuals with both MH and SUD conditions.

Licensing, Regulation, and Policy

OMHSAS has seen improvements in standardization and uniformity of policy and procedures across all departments since the start of the initiative. Licensing groups across departments have also seen greater levels of consistency across key functions. There are opportunities to streamline regulation approval processes and review existing programmatic and fiscal regulations to allow counties, PCs, BH-MCOs, and providers the necessary flexibility to deliver services. In addition, Commonwealth regulations associated with the exchange of personal health information are more stringent than federal regulations. These regulations are barriers to integrated care, and there should be opportunities for review to ensure that they conform to practices found in other states and support, not hinder, integrated care.

Financing

OMHSAS noted opportunities to support the improvement of data reporting to help direct enhanced funding. OMHSAS launched the Consolidated Community Reporting Initiative in 2008 as a major data collection requirement. Leadership acknowledged continuing challenges with collecting member-level data. OMHSAS sees opportunities to build infrastructure to collect more real-time information to support decision-making. OMHSAS also recognizes the importance of additional funding opportunities to support a fuller continuum of community-based BH services across the Commonwealth.

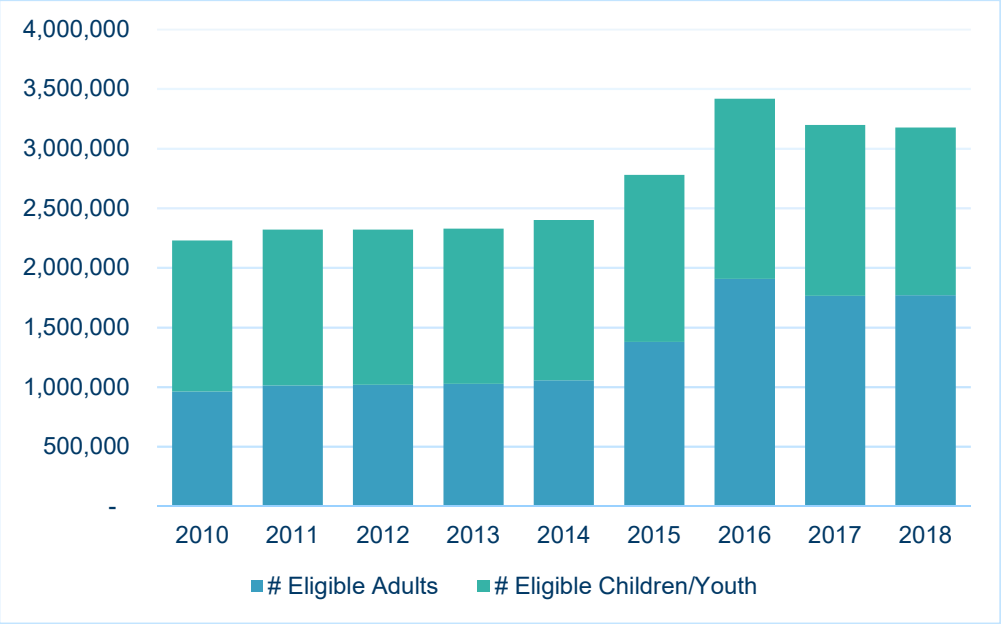
Years of Growth

From 2010 to 2014, the number of total Medicaid-eligible members increased by 171,107 individuals. During this time period, the number of eligible adults increased by 94,077 and the number of children and youth increased by 77,030.

"Having worked for OMHSAS in some capacity for 28 years, I have witnessed the transition from institutional to community treatment, the creation of Centers of Excellence to fight the opioid epidemic, and most recently an expansion of telehealth to assure needs are being met during a pandemic. I believe Martin Luther King said it best, "Human progress is neither automatic nor inevitable. Every step toward the goals requires sacrifice, suffering, and struggle; the tireless exertions and passionate concern of dedicated individuals." These dedicated individuals are my co-workers in OMHSAS."

In 2015, the Commonwealth expanded Medicaid to cover childless adults between 21 and 64 years of age, in addition to the historical groups of Medicaid recipients. As noted in the following chart, this expansion entailed an additional 776,256 Medicaid-eligible individuals, or a 32.3% increase from 2014 to 2018. Adult members increased 714,294. Children and youth increased 61,962, the latter reflecting incremental growth in non-expansion populations.

Chart A: Growth of Eligible Members from 2010 through 2018



Year over year percentage increase of HC-BH Medicaid-eligible individuals are presented in the following table:

Table 1. Annual Percentage Increase/Decrease in Medicaid-Eligible Individuals 2010–2018

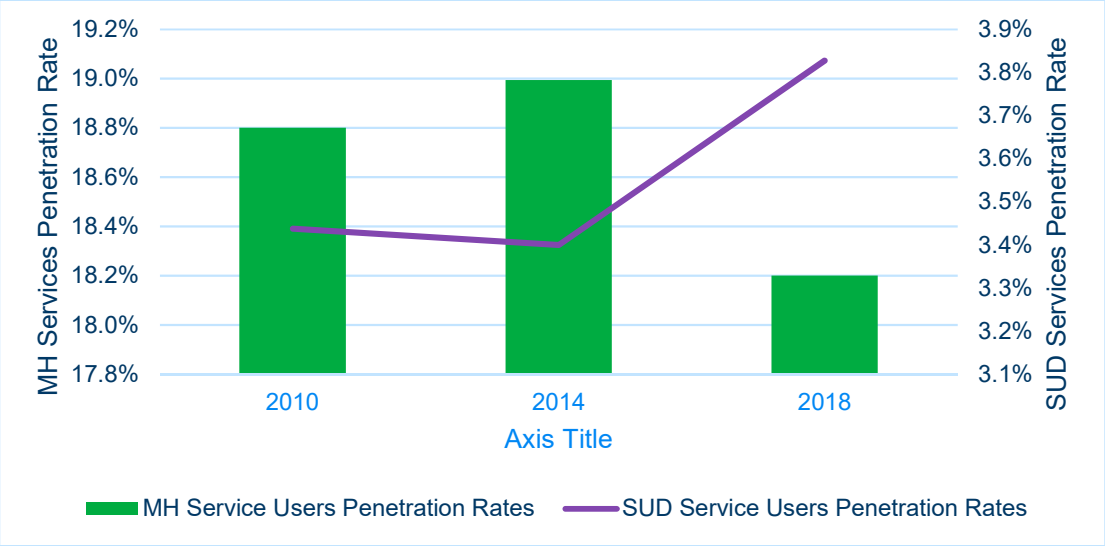
HC-BH Eligible Members	2010 to 2011	2011 to 2012	2012 to 2013	2013 to 2014	2014 to 2015	2015 to 2016	2016 to 2017	2017 to 2018
Adults	5.4%	0.6%	0.6%	3.0%	30.6%	38.2%	-7.5%	0.4%
Children and Youth	3.1%	-0.6%	0.3%	3.1%	4.1%	8.0%	-5.0%	-2.0%
Total Members	**4.1%**	**-0.1%**	**0.4%**	**3.1%**	**15.8%**	**23.0%**	**-6.4%**	**-0.7%**

In the first two years of Medicaid expansion (2015), the number of Medicaid adult enrollees increased 30.6% in 2015 and 38.2% in 2016, followed by a small decrease in enrollees during 2016. During the same time, children and youth enrollees had an uptick followed by a decrease in 2017 and 2018. The average annual percentage increase in children and youth enrollees from 2011 and 2018 was 1.4%.

Service Penetration Rates. Prior to the Medicaid expansion, the number of BH service users as a percentage of those eligible for Medicaid (known as the user or penetration rate) was relatively stable, (20.1% in 2013 and 19.9% in 2014), as was the penetration rate for the sub group of SUD service users, at 3.4%.[14] These penetration rates compared favorably with a national benchmark. Compared to national statistics for Medicaid managed care plans, the 2014 HC-BH program performed between the 75th and 90th percentile for MH penetration and just above the 50th percentile for SUD penetration.

In the first year of expansion, the penetration rate declined from 19.9% in 2014 to 18.2% in 2015. This decline could have been due to the significant increase in enrollment of new adult members without a comparable increase in utilization. Interestingly, this slight downward shift in MH penetration was accompanied by an uptick in SUD related services. The following chart below represents this shift in penetration with Medicaid expansion:

Chart B: Changes in MH/SUD Service Penetration Rate



The timing of this increase of SUD services could represent the SUD needs of the Medicaid expansion population.

[14] OMHSAS. (2015). *HealthChoices Behavioral Health Program Calendar Year 2014 Annual Report.* Page 3.

4

Strategies for Implementation of Recovery and Resilience through Managed Care

Strategies Recommended in A Call for Change

Each of the following areas describes strategies, goals and activities to support implementation of R/R through managed care as identified in *Strategies for Promoting Recovery and Resilience and Implementing Evidence-Based Practices.*[15] Suggested activities for implementing R/R are for consideration and are not all-inclusive. Additional activities related to these strategies may have emerged in the intervening 15 years and are included in this section.

Service Development Strategies: Develop an array of R/R services including consumer run services and R/R-oriented providers. Institutionalize self-direction and choice in assessment and treatment plan/process. Evaluate all BH-MCO activities, policies and procedures for alignment with R/R principles. In addition, develop standards for BH-MCO provider contracting to enhance the development of providers' incorporation of R/R principles and the expansion of consumer-run services.

Activities suggested for this area include Peer Support Specialists and consumer-run drop-in programs that support a variety of recovery goals. Self-direction/choice activities should include redesigning the clinical format, medical record, and treatment and recovery plans to assess relevancy to R/R. Support the routine development with providers of crisis plans and advanced directives and assess whether the individual has access to self-management tools such as a Wellness Recovery Action Plan (WRAP). In addition, evaluate all BH-MCO activities, policies and procedures for alignment with R/R principles. Lastly, consider developing standards for BH-MCO provider contracting to enhance the development of providers' incorporation of R/R principles and the expansion of consumer-run services.

Funding Strategies: Identify funding for consumer-run programs and initiatives that support R/R.

Activities suggested for this area include directing BH-MCOs to allocate a percentage of their administrative fee for R/R development in supporting consumer-run organizations, address R/R quality

[15] Mercer Government Human Services Consulting. (October 2006). *Strategies for Promoting Recovery and Resilience and Implementing Evidence-Based Practices*. Pages 26–31.

management initiatives, and assist consumer-run organizations in startup funds including providing administrative support to obtain small disadvantaged business status.

Monitoring/Data Strategies: Develop performance indicators at all levels of the health delivery system and structures to support R/R.

Activities suggested for this area include establishing performance indicators for meeting R/R goals for BH-MCOs, providers, and professional organizations. Other activities include setting performance goals and timeframes for the network, incorporate National Outcomes Measures service outcomes, and expand the use of consumer satisfaction teams. Additional activities include develop a Commonwealth-wide consumer satisfaction questionnaire and conduct focused studies to identify transition to R/R principles such that treatment plans and medical records are inclusive of consumer self-management tools (e.g., WRAP).

Fifteen Years of Accomplishments and Trends

The Commonwealth is known as a leading state in the employment of peer providers in MH/SUD services. In 2003, OMHSAS initiated a transformation of its public MH system to become a recovery-oriented SOC. OMHSAS pursued and was awarded the Substance Abuse and Mental Health Services Administration's (SAMHSA's) Mental Health Transformation State Incentive Grant in 2004 to support the development of a training curriculum and peer certification process, the Pennsylvania Peer Specialist Initiative.

By 2007, the Commonwealth had received approval from the Centers for Medicare & Medicaid Services (CMS) to include Peer Support Services as a component of rehabilitative services. Every county or county joinder was required to make Peer Support Services, provided by CPS available to HC-BH members. Since then, continuing education trainings have been developed for CPS specialty areas such as older adults, forensics, veterans, youth, MH/IDD, supported employment, and crisis services. Training and certification is also in place for CRS, providing peer support for those in recovery from substance use conditions.[16]

In 2016, the bulletin OMHSAS-16-12 was issued. The revised Peer Support Services bulletin and provider handbook allows youth 14 years of age through 17 years of age who meet the admission criteria and want to receive Peer Support Services to be served by approved peer provider agencies.[17]

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[16] Blash, L., Chan, K., & Chapman, S. (November 2015). *Health Workforce Policy Brief - Peer Provider Workforce in Behavioral Health: A Landscape Analysis*. University of California, San Francisco. https://healthworkforce.ucsf.edu/sites/healthworkforce.ucsf.edu/files/BRIEF_PeerProviderWorkforceBehavioralHealth.pdf

[17] Commonwealth of Pennsylvania Department of Human Services. *Peer Support Specialist Services*. https://www.dhs.pa.gov/Services/Mental-Health-In-PA/Pages/Peer-Support-Services.aspx

As of January 2021, Pennsylvania has 2,490 CPS, 1,630 CRSs, and 265 Certified Family Recovery Specialists credentialed through the Pennsylvania Certification Board with many more who have completed training.[18]

PC and BH-MCO Interviews

Service Development

Empowerment and Shared Decision Making

All PC's in collaboration with their contracted BH-MCOs led efforts to develop and expand access to Peer Services to transform the public MH system to become fully recovery oriented. Based upon principles of recovery, the service is conducted by individuals with lived experience and designed to promote empowerment, self-determination, understanding, coping skills and resiliency through mentoring and service coordination. Peers bring hope to individuals and empower them to speak up more and take an active role in recovery. Varying by county, an example of expansion efforts include embedding peers in a variety of settings such as inpatient (IP) units, drug and alcohol (D&A) clinics, crisis settings, Extended Acute Care (EAC) units, and drop-in centers. To better engage individuals with stepping down from IP levels of care into the community, CPS/CRS assists the treatment team with discharge planning, meets with individuals prior to discharge and once discharged, the CPS/CRS helps orient and links the individual to recovery services in the community and works to ensure he/she keeps follow-up appointments. Peers have also developed training materials for staff to help transform the culture of IP units to be more recovery oriented. Most importantly, PCs and BH-MCOs reported outcomes including reduced hospitalizations and lengths of stay, increase in follow-up rates after discharge, increase of social support and community integration, improvement in self-being, self-esteem and social functioning, and a decrease in readmission to detoxification and/or rehabilitation settings.

MEMBER STORY

*This is the best service I've ever had. It's like having a counselor, advisor, case manager and Big Sister all rolled into one. Peer Support saved my life I think. The encouragement coming from someone who really knew what it was like to hear voices, think of suicide, feel worthless, long for hope was the best thing to ever happen to me. I get to speak for **me**, take care of me, and make goals for me… with a helper who is cheering for me all the way. I think this helped my family become more accepting of me or, maybe it was just me being more accepting of me. I am using what I was shown to help others who need help.*

PCs and BH-MCOs have also expanded access to Psychiatric Rehabilitation Services (PRS) across the Commonwealth, which promotes recovery, full community integration, and improved quality of life for individuals. PRS is collaborative, person-directed and assists individuals to develop the emotional, social and intellectual skills needed to live, learn, and work in the community. Individuals identify and

[18] PA Peer Support Coalition. *History of Peer Support*. https://papeersupportcoalition.org/peer-support/history-of-peer-support/

achieve personal goals such as education, social connectedness, symptom management and health and wellness. Expansion efforts include site-based, mobile and clubhouse PRS, which is tailored to the individual's expressed goals and needs. For example, Lycoming/Clinton implemented an enhanced mobile PRS to address the needs of adults with a serious mental illness (SMI) and chronic physical health (PH) condition(s), which was compromising their ability to reach recovery goals. Community Care Behavioral Health (CCBH) has supported the implementation of cognitive enhancement therapy in PRS in one contract, including a program participating in the First Episode Psychosis (FEP) Program funded by the Community Mental Health Services Block Grant (CMHSBG).

To support personal activation and shared decision making in care, a web application designed by Pat Deegan PhD & Associates, LLC is integrated into outpatient (OP) clinics in a peer-run Decision Support Center. This approach, the CommonGround Program (CommonGround), increases access to resources and peer supports, empowers individuals in their use of medication as a tool in the recovery process, supports individual's self-determination and develops a collaborative relationship between the practitioner and individual. The first Decision Support Center opened in 2008, and by 2020, there are 19 locations across North/Central State Option[19], Chester, Carbon/Monroe/Pike, Berks, Lycoming/Clinton, and Allegheny counties.

> *"I learned that I have an important part to play in my own recovery, because this is about me, and what I think is important."*
>
> *- Member using CommonGround*

A drop-in center is another model that is intended to be a safe and accepting place for anyone in need of support, advocacy and self-empowerment on their recovery journey. Started as a member-led initiative, Open Arms Drop-In Center in Greene County incorporates BH and PH needs of individuals including dental education and exams, various wellness groups to promote active lifestyles (e.g., walking groups), breast cancer screenings, and speakers present a different topic weekly. The Drop-In Center promotes empowerment by allowing individuals to plan activities that they themselves see as useful. Transportation is provided to and from the center.

Beginning in 2011, in response to a request by a young adult with MH needs, Butler County and Beacon created a Transition Age Advisory Group (T.A.A.G.). Youth and young adults (ages 16–29 years old) share life experiences and discuss issues associated with their recovery. Participants create a voice to inspire and motivate others along with building leadership skills and improving self-esteem. Monthly meetings are both educational and social, and participants choose speakers and topics such as Peer Services, anti-bulling, and SUD treatment services.

[19] 23 Counties: Bradford/Sullivan, Cameron/Elk, Centre, Clarion, Clearfield/Jefferson, Columbia/Montour/Snyder/Union, Forest/Warren, Huntingdon/Mifflin/ Juniata, McKean, Northumberland, Potter, Schuylkill, Tioga, Wayne Counties

Reinforcement of R/R Principles

Since BH-MCO clinicians interact with providers' community on a daily basis, they have the ability to reinforce R/R principles within their organization and across providers. Examples are highlighted below.

Over time, BH-MCOs have supported a shift to a more recovery-oriented culture within its clinical team though training on recovery principles, focusing on the individual's recovery goals during clinical supervision and clinical rounds, and discussing the application of recovery principles during staff meetings. In order to assess and monitor progress in building a more recovery-oriented culture within the BH-MCO, it is common that clinical team's notes are audited for incorporation of recovery principles. Additional examples are highlighted below:

- Beacon met with individuals to develop questions for clinicians to use during utilization reviews based on SAMHSA's 10 Guiding Principles of recovery, including a focus on being person-driven, strengths-based, respectful, and hopeful.
- More recently, some PCs and BH-MCOs are directly employing CPS and CRS whom participate in clinical rounds, complaint and grievance activities, develop and provide trainings, and engage directly with members.
- Community Behavioral Health (CBH) developed a peer program for individuals with autism spectrum disorders and over 20 individuals participated in the peer trainings.

Building a recovery culture includes modifying the electronic clinical information system to prompt care managers to assess for strengths, challenges or barriers impeding an individual's progress; encouraging providers to promote member choice when considering treatment options; and coordination with providers to focus on SDOH and their impact on member outcomes.

CCBH has sponsored several year-long recovery learning collaboratives to support adoption of shared decision making. The learning collaboratives supported BH agencies and providers with efforts to increase an individual's involvement in decision making about their recovery, health, and wellness. Recovery toolkits with supporting informational materials available to providers include Personal Medicine, Power Statements, Whole Health Recovery, and Decision Support.

Four service domains were identified as essential to an R/R system including assertive outreach and initial engagement; screening, assessment, service plan and delivery; continuing support and early re-intervention; and community connection and mobilization.

Established in 2011 and implemented in 2013, the Philadelphia Department of Behavioral Health and Intellectual disAbility Services (DBHIDS), CBH, members, advocates, providers, and other community stakeholders contributed to the development of practice guidelines for R/R oriented treatment. The guidelines have assisted agencies and BH providers at all levels of care with implementing services and supports that promote R/R, self-determination and wellness in children, youth, adults, and families. Core values were identified and incorporated into the guidelines such as strengths-based approaches that promote hope; community inclusion; family inclusion and leadership; peer culture; TIC; holistic approaches; safety needs of children and adolescents and partnership and transparency.

Funding

Funding for development of R/R draws from several different sources. Peer Support Services became a Medicaid funded service in 2007[20]. One of the barriers identified impacting further expansion of Peer Support Services by PCs and BH-MCOs include the costs for individuals to attend certification trainings. Certification trainings can be held in other regions of the Commonwealth, which require travel and registration fees that can range up to $2,000. Utilizing reinvestment funds, Capital Area Behavioral Health Collaborative (CABHC) provided funds for one year to employ and embed a CPS in four acute care IP hospitals. If objectives are achieved such as, the CPS is an integrated and respected part of the treatment team 9e.g., participates in clinical rounds at the hospital, participates in the treatment planning process, etc.), the provider is eligible for a per diem rate increase.

Although varying by county, CRS has been implemented and expanded through a variety of funds including county, reinvestment, and grant.

PerformCare utilized reinvestment funds to implement PRS in all seven counties until it became an HC-funded service, which has also allowed for expansion and sustainability of the service. Technical assistance was provided to providers with regards to Medical Assistance (MA) requirements for both billing and documentation as well as ensuring the PRS service description and delivery of care align with R/R principals.

[20] Although CPS services, supporting individuals in recovery from mental health conditions, are an in-plan Medicaid service in Pennsylvania, Certified Recovery Specialist (CRS) services, supporting individuals with substance use conditions, are not covered as an in-plan service. However, CRS services in some parts of the Commonwealth are covered under Pennsylvania's 1915b Medicaid Managed Care waiver.

Funding for start-up of the Decision Support Center utilized a combination of reinvestment, county and grant funds. Lycoming/Clinton secured reinvestment funds for the implementation, with the requirement to hire a Peer Specialist to assist with individuals using the Center. CCBH sponsored certified CommonGround Specialists to provide training and technical assistance and offers enhanced rates to providers.

Beacon funds T.A.A.G. and just recently, T.A.A.G. applied for and received a grant to duplicate the program in other counties in Southwest Pennsylvania. Ongoing evaluations monitor the member's satisfaction with the program.

Monitoring/Data

The monitoring, data, and outcomes of R/R efforts have demonstrated positive results. Examples are highlighted below:

As Peer Services have grown and matured, it is has become increasingly important to monitor Commonwealth-wide utilization, duration, and intensity. Magellan Behavioral Health (MBH) completed an effectiveness study of CPS services between January 1, 2012 and May 1, 2015. The study examined 778 members with a CPS and compared member's utilization, duration, and intensity pre-CPS, during CPS and six months after last CPS claim. Key outcomes were reported:

- 43% decline in number of members with psychiatric IP admission
- 14% decline in number of psychiatric IP days
- 16% decline in crisis service use
- 20% decline in IP and crisis dollars

Reported outcomes of PRS include a decreased need for or shortened length of stay (LOS) in IP, partial hospitalization or day treatment settings. In addition, PRS helps individuals achieve valued roles in the community in living, learning and social environments. In CCBH counties, a formal tool was developed with provider and member input to measure progress of individuals and progress is tracked over time.

Annual program fidelity reviews are completed of the Decision Support Center along with experience or satisfaction surveys. Monitoring metrics include: monthly statistics on completed health reports, percent with personal medicine, power statements, shared decisions, and medicines entered. To date, the Decision Support Centers have served 200,482 individuals and 192,042 individuals completed health reports, 91% with personal medicine, 91% with power statements, and 52% of individuals' experienced shared decisions. CCBH received a 2013 Gold Achievement Award from the American Psychological Association (APA), recognizing its support for shared decision making in MH/SUD programs.

MEMBER STORY

My mental illness hit me hard — after I'd been doing well for a while. I worked, was in a number of good relationships, I lived relatively well. My Case Manager talked me into trying Psych Rehab (PRS) when I was close to hitting rock bottom. Being with other people and in a situation that talked about something I had not heard about before — recovery — helped me in an amazing way. I was ready to take a job with the company I worked for before but the Rehab offered me a paid position! I began to regain things I lost and learned skills and I grew in a way that will help me to remain healthy and help others do so.

Results of the year-long recovery learning collaboratives demonstrated that use of the Decision Support Toolkit and learning collaborative approach resulted in providers becoming more recovery focused, while individuals have reported increased confidence in accessing reliable information on the internet and increased involvement in making decisions with their provider.

The Network Improvement and Accountability Collaborative (NIAC) uses a comprehensive objective scoring tool in conjunction with other internal reliability measures to determine the degree to which providers are aligned with the principles outlined in the Practice Guidelines for Resilience and Recovery Oriented Treatment. Provider agencies must demonstrate core capabilities to be approved for network recognition and maintained within the network. The process has established a consistent evaluative approach to monitoring all providers in the network, regardless of level of care to ensure alignment with R/R-oriented treatment in Philadelphia.

Stakeholder Findings

Provider Comments

All provider groups identified the implementation of CPS into the service array has enhanced member care, helped systems shift language and provider/member relationships, and have embodied empowerment and choice for individuals. Over the years, progress has been made in the HC-BH system to accept Peers as an integral part of the continuum of care and services for individuals.

Consumer owned providers also made the following observations about the ongoing implementation of the R/R model:

- With more individuals and providers focused on strengths instead of illness and deficits, the culture of the BH care system supports the journey into recovery and helps individuals excel in areas previously considered impossible. The change in language about themselves shifts from being illness-oriented to a language of strengths and recovery.
- Enhancing individual choice in treatment and in programs like SDC has increased individual's sense of self-efficacy and self-determination, and represents one of the biggest cultural shifts due to the R/R model.
- A forensic CPS program for individuals leaving jail has decreased the recidivism rate and supports these individuals in making a change into a different lifestyle.
- The peer-operated drop-in center allow individuals to share stories as well as their hopes and dreams, and to see their peers in leadership positions, which supports this culture shift amongst individuals.
- R/R has allowed youth and families to have a larger voice in treatment decisions, services and policies, as well as increased collaboration with other youth services such as the juvenile justice system and public welfare system. Youth CPS programs have also been helpful to introduce families to peers. Although integration of these different types of services is not yet complete, the Commonwealth has made significant progress in this area.

Language Matters

Traditional, medical model clinical documentation.

For the last 18 months, the patient has been compliant with medications and treatment. As a result, she has been clinically stable and has stayed out of the hospital. However, patient has no-showed for last two visits and the team suspects she is flushing her medications. Patient was brought in for evaluation by the Mobile Crisis Team today after she failed to report to Clozaril clinic for bloodwork.

Recovery-oriented clinical documentation of the same individual and situation.

In the last 18 months, Sandra has worked with her M.D. to find medications that are highly effective for her. She has been active in activities at the clinic and the social club. Sandra and her Team all feel as though she has been doing very well, e.g., returning to work, spending time with friends, and enjoying her new apartment. People have become concerned, as she has been missed at several activities, including a bloodwork appointment at today's Clozaril clinic. The Mobile Outreach Team did a home visit to see if there was any way the clinic staff could assist her.

- Consumer-owned providers suggested that children, youth, and young adults have increased access to respite services, especially for transition age adults (18–21).

Integrated care providers report a growing interest in incorporating R/R services into PH. They encourage individuals with CPS or other supports to attend appointments, finding that they are particularly helpful with medication management during Primary Care Provider (PCP) visits. These clinics may also employ a health coach and report considerable success in the management of hypertension, cholesterol levels, and weight loss. Some of these providers reported having CPSs teach group wellness programs.

Providers suggested additional initiatives to support and enhance the R/R model. One provider suggested the creation of a Commonwealth-wide advocate from OMHSAS. This position could provide support for individuals in the Emergency Room (ER) who need someone to empower them in making choices about treatment. Other providers suggested that training and education about R/R be expanded beyond HC-BH to other areas, including the private sector. When individuals are successful in employment and have commercial insurance, these providers noted that they do not have access to the same services and recovery supports in the private sector.

Also recommended is continued development and expansion of CPS specialty areas, including certified recovery coaches to work with individuals with substance use conditions, forensic and young adults, and increased access to respite services for children and young adults, including peer respite for young adults and teens. An additional next step for CPS development would be to also decrease current training barriers through the addition of another vendor who has hands on experience.

Member Comments

Adults reported multiple advantages arising from the transition to R/R models of BH care. Service improvements noted included better communication with providers, the presence of the peer advocacy program, services that are more person-centered instead of based on diagnosis and provider, and county and OMHSAS openness to listen to feedback. Other improvements over the years noted by members were the increased focus on addressing racial disparities in health and historical trauma for some groups. One member noted that this can be a contentious process, but results in better services.

Individuals recognized the increase of Peer Services and the value of being able to talk to someone in recovery instead of talking with clinicians. Peers speak the same language and provide a voice for the member. One individual described how a CPS empowered her to focus on her wellness and recovery instead of her crisis episodes.

Several individuals noted the importance of programs that support employment, such as the Medical Assistance for Workers with Disabilities (MAWD) program.[21] The value of these programs in helping

[21] Commonwealth of Pennsylvania Department of Human Services. *Medical Assistance Benefits for Workers with Disabilities*. https://www.dhs.pa.gov/Services/Assistance/Pages/MA-for-Disabled-Workers.aspx

individuals stay employed, and how those supports and a job improved the quality of their lives was also noted. They suggested that these programs be more widely advertised in the community, especially to providers.

Family members of youth reported the growth and availability in family support or family partner services in some areas of the Commonwealth. They identified this support as making a significant impact on families of children with newly emerging MH conditions by providing information and support in navigating the healthcare system. One member noted the progress made in growth in acceptance and supporting LGBTQ youth.

Other family members noted that progress has been made with inclusion of families, but there is more work to be done.

Listening Sessions

All stakeholders identified affordable housing as a gap in services and supports and the most critical need to support R/R. Transportation, education, job training, and employment were also identified.

TAC initiated this *Call for Change* effort by conducting regional listening sessions across the Commonwealth along with gathering survey responses from stakeholders. Mercer then reviewed the results of the listening sessions to summarize the key findings below.

The development and expansion of Peer Services was identified as the largest accomplishment in the HC-BH system transformation since *A Call for Change*. Also consistently identified was the Commonwealth-wide implementation of the HC-BH program, which supports recovery through improving access and capacity in treatment and services, funding supplemental services such as PRS and utilizing reinvestment funds to create initiatives such as supportive housing. In addition, the broad array of BH services for children, youth, and adults was identified to promote R/R.

Although much progress has been made toward recovery transformation, it was reported that the role of individuals and families has diminished. Some counties and providers maintain a stronger commitment to R/R than others. Attributing factors reported by stakeholders include the perception that OMHSAS has reduced its emphasis on the involvement of individuals and families; funding cuts to services and individual and family advocacy organizations; provider staff turnover and new staff are unaware of R/R; differences among counties in access to R/R supports; and heavy reliance on Medicaid which is perceived by some stakeholders as reinforcing a “medical model”.

Individuals from all stakeholder groups identified staffing issues including recruitment and maintaining staff as the biggest concern for the BH system.

A Call for Change Online Stakeholder Survey

A summary of key stakeholder ratings of domains and indicators[22] of a recovery-oriented system are highlighted below. In total, 440 individuals participated in the survey. Providers, county staff, and BH-MCOs represented 61.59% of all respondents, while members, family members, and advocates represented 28.63% of all respondents. Many respondents did not complete every question and OMHSAS calculated the responses among stakeholder groups to identify differences. Mercer summarized key findings below.

- ***Recovery Domains and Indicators.*** Across four indicators, that the BH system values individuals and families as contributing participants in the system, out of 338 total respondents[23] the average rating was 53%.
- ***Services and Supports.*** Across 10 indicators that the BH system offers a full range of age-appropriate BH services and supports that promotes R/R, out of 274 total respondents, the average rating was 61.38%. Within this indicator group, services that utilize EBPs was rated the highest by members at 60.27%, while services that are readily available when needed was rated the lowest by members, family members, and advocates.
- ***Treatment/Service Planning and Individual Choice and Preference*.** Across seven indicators, that the BH system assures treatment and service plans are strengths-based and developed based on individuals' choices and preferences, out of 329 total respondents the average rating was 54.15%. Within this indicator set, including individuals' as part of the treatment planning was rated the highest by members, family members, and advocates at 71.74%.
- ***Self-Care, Wellness and Meaning.*** Across five indicators that the system supports and connects individuals and families with resources to help them to take care of themselves and improve their physical and emotional health, out of 280 total respondents, the average rating was 62%. Within this indicator set, developing an individualized, strengths-based approach to recovery was rated the highest by members, family members, and advocates at 73.68%.
- ***Peer Support and Self-Help Opportunities.*** The rating varied significantly for the provision of peer support and self-help opportunities. The provision of adult CPS (indicating that the service was provided) was rated the highest by members at 89.61% while Youth Support Partners and Youth Family Mentors was rated the lowest by members at 18.18%, respectively.

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[22] Domains and indicators of a recovery-oriented system can be found in *A Call for Change Toward A Recovery-Oriented Mental Health Service System for Adults*. Pennsylvania Department of Public Welfare. (November 2005). Pages 36–48. Pennsylvania Department of Human Services. https://www.dhs.pa.gov/Services/Mental-Health-In-PA/Documents/CallForChange.pdf

[23] Total respondents include the following stakeholders: providers, county staff, BH-MCOs, youth, adults, older adults, family members, and advocates.

Per survey respondents, challenges and barriers to R/R include availability of qualified staff and/or staff turnover, lack of funding/rates that providers are paid, and stigma.

Survey respondents were also asked to rate the degree to which the domain impacts stakeholders and the degree to which the system addresses the various domains. Respondents choices were: almost always, often, sometimes, seldom, and never. Across members, the average response was "sometimes" when asked:

- "Does the BH system promote and support resilience and recovery?"
- "Does the system show respect for individuals' whose cultural backgrounds, ethnicity and sexual orientation and/or gender identity are different?"

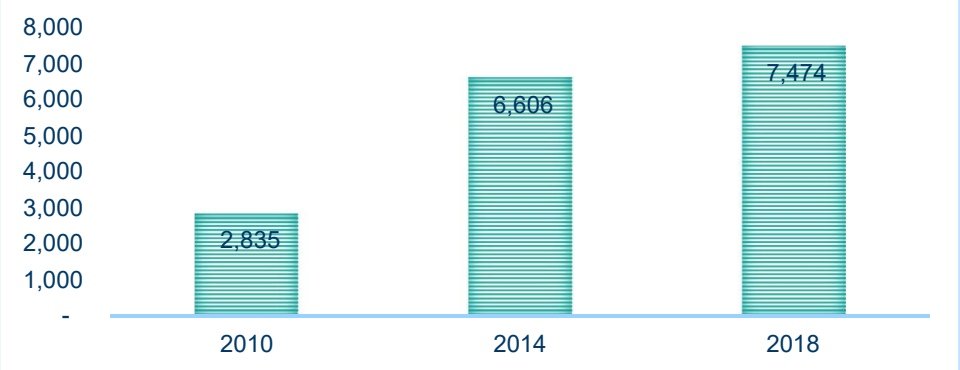
Providers, county staff and BH-MCOs typically responded with "often" to these questions.

"Almost always" was the average response across all stakeholders groups when asked, "Does the BH system inform individuals' and family members of their rights and protect their rights in receiving services".

Service Trends[24]

In 2010, six years after the first SAMHSA grant was obtained to develop CPS training and three years after Peer Support Services were incorporated into the State Plan Amendment (SPA) as a rehabilitative service, 2,836 unique individuals received these services. The number of unique individuals of Peer Support Services increased to 6,606 (133% increase) in 2014 and 7,474 in 2018 (163.6% increase from 2010).

Chart C: Number of Unique Users of Peer Support Services



[24] Note that Medicaid expansion occurred in 2015, and added a population of adults to the Medicaid eligible individuals.

During this same period, the Peer Support Service penetration rate increased from .1% to .3% between 2010 and 2014, and decreased to .2% in 2018. This decreased penetration rate was due to Medicaid expansion with corresponding increase in the denominator used to calculate the penetration rate.

The increase in Peer Support Services also created an increase in peer support service costs, as indicated in the table below:

Table 2. Peer Support Service Costs

Peer Support Services	2010	2014	2018
Dollars	$ 6,857,250.00	$ 27,959,328.00	$ 28,998,330.00
Cost per User	$ 2,418.78	$ 4,232.41	$ 3,879.89

As described in the preceding table, the cost per user increased 75% between 2010 and 2014, and decreased 8.3% between 2014 and 2018. The 75% increase in cost per user from 2010 and 2014 may reflect the maturing of this service as the number of individuals trained in Peer Support Services, and a larger number of CPSs with experience shaping this service in the Commonwealth.

Literature Review and National Scan

Recovery orientated services provide an environment in which individuals can learn to develop a sense of self-efficacy. This self-efficacy is based on the development of skills that support self-management of symptoms through individual self-management tools (e.g., WRAP, advanced directives, crisis plans, and therapies such as Dialectical Behavioral Therapy [DBT]). Corresponding shifts must be made in the healthcare environment to provide access to self-management tools and emphasize self-direction and member choice throughout the healthcare services delivery system. This cultural shift to a recovery-oriented approach includes a change in language, thinking and practice. The following table summarizes Connecticut's example of movement towards a recovery-oriented approach to BH services:[25]

[25] *Practice Guidelines for Recovery-Oriented Behavioral Health Care*. (2006). Connecticut Department of Mental Health and Addiction Services. https://portal.ct.gov/-/media/DMHAS/Publications/practiceguidelinespdf.pdf

Table 3. Recovery Oriented Approach to BH Services

Presenting Situation	Traditional Approach to Services		Recovery-Oriented Approach to Services	
	Perceived Deficit	Intervention	Perceived Asset	Intervention
Person demonstrates potential for self-harm.	Increased risk of suicide.	Potentially intrusive efforts to "prevent suicide".	Indicators of potential for self-harm are important signals to respond differently. The person is likely to have a weakened sense of efficacy and feel demoralized, and thus may require additional support. On the other hand, the person has already survived tragic circumstances and extremely difficult ordeals, and should be praised for his or her prior resilience and perseverance.	Rather than reducing risk, the focus is on promoting safety. Supportive, ongoing efforts are oriented to "promote life", e.g., enabling people to write their own safety/prevention plans and advance directives. Express empathy; reinforce efficacy and autonomy; enhance desire to live by eliciting positive reasons and motivations, with the person, not the provider, being the source of this information.

The primary initiative used to promote this culture change towards individual self-efficacy has been the implementation of Peer Support Services and other consumer-run services. Self-directed care programs are equally effective in promoting member self-efficacy, but are less well known.

Service Development

Peer Support Services

Georgia first added Peer Support Services to their SPA to provide support to individuals with SMI in 1999. Since that time, peer support has expanded to include a broad range of specialty areas, from forensic to youth and family peers to recovery specialists/coaches supporting individuals with SUD to Peer Support Services who specialize in older adults.[26]

Likewise, the settings in which Peers work has expanded include MH OP and IP facilities, jails and prisons, substance use treatment services, recovery communities and consumer-run programs, hospitals and Patient-Centered Medical Homes, and community health centers. Peer service practice

[26] A Cross-Systems Approach to Addressing the Mental Health Needs of Older Americans. (2015). *SAMHSA*. https://www.nasmhpd.org/sites/default/files/COAPSWebinar.FINAL_.5.6.15.pdf

models vary according the specialty area and the Peer Support Service's context. Examples of specialty area and practice models include the following:[27]

Integrated Healthcare Teams	Crisis Service Teams	Medication-Assisted Treatment Teams	Criminal Justice Settings
• Wellness coaching for individuals with complex physical conditions • Provider navigation and linkage	• Mobile crisis teams • Crisis stabalization units • Supports transition to community-based services	• Individual coaching and support for sobriety • Group education and support	• Specialty courts for individuals with BH conditions • Mentors, coaches • Supports transition into community life

Training and Credentialing of Peer Workers

States and organizations have considerable variability in peer worker training program structure and content, as well as variability in credentialing requirements. With the exception of South Dakota and Vermont, all states offer at least one type of statewide peer support credential, for a total of 65 different peer credentials.[28] None of the credentials requires a college degree. Sixty-three of the 65 credentials are full peer worker credentials, whereas one Kansas credential is for a peer-in-training, and one of the Maryland credentials is for peer supervisor.

The average number of required training hours is 50 across all programs, and range from 30 to 100 hours. Twenty-nine states require paid, unpaid, or volunteer work as a peer worker prior to receiving a credential, with an average of 548 hours.[29] Twenty-eight states require an average of 49 hours of direct supervision.[30] In addition to core peer training, trainings have been created to prepare peers to acquire advanced skills (e.g., conducting groups or providing supervision), or specialized skills (e.g.,

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[27] A complete list of states and specialty areas can be found in Cronise, R., Teixeira, C., Rogers, E. S., & Harrington, S. (2016). *The peer support workforce: Results of a national survey*. Psychiatric Rehabilitation Journal. Special Issue on Peer Support Services, Pages 39, 211–221. http://dx.doi.org/10.1037/prj0000222

[28] See Appendix D for complete list of credentials, required training and continuing education associated with peer workers.

[29] Videka, L., Neale, J., Page, C., Buche, J., Beck, A., Wayment, C., & Gaiser, M. (August 2019). *National Analysis of Peer Support Providers: Practice Settings, Requirements, Roles, and Reimbursement*. University of Michigan School of Public Health Behavioral Health Workforce Research Center. https://behavioralhealthworkforce.org/wp-content/uploads/2019/10/BHWRC-Peer-Workforce-Full-Report.pdf

[30] *Scopes of Practice for Behavioral Health Professionals*. University of Michigan School Behavioral Health Workforce Research Center. https://www.behavioralhealthworkforce.org/tableau-embed-new/

supported employment), or skills in working with individuals focused with co-occurring disorders or criminal justice involvement.[31]

Self-Directed Care

Another mechanism to increase self-efficacy is Self-Directed Care. In these programs, individuals use Medicaid, or other public funds, to purchase supportive goods and services of their choice. SDC programs have been utilized with individuals with physical and developmental disabilities. In the early and mid-2000's, SDC pilot programs for individuals with BH conditions were implemented and evaluated in multiple states, including Pennsylvania.[32]

SDC program participants were found to have increased community tenure, fewer crisis services, and services that are more preventive.[33] Furthermore, in one randomized controlled trial, self-directed care participants had significantly greater improvement over time in recovery, self-esteem, coping mastery, autonomy support, somatic symptoms, employment, and education.[34]

Texas Health and Human Services Commission completed a SDC pilot project in 2020.[35] Implemented as a performance improvement project, the MH SDC was conducted in partnership with two Medicaid MCOs in the Travis Service Delivery Area. The project, also known as *My Voice, My Choice*, assessed the impact of SDC on MH.

In this pilot project, individuals deemed to have a SMI developed a person-centered recovery plan and created a budget that allocated dollar amounts to traditional and nontraditional services to support meeting recovery goals. Advisors were available to help develop budgets, and identify and obtain the services and goods. A fiscal intermediary approved and processed payments for expenses authorized

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[31] Myrick, K., & Del Vecchio, P. *Peer support services in the behavioral healthcare workforce: State of the field*. National Library of Medicine. https://pubmed.ncbi.nlm.nih.gov/27183186/#:%7E:text=Peer%20support%20services%20have%20the,undertaken%20to%20build%20this%20workforce

[32] Ahrens, K., & Vengraitis, K. (June 2015). *Sustainable Self-Directed Care in Pennsylvania's Behavioral Health System*. Temple University Institute of Disabilities. http://www.temple.edu/instituteondisabilities/docs/pds/SDC_BH_System_PA-2015.pdf

[33] U.S. Department of Health and Human Services Assistant Secretary for Planning and Evaluation Office of Disability, Aging and Long-Term Care Policy. (November 2007). *THE CONTRIBUTION OF SELF-DIRECTION TO IMPROVING THE QUALITY OF MENTAL HEALTH SERVICES*. https://aspe.hhs.gov/system/files/pdf/75296/MHslfdir.pdf

[34] Cook, J., Shore, S., Burke-Miller, J., Jonikas, J., Hamilton, M., Ruckdeschel, B., Norris, W., Frost Markowitz, A., Ferrara, M., & Bhaumik, D. (2019). Mental Health Self-Directed Care Financing: Efficacy in Improving Outcomes and Controlling Costs for Adults with Serious Mental Illness. *American Psychiatric Association*. Pages 1–11. https://ps.psychiatryonline.org/doi/10.1176/appi.ps.201800337

[35] *Innovation & Self-Directed Care Project*. Texas Health & Human Services Commission. https://hhs.texas.gov/about-hhs/process-improvement/improving-services-texans/behavioral-health-services/innovation-self-directed-care-project

under the individual budget. A program evaluation that will compare outcomes at program intake, 12-months and 24-months post-intake. Study outcomes include participant satisfaction, service use and costs, clinical indicators, and recovery outcomes such as employment, education, social integration, and quality of life.[36]

Funding Strategies

Peer Support Services Funding

Although originally funded exclusively by Mental Health Block Grants (MHBG) and administrative financing mechanisms,[37] the majority of the states have established Medicaid reimbursement for Peer Support Services. States use one of the following authorities for Medicaid funded Peer Support Services:

1. The Medicaid State Plan
2. 1915(i) Home- and Community-Based Services (HCBS) State Plan Option Waiver
3. 1915(b)(3) Waiver (uses costs savings to provide Medicaid services not included in the State Plan)
4. 1115 Demonstration Waivers
5. 1915(c) HCBS Waivers

As of 2018, 35 states reimbursed MH Peer Support Services with Medicaid. Twenty-six states use a State Plan funding authority, and one state each use a 1915(b), 1915(c), and a State Plan as their funding authority for Peer Support Services.[38] A 2019 analysis of state Medicaid fee schedules, peer services reimbursement average $13.08 for 15 minutes, with a range of $1.94 for group therapy in Ohio to $36.68 for a per 15 minutes of "Whole Health & Wellness," in Georgia.[39]

Twenty-seven states reimburse SUD peer services with Medicaid funding. Sixteen states use a State Plan funding authority, while six use 1115 funding authority. Two states each use a 1915(b) and

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[36] Texas Self-Directed Care. *Texas Self-Directed Care Program*. https://www.texassdc.org/default.html

[37] SAMHSA. (August 2019). *BRIEF REPORT | Peer Support in CSC Programs*. http://nri-inc.org/media/1624/6-use-of-peer-support-in-csc-programs.pdf

[38] Videka, L., Neale, J., Page, C., Buche, J., Beck, A., Wayment, C., & Gaiser, M. (August 2019). *National Analysis of Peer Support Providers: Practice Settings, Requirements, Roles, and Reimbursement*. University of Michigan School of Public Health Behavioral Health Workforce Research Center. https://behavioralhealthworkforce.org/wp-content/uploads/2019/10/BHWRC-Peer-Workforce-Full-Report.pdf

[39] OPEN MINDS. *State Medicaid Reimbursement For Peer Support Service: An OPEN MINDS Reference Guide*. https://openminds.com/market-intelligence/reference-guide/state-medicaid-reimbursement-for-peer-support-service/

1915(c), and one state uses both a State Plan and a 1915(c).[40] A complete listing of states and their authorities is in Appendix C.

Multiple Funding Sources for Consumer Owned Providers

While Medicaid reimbursement has provided a stable foundation upon which states have developed a recovery-oriented work force, as is true of most businesses, individual peer support and other consumer owned organizations have the most financial stability when their revenue is generated from multiple sources. A recent example of the benefits of multiple sources of funding and revenue is demonstrated with the onset of the COVID-19 pandemic and the Public Health Emergency.

Telehealth options were expanded during the Public Health Emergency that allows more telehealth services, but the revenue generated by these services do not replace revenue lost due to disruption of other services. Nationally, many BH providers, including R/R providers, were forced to lay off or furlough staff due to disrupted service delivery. However, some R/R providers, like the New York Association of Psychiatric Rehabilitation Services Inc., had revenue streams from MCOs, state grants, MHBG, and Medicaid-funded services. These multiple revenue streams allowed this provider to maintain their full workforce and services when the state initiated mitigation measures to prevent a surge in COVID-19 cases in the spring of 2020.[41] Going forward, consumer-owned providers of R/R services will benefit from developing additional funding sources, and increased flexibility in approaches to service delivery.

Self-Directed Care Funding

Funding sources for SDC programs rely on Medicaid dollars for Medicaid services. Additional sources of funding include state general revenue; a community reinvestment fund created by setting aside 2.5% of capitation fee under Medicaid managed care contract, and a Medicaid concurrent section 1915(b)/1915(c) waiver.[42]

Monitoring/Data Strategies

Early SAMHSA guidance for consumer-owned providers encouraged the use of both Fidelity Assessment Common Ingredients Tool (FACIT) fidelity assessments as well as outcome evaluations

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[40] Videka, L., Neale, J., Page, C., Buche, J., Beck, A., Wayment, C., & Gaiser, M. (August 2019). *National Analysis of Peer Support Providers: Practice Settings, Requirements, Roles, and Reimbursement*. University of Michigan School of Public Health Behavioral Health Workforce Research Center. https://behavioralhealthworkforce.org/wp-content/uploads/2019/10/BHWRC-Peer-Workforce-Full-Report.pdf

[41] Personal communication with Harvey Rosenthal, Chief Executive Officer, April 2020.

[42] U.S. Department of Health and Human Services Assistant Secretary for Planning and Evaluation Office of Disability, Aging and Long-Term Care Policy. (November 2007). *THE CONTRIBUTION OF SELF-DIRECTION TO IMPROVING THE QUALITY OF MENTAL HEALTH SERVICES*. Page 15. https://aspe.hhs.gov/system/files/pdf/75296/MHslfdir.pdf

to monitor and improve recovery-oriented services.[43] A variety of other instruments has been used to monitor recovery services by states. These instruments focus on individual report on various recovery domains. One tool is the Recovery Self-Assessment Scale (RAS) with five domains: Diversity of Treatment Options, Consumer Involvement and Recovery Education, Life Goals vs. Symptom Management, Rights and Respect, and Individually Tailored Services.[44] The RAS has four versions: one each for administrators, practitioners, clients, and family members or advocates.

Another approach states have used to monitor and assess their healthcare delivery system for recovery orientation uses the Recovery-Oriented System of Care (ROSC) as the organizing principle. Although the areas of concern in the ROSC are system-wide, the actual monitoring and assessment of the system is based upon individual report. For example, in 2019, Ohio released a 2018 assessment of their ROSC.[45] The state plans to conduct this assessment as the primary approach to ongoing monitoring of Ohio's ROSC. The study uses a ROSC Assessment Tool to capture information from stakeholders for various aspects of recovery provided by the ROSC.[46]

A structure for a truly system-wide approach to monitoring and assessment was proposed in 2010.[47] This model for monitoring is based upon ten key organizational challenges and three stages of system transformation: 1. Engagement, 2. Development, and 3. Transformation. For each of the ten organizational challenges, the authors provide an operational definition for each of the three stages of development, coupled with the type of information and data that could be used to monitor and assess each stage of development. Information and data are identified at all levels of the system (e.g., utilization, individual report) as well as from all components of the system (e.g., individuals who use the services, providers). Although the model is based upon the United Kingdom SOC, it provides a framework that could be translated to a state organizational assessment and monitoring of the movement of the healthcare delivery system towards recovery orientation. The advantage of a model

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[43] *Evaluating Your Program: Consumer-Operated Services*. (2011). SAMHSA. https://store.samhsa.gov/sites/default/files/d7/priv/sma11-4633-evaluatingyourprogram-cosp.pdf

[44] Abt Associates, & Laudet, A. (March 2009). *Environmental Scan of Measures of Recovery*. Faces & Voices of Recovery. https://facesandvoicesofrecovery.org/wp-content/uploads/2019/06/Environmental-Scan-of-Measures-of-Recovery.pdf

[45] College of Social Work The Ohio State University, Bunger, A., & Beer, O. (February 2019). *RECOVERY-ORIENTED SYSTEMS OF CARE (ROSC) IN OHIO: Statewide Assessment Results (2018)*. Ohio Association of County Behavioral Health Authorities. https://www.oacbha.org/docs/ROSC_State_Report.pdf

[46] *Recovery-Oriented System of Care Self-Assessment*. Ohio Association of County Behavioral Health Authorities. https://www.oacbha.org/docs/ROSC_Stakeholder_Assessment.pdf

[47] Shepherd, G., Boardman, J., & Burns, M. (2010). *Implementing Recovery: A methodology for organisational change*. Sainsbury Centre for Mental Health. https://www.meridenfamilyprogramme.com/download/recovery/what-does-recovery-mean/implementing_recovery_methodology.pdf

such as this one is that it provides a rating system to compare different aspects of recovery orientation, and helps to pinpoint those areas that require additional attention.

Summary of Findings

Since *A Call for Change*, the addition and growth of Peer Services has been the most impactful development that has spread the R/R model throughout the HC-BH delivery system. OMHSAS, peers, providers, counties, and BH-MCOs have led efforts to empower individuals to take an active role in their recovery along with identifying and focusing on strengths instead of illness. PRS, Drop-In Centers, and Decision Support Centers are just a few initiatives that have supported a culture shift. Varying by county across the Commonwealth, R/R principles have been reinforced through provider learning collaboratives, trainings, and practice guidelines.

The ability of CPS to use their lived experience in a way that adds hope and recovery to their own lives as well as to the lives of those they serve. Feeling valuable and helping others feel this way is a two way blessing. Being able to say, "We have had a lot in common" has been a literal "Key" that opens doors others have been denied access to.

Opportunities exist to expand peer specialty areas, including forensic, transition age youth, and older adults as well as integrating peers in all levels of care across the Commonwealth. In addition, the Commonwealth should continue to strengthen the focus and commitment to R/R including the role of the individuals and families in all aspects of the HC-BH system. Everyone at all levels of the system should have a strong understanding of R/R principles and how they apply to everyday situations. There is a need for R/R training for current and new staff across the system and through oversight and monitoring, OMHSAS can help ensure R/R and Peer Services are prioritized similarly across the Commonwealth.

5

Implementation Strategies for Evidence-Base Practices that Support the Goal of Transforming the HC-BH Delivery System

Strategies Recommended in A Call for Change

Each of the following strategy areas describes strategies, goals and activities to support implementation of EBPs as identified in *Strategies for Promoting Recovery and Resilience and Implementing Evidence-Based Practices*.[48] Suggested activities for implementing EBPs are for consideration and are not all-inclusive. Additional activities related to these strategies may have emerged in the intervening 15 years and are included in this section.

Service Development Strategy: Implement EBP services.

OMHSAS messaging activities to implement EBPs include establish communities of practice to support adoption of new EBPs, collaborate with universities to establish special initiatives (that include individuals and families) to implement and monitor EBPs, and to deliver periodic "state of the union" messages that report on and encourage the development of R/R and EBPs in the Commonwealth.

Funding Strategy: Enhance funding for EBPs and create financing and reimbursement strategies for funding and overcoming barriers.

Activities for funding EPBs include targeting reinvestment dollars and develop financing transition plans from traditional services to EBPs. In addition, assess and address benefit designs and reimbursement methods for barriers to implementing and using EBPs. Lastly, fund service

[48] Mercer Government Human Services Consulting. (October 2006). *Strategies for Promoting Recovery and Resilience and Implementing Evidence-Based Practices*. Pages 42–44.

components of EBPs with Medicaid dollars and reserve state and local funds for non-Medicaid reimbursable services (e.g., housing subsidies).

Monitoring/Data Strategy: Establish tools/strategies and measures for implementing and monitoring best practices.

Activities for developing tools, strategies and measures include establishing a state-level clearinghouse on EBPs, promising practices, innovations, and fidelity instruments. Additional activities include analyze service encounter and claims as well as pharmacy data to identify trends, establish benchmarks, and target areas for focused studies and areas of questionable medication prescription practices.

Fifteen Years of Accomplishments and Trends

An EBP integrates the clinical expertise of the practitioner, the member's personal preferences and unique concerns, and the treatment with the best research evidence for helping individuals with a particular challenge. Promising practices demonstrate positive outcomes during initial research but have not been as thoroughly studied as EBPs. A focus on evidence-based and promising practices is the cornerstone of OMHSAS' commitment to support recovery for adults and promote resilience in children and youth.

The Commonwealth has made progress in the promotion of EBPs and promising practices. One of the advances is promotion of TIC. In 2006, Dr. Gordon Hodas, Child and Adolescent Psychiatric Consultant to the Bureau of Children's Behavioral Health Services and OMHSAS, wrote, *"Responding to Childhood Trauma: The Promise and Practice of Trauma-Informed Care*".[49] This paper helped to push the Commonwealth (and Nation) beyond the goals of reducing the use of seclusion and restraint to a holistic theory of how the care of children and adolescents in the MH and child-serving systems should be guided by a Public Health Model of Care emphasizing principles of: 1) Child and Family Strengths and Resiliency, 2) Non-coercion and Prevention of Re-traumatization, and 3) Access to Trauma-Specific Treatments for those most impacted. The evolution of this thinking and practice led to available funds through DPW for residential facilities to receive training and technical assistance in the Sanctuary® Model, an evidence-informed method for creating a trauma-informed and trauma responsive organizational culture, where services are delivered in a safe therapeutic environment, allowing for developing new ways of forming relationships and healthier interactions.[50] Efforts have continued to focus on supporting trauma-informed trainings including those who serve youth, families, and caregivers, and a TIC training curriculum was developed for certified peer support staff. In

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[49] Hodas, G. (February 2006). *RESPONDING TO CHILDHOOD TRAUMA: THE PROMISE AND PRACTICE OF TRAUMA INFORMED CARE*. Pennsylvania Office of Mental Health and Substance Abuse Services. https://www.nasmhpd.org/sites/default/files/Responding%20to%20Childhood%20Trauma%20-%20Hodas.pdf

[50] Creating Presence. *Changing your organizational trauma lens through Creating PRESENCE*. https://www.creatingpresence.net/

addition, the OMHSAS Bureau of Children's Behavioral Health Services continues to provide technical assistance to Residential Treatment Facilities (RTFs) in the areas of trauma and complex TIC, screening, identification, family engagement, and discharge planning for youth. Recently, the *Trauma-Informed PA: A Plan to Make Pennsylvania a Trauma-Informed, Healing-Centered State*, was issued in July 2020 by the Office of Advocacy and Reform under the Office of the Governor. The plan is designed to guide the Commonwealth and service providers Commonwealth-wide on what it means to be trauma-informed and healing-centered.[51]

In the treatment of SUDs, the Commonwealth has led an initiative to expand the EBP, Medication-Assisted Treatment (MAT). Although federally licensed methadone clinics and Commonwealth licensed PCPs were offering MAT to individuals with opioid SUDs, in 2016, the Commonwealth introduced an initiative for Centers of Excellence (COE) for Opioid Use Disorder (OUD). Forty-five centers including primary care practices, hospitals, Federally Qualified Health Centers (FQHCs), SUD treatment providers, and Single County Authorities were selected. These COEs are designed to take care of the whole person, including OUD treatment, PH treatment such as diabetes management and MH treatment, such as anxiety and depression. Among other supports, COEs provide each individual with a Peer Recovery Specialist as well as a Community-Based Care Management (CBCM) team who helps the individual identify, organize, obtain, and sustain treatment and supporting resources. What began as a grant program has moved into the Medicaid managed care system where COE care management services are reimbursed on a fee-for-service (FFS) basis.[52]

Pennsylvania has also endorsed multiple other EBPs discussed elsewhere in this report, including Peer Support Service, Assertive Community Treatment (ACT), and Parent-Child Interaction Therapy (PCIT).

PC and BH-MCO Interviews

All PCs and BH-MCOs highlighted efforts to expand access to EBPs addressing trauma and evidence-based approaches to recovery for OUD disorder, MAT.

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[51] *Wolf Administration Releases 'Trauma-Informed PA' Plan with Recommendations and Steps for the Commonwealth and Providers to Become Trauma-Informed*. (July 2020). Commonwealth of Pennsylvania. https://www.governor.pa.gov/newsroom/wolf-administration-releases-trauma-informed-pa-plan-with-recommendations-and-steps-for-the-commonwealth-and-providers-to-become-trauma-informed/

[52] Commonwealth of Pennsylvania Department of Human Services. *Centers of Excellence*. https://www.dhs.pa.gov/Services/Assistance/Pages/Centers-of-Excellence.aspx

Service Development

Addressing Trauma

DBHIDS and CBH launched an Evidence-based Practice and Innovation Center (EPIC) in 2013 to provide a common framework to implement, utilize and sustain EBPs over time in Philadelphia. National EBP experts have provided extensive training and consultation and through EPIC, numerous EBPs for children and adults have been strongly promoted and sustained. The following examples of EBPs address trauma and build capacity in child and adult treatment settings:

- Trauma-Focused Cognitive Behavior Therapy (TF-CBT) which combines cognitive therapy, behavioral therapy, and family therapy and is designed to assist children, adolescents and their families in overcoming the negative effects of traumatic experiences.
- DBT to help individuals who have struggled with suicidal thoughts, self-harm, and emotion dysregulation to develop coping strategies and skills for committing to a “life worth living”.
- Prolonged Exposure (PE) therapy aimed to reduce post-traumatic stress disorder symptoms.

In 2015, both Southwest Behavioral Health Management (SBHM) and Northwest Behavioral Health Partnership (NWBHP)[53] identified the need for a network of clinicians with specialized training in the treatment of individuals with trauma to ensure effective treatment in the least restrictive setting for children and adolescents. To increase capacity of TF-CBT providers, SBHM sponsored trainings as providers faced barriers with funding, supervision, and concerns about loss of revenue due to productivity decrease when clinicians participate in TF-CBT training. Upon TF-CBT certification, the clinician is designated as a Preferred Provider of Trauma Treatment. The initiative started with 12 TF-CBT providers and grew to 40 providers across the network.

Additional efforts to address trauma include, but are not limited to:

- Counties in collaboration with PerformCare expanded access to Eye Movement Desensitization and Reprocessing (EMDR), which helps individuals who have experienced traumatic events process and address symptoms related to traumatic memories.
- MBH contracted with a special group to provide training and serve in a consultative role to providers, including reviewing cases, role-play, and developed a quality team to monitor the implementation of DBT. MBH reported very low clinician turnover due to member successes of DBT, including a decrease use of psychiatric IP levels of care after completion of DBT.
- Beginning in 2015, North/Central State Option counties in collaboration with CCBH implemented strategies to achieve trauma-informed system transformation. County stakeholders were offered trauma training provided by the Lakeside Global Institute. Thousands of training hours were

[53] Northwest Three and Southwest Six Counties include Armstrong, Beaver, Butler, Fayette, Greene, Indiana, Crawford, Mercer, and Venango.

provided to school personnel, first responders, child welfare, juvenile justice, families, youth and other representatives. OP providers were also offered opportunities to participate in a Trauma Institute where they received training in Seeking Safety, TF-CBT, and Cognitive Processing Therapy (CPT) EBPs. In addition, trauma-informed language was added to local policies and procedures.

Medication Assisted Treatment

To help individuals make informed decisions, providers educate individuals about treatment options, benefits of MAT, overdose prevention education, and the need for naloxone/Narcan in case of an overdose.

Successful MAT programs incorporate recovery-oriented principles with medication support to help individuals achieve and sustain sobriety. In addition to expansion efforts, PCs and BH-MCO have led trainings, hosted conferences with national addiction experts, and provided technical assistance and support to individuals, providers and community stakeholders. Highlights are described below:

- PCs in collaboration with CCBH have developed community-based approaches to improve initiation and engagement in OUD and SUD treatment including creating warm hand offs from local Emergency Departments (EDs) to MAT in the community. In partnership with the Department of Drug and Alcohol Programs (DDAP), a SAMHSA MAT Prescription Drug and Opioid Addiction grant supported a “hub-and-spoke” model of service delivery in four rural counties. This grant supported development of a continuum of care for individuals with OUD that includes emergency departments, hospitals, criminal justice system, primary care, and addiction treatment providers. All CCBH addiction treatment providers are required to provide access to MAT across all levels of care as well as develop the capacity to maintain individuals of United States (US) Food and Drug Administration (FDA) approved medications for OUD as they transfer across levels of care.

- Across the Beacon counties, methadone providers had the opportunity to participate in a continuous quality improvement (CQI) initiative to ensure quality and effectiveness in psychotherapy services, a key factor to help individuals progress in treatment provided by methadone programming. Because the initiative has been so successful, efforts are focused on expanding the initiative to an additional group of providers.

- PCs in collaboration with MBH promoted increased access to and use of certified recovery coaches to support individuals in recovery. In addition to increasing access to withdrawal management and OP capacity for access to methadone, buprenorphine, and Vivitrol®, MBH tracks care manager promotion of MAT, MAT follow-up appointments with MAT prescribers, and referrals for counseling support.

- In 2017, DBHIDS, CBH and other experts formulated a comprehensive and coordinated plan to reduce OUD. Recommendations were developed related to prevention and education, overdose and harm reduction, addressing homelessness among opioid use users, expanding capacity for diversion to treatment, and expansion of treatment programs (i.e., embedding withdrawal management into all levels of care).

- To address whole-person approach to recovery, PCs in collaboration with PerformCare expanded access to Recovery Oriented Methadone Maintenance Service, MAT, recovery support services, and D&A OP clinics.

Funding

DBHIDS and CBH have financially invested in supporting relationships with EBP experts to provide training and consultation on delivering and implementing EBPs. In 2017, EPIC recognized and identified high quality EBPs through a designation process with a goal to increase the number of individuals who receive evidence-based services. In 2019, CBH began providing an enhanced rate for EBP-designated programs in MH and substance abuse OP services and providers that receive the rate are expected to develop strategies to direct financial incentives to the clinicians delivering the EBPs.

Enhancing staff compensation and retention of EBP-skilled staff is a key strategy for EBP sustainability.

PerformCare originally used reinvestment funding to pay differential rates to providers. Enhanced rates are now available for providers who offer services with fidelity to the evidence-based models for EMDR, DBT, and TF-CBT. MBH also offers an enhanced rate for the DBT model and asked providers to ensure reimbursement is passed down to the clinicians. MBH continues to offer ongoing technical assistance and support.

Regarding the Methadone CQI initiative, as clinical services are increased, the methadone provider is compensated by Beacon for the added intensity in a FFS methodology, which incentivizes additional quality therapy.

Monitoring/Data

To assist with maintaining quality and fidelity, EPIC offers training and consultation as well as service delivery and quality assurance mechanisms. CBH monitors EBP delivery through claims data and tracks provider trends. In 2018, CBH reported that over 5,200 unique individuals received EBPs in OP programs.

Bucks, Delaware, and Montgomery counties conducted an outcomes study for individuals receiving DBT services. Outcomes include a decline in quality of life indicators for days of homelessness and days without work due to symptoms and a decline in the number of individuals using a non-hospital detoxification or rehabilitation services six months after completion of DBT.

Behavioral Health Alliance of Rural Pennsylvania (BHARP's)[54] multifaceted trauma-informed system transformation approach and commitment to training all the "touch points" in the service system contributed to successful outcomes. Longitudinal dashboards use SAMHSA criteria to determine

[54] BHARP provides monitoring of the North/Central State Option HC-BH contract.

positive and negative outcomes. Positive outcomes include in the youth's ability to function in daily life and improvements to a youth's overall health.

Between 2011 and 2018, across CCBH counties, there has been over a 114% growth in MAT treatment slots. MBH reported a 50% decrease in overall readmissions when individuals are connected to MAT upon discharge from a residential program.

As part of the Methadone CQI initiative, the Institute for Research, Education and Training in Addictions (IRETA) implements a participant survey that is completed at the conclusion of every group session, as well as weekly face-to-face consultation meetings with therapists. Data is collected regarding length of stay, reasons for discharge, and follow-up service provision. The initiative has promoted a move from methadone as a terminal service to being seen as a recovery-oriented treatment.

Stakeholder Findings

Provider Comments

Since 2005, providers reported that certain structural changes in the HC-BH service delivery has had a positive impact on access to services and are considered promising practices. The following three changes in practice were noted to have particularly positive results:

1. The implementation of community-based services has created more open and easier access to services.

2. Clinics changing to an open access model has resulted in a 15% increase in the number of new clients, although additional revenue is required to sustain this model.

3. Access to MH services has increased with telehealth, especially telehealth. In addition to enhancing access, providers reported telehealth has improved the clinical quality of the services offered by bringing the therapist into the member's life. The therapist can enter the member's world and observe family dynamics and other clinically valuable information. Providers hope to continue with telehealth with those individuals who respond well to the modality. It circumvents transportation and other barriers, and helps the individual to have options for service delivery.

Community-based providers reported implementing multiple EBPs, including ACT teams, career centers staffed by CPSs, and TIC approaches for all staff. These providers highlighted their appreciation of the flexibility for the PCs and BH-MCOs to make enhanced payments for EBPs, as implementing EBPs is costly. Some providers also noted that the emphasis on implementing EBPs can decrease more creative, person-centered services.

As provider stakeholders discussed the development of EBPs, most voiced the need for a focus on removing barriers to the development of the HC-BH workforce. One reported barriers includes educational requirements (e.g., registered nurse [RN] cannot assume the lead in an ACT team without

a master's degree). Different regulations (and, at times, conflictual) for MH/SUD operations complicate providing treatment for individuals with co-occurring conditions.

Inadequate compensation for services are a particular concern for sustaining the workforce delivery of EBPs. Many providers reported that staff pay is low and the job is stressful, consequently they have high turnover as staff move on to better paying positions. One provider noted that fees for services have been the same for the past 10–15 years. OP providers stated that OP services are not sustainable with the current reimbursement model. These providers must supplement revenue with grants and other sources of revenue to stay solvent.

Inadequate compensation for services are a particular concern for sustaining the workforce delivery of EBPs.

An additional barrier to an adequate workforce includes provider enrollment for the Medicaid program, which was felt to be an onerous process, and managed care can provide additional barriers.

Member Comments

Adult's readily identified CBT and DBT as providing particularly useful tools for managing thoughts and feelings. Several individuals stated that they use the tools they learned in CBT and DBT every day to manage thoughts and relationships. Other members identified support groups, such as the Hearing Voices Support Group, and the Traumatic Brain Injury (TBI) groups, as particularly helpful. The Warm Line and Community Support Program were both deemed very helpful by members, who also noted that awareness of these services should be increased among providers.

Also noted were those who live in rural areas do not have the same access to EBPs as those who live in metro areas. Some members living in rural areas report spending an entire day each week to commute to a provider for an EBP.

Family members of youth agreed that few EBPs are available in rural areas. Further, they noted that many of the clinical staff were newly graduated and inexperienced. One mother described the difference in their experience with an EBP when they were assigned a more experienced clinician after leaving a situation with an inexperienced clinician.

Service Trends

In Pennsylvania, MAT is offered as a BH service as well as a PH service. The PH MAT benefit is administered by specially licensed PCPs, either in their offices or in a clinic. The BH MAT service is located in federally licensed methadone clinics. These clinics may provide other medications in addition to methadone, as well as care coordination and/or additional services to support the individual's recovery journey.

The number of individuals who receive BH MAT services increased from 20,702 unique users in 2014, to 26,740 unique users in 2018. These additional 6,038 individuals receiving MAT services represent a 30% increase over the four years.

As noted in the following table, the total annual costs for BH MAT services increased 43.4%, and the cost per user increased 11%.

Table 4. MAT Costs Comparison for 2014 and 2018

	2014	2018
Annual Cost	$ 60,519,646.00	$ 86,802,775.00
Cost per User	$ 2,923.37	$ 3,246.18

The total MAT cost increase of 43.4%, with only a 30% increase in the number of individuals receiving services and a 11% increase in cost per user indicates that the additional costs not accounted for by the number of additional users or the cost per user are most likely generated by an increase in the number of visits per year. That is, on average, MAT service recipients are using services more frequently or longer, or a combination of the two variables.

Literature Review and National Scan

The APA defines an EBP as "the integration of the best available research with clinical expertise in the context of patient characteristics, culture and preferences".[55] SAMHSA maintains a list of BH interventions supported by research in their *Evidence-Based Practices Resource Center.*[56] An ongoing quality concern for states has been the training and implementation of BH treatments that have empirical support.

Service Development

This section includes examples of EBPs in a specialized setting that is an interest in many states, examples of TIC EBPs for adults and children, and the promising practice of telehealth.

EBPs in Specialized Settings

In the past decade, one specialized setting for EBPs that has received significant attention and development is county jail systems. The setting requires considerations unique to that setting in

[55] American Psychological Association. *Evidence-Based Practice in Psychology*. https://www.apa.org/practice/resources/evidence

[56] SAMHSA. *Evidence-Based Practices Resource Center*. https://www.samhsa.gov/resource-search/ebp/all?keys=&items_per_page=15&sort_bef_combine=field_rc_publication_date_DESC

implementing EBPs. EBPs being offered in this setting include MAT, forensic peer support, and care coordination and a continuum of care in transitions between the jail and community services.

MAT during incarceration results in reduced recidivism, morbidity, and mortality. Jails with comprehensive substance abuse programs that include behavioral therapy as well as MAT also result in reduced costs. Unique challenges associated with MAT in jail include detoxification if an individual is transferred to a facility where MAT is not available and ensuring that MAT cannot be diverted within the facility, such as by monitoring direct ingestion.

One example of a successful MAT program in a correctional setting is the Rhode Island Department of Corrections (RIDOC). RIDOC introduced a MAT program in 2016 due to the growing opioid crisis along with screening and assessing all incoming inmates for MAT. The Department increased staffing to screen for chemical dependency and partnered with a local provider to introduce recovery coaches into the facility. Correctional staff monitors to ensure that medications are ingested appropriately. In a one-year follow-up study, the program has contributed to a decrease in recidivism and relapse in the population served.[57]

Another EBP being provided to justice-involved individuals is Forensic Peer Support. For example, Arizona has developed Peer Run Organizations that are skilled in forensic support. The Arizona Forensic Peer and Family Support Training Course is for credentialed Peer and Family Support Specialists who are working in the Targeted Investment (TI) Program Adult Ambulatory Projects that have a criminal justice focus. In 2018, Arizona projected that there would be at least 60 participants who need this new training statewide serving approximately 5,500 individuals.[58]

For justice-involved individuals, the transition between the county jail and community is challenging. Arizona's Targeted Investment Program (TIP), a Medicaid-funded program, integrates services for probationers and parolees with significant MH needs. Within the same visit and in the same location, these individuals meet with their probation or parole officer and healthcare and wrap-around services providers. TIP establishes relationships with community-based social service agencies, self-help referrals, and other treatment supports. The program does not just rely on handouts and flyers, instead forming community relationships to ensure resources are in place. A key component is same-day appointments on the day of release as well as on the same day as the visit to probation or parole. The same-day appointments are facilitated without terminating Medicaid when an individual enters a county jail or prison, but rather suspending Medicaid to ensure access to services upon release.

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[57] National Institute of Corrections. (October 2018). *Jail-Based Medication-Assisted Treatment: Promising Practices, Guidelines, and Resources for the Field*. https://www.sheriffs.org/publications/Jail-Based-MAT-PPG.pdf

[58] AHCCCS. *Support for Individuals Transitioning out of the Criminal Justice System*. https://www.azahcccs.gov/AHCCCS/Initiatives/CareCoordination/justiceinitiatives.html

Trauma-Informed Care

The Key Ingredients for Successful Trauma-Informed Care Implementation identifies three models of TIC for adults that have strong research support. Adult-focused TIC treatment models include:

1. *PE Therapy*: Research indicates PE therapy is the most effective treatment for posttraumatic stress disorder (PTSD). Treatment components include PTSD education, breathing techniques, exposure practice with real-world situations, and talking through the trauma.

2. *EMDR*: An information processing therapy that reduces trauma-related symptoms of stress and strengthen adaptive beliefs. Treatment components include spontaneous associations of trauma-related images, thoughts, emotions and sensations, and dual stimulation during trauma-related experiences to disrupt information pathways.

3. *Seeking Safety:* A present-focus therapy to help individuals attain a sense of safety. Treatment components include prioritizing safety, integrating trauma and substance use, rebuilding a sense of hope for the future, building cognitive, behavioral, interpersonal, and case management skill sets, and refining clinicians' attention to processes.[59]

For treatment of PTSD, the APA "strongly recommends" CBT, CPT, Cognitive Therapy, and PE therapy, and "conditionally recommends" Brief Eclectic Psychotherapy, EMDR, Narrative Exposure Therapy and certain medications for youth and adults. Therapies recommended by both of these organizations are well supported by research and are used across a wide spectrum of populations by clinicians from multiple professions.[60]

SAMHSA identifies CBT as a treatment option for trauma and used as TIC.[61] Sometimes called TF-CBT, the treatment is a structured intervention that focuses on stress management, education about symptoms, creating a narrative of the trauma as a means of exposure, and cognitive reprocessing of the trauma and resultant symptoms.[62]

Connecticut implemented the EBP of TF-CBT for children through a Learning Collaborative. The Learning Collaborative was a 6–15 month process that is a team-based approach employing several in-person trainings and individual consultations throughout the year and emphasizing organizational change and sustainability. Teams of staff from four to six community MH agencies were trained per

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[59] Menschner, C., & Maul, A. (April 2016). *Key Ingredients for Successful Trauma-Informed Care Implementation*. Center for Health Care Strategies. https://www.samhsa.gov/sites/default/files/programs_campaigns/childrens_mental_health/atc-whitepaper-040616.pdf

[60] American Psychological Association. *PTSD Treatments*. https://www.apa.org/ptsd-guideline/treatments

[61] SAMHSA. (March 2014). *TIP 57: Trauma-Informed Care in Behavioral Health Services*. https://store.samhsa.gov/product/TIP-57-Trauma-Informed-Care-in-Behavioral-Health-Services/SMA14-4816

[62] Healthline. *9 CBT Techniques for Better Mental Health*. https://www.healthline.com/health/cbt-techniques

year, for each of three years. One major success of the Learning Collaborative model was that it was self-sustaining. As team members left, the team was able to train and support new members rather than for a new team or service. In two years, 33% of current TF-CBT team staff participated in the initial Learning Collaborative training, while the other 67% have been subsequently trained internally by their team and through ongoing training opportunities.[63]

Telehealth

Although not an EBP, use of telehealth during the COVID-19 pandemic has resulted in early evidence of a promising practice. BH services provided as telehealth has improved patient access to services and can enhance some types of BH services.

Telehealth, telemedicine, and related terms generally refer to the exchange of medical information from one site to another through electronic communication to improve a patient's health.[64] For purposes of Medicaid, telemedicine seeks to improve a patient's health by permitting two-way, real-time interactive communication between the patient, and the physician or practitioner at the distant site. This electronic communication means the use of interactive telecommunications equipment that includes at a minimum, audio and video equipment.[65] Prior to COVID-19, CMS only reimbursed for telehealth services if both audio and video were used. With the onset of COVID-19, CMS issued temporary flexibilities for providers to be reimbursed for audio-only services in addition to video/audio telehealth services.

Telehealth has increasingly become an accepted method of delivering healthcare services, including BH services, as a way to address gaps in transportation and access to providers (for rural areas). In a letter to CMS, the American Medical Association strongly recommends that CMS continue to pay for audio-only telehealth visits beyond the COVID-19 public health emergency. Among other impacts of discontinuing Medicaid coverage of audio-only services, the letter notes that discontinuing payment for these services would exacerbate inequities in health care.[66]

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[63] Lang, J., Franks, R., and Bory, C. (July 2011). *Statewide Implementation of Best Practices: The Connecticut TF-CBT Learning Collaborative*. https://www.chdi.org/index.php/publications/reports/impact-reports/statewide-implementation-best-practices-connecticut-tf-cbt-learning-collaborative

[64] CMS. (March 2020). *MEDICARE TELEMEDICINE HEALTH CARE PROVIDER FACT SHEET*. https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet#:%7E:text=Telehealth%2C%20telemedicine%2C%20and%20related%20terms,to%20improve%20a%20patient%E2%80%99s%20health

[65] CMS. *Telemedicine*. https://www.medicaid.gov/medicaid/benefits/telemedicine/index.html

[66] Robeznieks, A. (April 2021). *Why audio-only telehealth visits must continue*. American Medical Association. https://www.ama-assn.org/practice-management/digital/why-audio-only-telehealth-visits-must-continue

Funding Strategies

EBPs in Specialized Settings

Medicaid funds clinical EBPs for eligible individuals and other insurance as a medical service. The costs associated with EBPs that require funding from other sources are associated with training, fidelity assessment, and monitoring.

Because incarcerated individuals are not eligible for Medicaid, the Rhode Island system of MAT in jails is supported by state funds through the Department of Corrections. In addition, the Governor's Overdose Prevention and Intervention Task Force and the Narcan® distribution subcommittee supports the initiative. Associated costs include an increase in staff and purchase of MAT, in addition to engaging community providers to assist with therapeutic interventions and transitions to the community.[67]

The Arizona SOC for the incarcerated population post-release is funded by the Arizona Health Care Cost Containment System (AHCCCS), the state Medicaid agency, and is paid per implementation milestone per unique member per year. The TI payment incentivizes providers to provide effective interventions such as ensuring appointments are kept and community connections are maintained.[68]

Trauma-Informed Care

The Connecticut Department of Children and Families (DCF) funded the Connecticut TF-CBT Learning Collaborative initiative at a cost of approximately $427,000 per year for three years. Funds were used to establish and support the TF-CBT Coordinating Center, faculty, training, quality assurance, and evaluation activities. In addition, funds were used for a small annual stipend for each participating agency to offset lost productivity due to training and associated expenses. One of the main goals on the initiative was that following a year of participation in the Learning Collaborative, the TF-CBT model would be sustainable in each provider organization and services would be reimbursed as OP care through private insurance or Medicaid.[69]

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[67] National Institute of Corrections. (October 2018). *Jail-Based Medication-Assisted Treatment: Promising Practices, Guidelines, And Resources For The Field*. https://www.sheriffs.org/publications/Jail-Based-MAT-PPG.pdf

[68] AHCCCS. (July 2018). *Targeted Investments Program- Justice Clinics Forum*. https://www.azahcccs.gov/PlansProviders/Downloads/TI/CoreComponents/TIJusticeForumPresentation073018.pdf

[69] Lang, J., Franks, R., and Bory, C. (July 2011). Statewide Implementation of Best Practices: The Connecticut TF-CBT Learning Collaborative. https://www.chdi.org/index.php/publications/reports/impact-reports/statewide-implementation-best-practices-connecticut-tf-cbt-learning-collaborative

Telehealth

Telehealth services were provided significant funding in the Federal Coronavirus Aid, Relief, and Economic Security (CARES) Act, signed March 27, 2020, with $200 million earmarked for telehealth activities. States and private health insurers have been investing in payment parity during the COVID-19 pandemic, and payers are expanding telehealth, with measures such as eliminating cost-sharing requirements.[70] CMS is currently evaluating maintaining equitable rates for Medicare services post-pandemic for telehealth services. Factors influencing the continued payment of full rates for services will include consideration of infrastructure costs such as disinfectant and other items included in in-person rates as well as concerns about program integrity.[71]

Monitoring/Data Strategies

States use a variety of approaches to monitoring EBP initiatives. National measures sets such as the National Committee for Quality Assurance (NCQA) can be used to drill down into a population receiving a specific intervention and determine efficacy of services, either through comparing against a look back period of a similar population who did not receive an EBP or comparing data to other states with similar populations but different services. For example, NCQA quality measures including decrease in IP visits, use of two or more antipsychotic medications in children, and access to care and follow-up measures are used for monitoring services.

Monitoring of MAT in a jail or prison tracks both the number of individuals inducted into MAT upon entry and the number continuing treatment upon release. AHCCCS also requires that providers submit implementation milestones and performance measures as part of the provider incentive structure. This data, in turn, is used to evaluate the quality improvement of the program.[72]

With the growth of telehealth, utilization, and quality measures are in development to monitor these services. The American Medical Association recommends utilizing a survey to identify front line staff needs as part of an implementation plan for telehealth. Providers should convene an implementation team consisting of both leadership and front line workers to ensure planning continues to focus on the needs of the individual and provider's staff. As part of the planning process, providers will need to define measures of success whether it be reduced hospitalizations, increased efficiency in client caseloads, or increased satisfaction scores from both staff and patients. At the time of this report, NCQA updated 40 measure sets to include telehealth as part of the denominator, including BH

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[70] Knopf, A. (April 2020). *Telepsychiatry coming into its own with COVID-19*. The Brown University Child & Adolescent Psychopharmacology Update. https://onlinelibrary.wiley.com/doi/full/10.1002/cpu.30487

[71] LaPointe, J. (July 2020). *CMS to Assess Telehealth Reimbursement Rates Post-Pandemic*. RevCycleIntelligence. https://revcycleintelligence.com/news/cms-to-assess-telehealth-reimbursement-rates-post-pandemic

[72] National Institute of Corrections. (October 2018). *Jail-Based Medication-Assisted Treatment: Promising Practices, Guidelines, and Resources for the Field*. https://www.sheriffs.org/publications/Jail-Based-MAT-PPG.pdf

measures. In addition, NCQA is temporarily allowing virtual access to meet provider network requirements for accreditation.[73]

Summary of Findings

Over the past 15 years, the Commonwealth has demonstrated a commitment to expanding EBPs and promising practices. Counties and BH-MCOs have assisted providers with training and implementation, offering differential rates for providers demonstrating evidence-based competency, and supporting providers to sustain EBPs. Providers have demonstrated expertise in services such as DBT, TF-CBT, MAT, and EMDR, although not always at a pace with the increasing demand as more individuals seek treatment. Many successful initiatives have targeted addressing trauma in children. Ongoing vigilance with development of EBPs and promising practices will allow for opportunities for treatment at lower levels of care by preventing crisis and IP stays.

Challenges to accessing EBPs remain due to issues with lack of transportation, lack of access in rural areas, and struggles to make reimbursement viable in an uncertain economy. Sustaining a well-trained and experienced workforce will be essential to expanding and maintaining access to EBPs. Social Determinates of Health (SDOH) such as inadequate housing increase the challenges of connecting individuals to necessary services and supports. Through ongoing analysis of gaps in the system and commitment to ever evolving promising practices, the Commonwealth will continue to mitigate these challenges. In addition, the demonstrated commitment of the Commonwealth to expand telehealth coverage will assist both in access to providers and increased choice for individuals. The landscape of BH care has shown great improvement over the past 15 years and continued commitment to building on strengths and addressing barriers will lead to further improvement.

[73] NCQA. *Telehealth*. https://www.ncqa.org/programs/data-and-information-technology/telehealth/

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Strategies to Reduce Reliance on State Psychiatric Hospitals and Increase Community Integration

Strategies Recommended in A Call for Change

Each of the following strategy areas describes strategies, goals, and activities to increase community-based services as identified in *Strategies for Promoting Recovery and Resilience and Implementing Evidence-Based Practices*.[74] Suggested activities for the development of community-based services are for consideration and are not all-inclusive. Additional activities related to these strategies may have emerged in the intervening 15 years and are included in this section.

Service Development Strategy: Develop a continuum of community-based services, supports, and implementation of best practice strategies to help individuals live in the community.

Activities to achieve this continuum of care should include BH-MCO development of a continuum of community-based services and supports, including ACT; a full continuum of crisis services; Peer Services; expectations for prescribing practices; supported housing; psychosocial rehabilitation; and supported employment. Additional activities to achieve a community-based services and supports continuum include: diversion for individuals involved in the justice system; outreach and mobile treatment; community level suicide prevention resources; integrated dual disorder treatment services for individuals with co-occurring MH/SUD conditions; support services (e.g., life and social skills training, housing, educational and vocational supports, job coaching); family psychoeducation; and transportation supports for individuals with mobility needs.

Funding Strategy: Develop funding and financial incentives for developing community integration services and practices. In addition, develop structures and messaging for reducing state hospital utilization and improving community integration.

Activities include provider incentives for developing community services that are tied to quality and outcome data. In addition, identification of funding mechanisms to support discharge plans for

[74] Mercer Government Human Services Consulting. (October 2006). *Strategies for Promoting Recovery and Resilience and Implementing Evidence-Based Practices*. Pages 75–78.

individuals discharged from long-term state hospital stays, as well as processes to ensure OP contact prior to discharge.

Monitoring/Data Strategy: Establish and implement BH-MCO and provider performance indicators associated with financial incentives.

Activities include establishing BH-MCO performance guarantees based on utilization measures of IP services and performance indicators on individuals discharged from state hospitals, including data derived from consumer/family satisfaction measures and community-based services.

Fifteen Years of Accomplishments and Trends

Pennsylvania's first state hospital, Harrisburg State Hospital opened in 1851. The state hospital system continued to grow until the 1940s, when it served over 40,000 individuals. Soon after, there was a push to serve individuals in the community and live independently. Since 1955, Pennsylvania has closed more than 10 state hospitals. Noticeable state hospital closures include Haverford (1998), Harrisburg (2006) — known as one of the oldest asylums in the nation, Mayview (2008), Allentown (2010), and in 2018, the Commonwealth announced closure of the civil unit at Norristown State Hospital (NSH) permanently. Over the years, the Commonwealth has focused on developing community-based services and supports to reduce reliance on state psychiatric hospitals.

PC and BH-MCO Interviews

Service Development

PCs, BH-MCOs, providers, and other community stakeholders have all made strong commitments to ensure individuals are supported in the community and in the least restrictive setting possible. Highlighted initiatives include Housing, EAC units, and ACT.

Housing

PCs and BH-MCOs consistently identified access to housing, a SDOH as a top priority to an individuals' recovery. Housing concerns are considered essential due to the direct impact on physical and emotional health, percent of IP admissions and readmissions, and follow-up with other BH services and supports. Housing initiatives are highlighted below:

Supportive Housing, an evidence-based housing intervention combine's affordable housing assistance with wrap-around supporting services.

- All MBH counties have utilized reinvestment funds to provide a clearinghouse and rental subsidies for individuals that would not be able to maintain affordable and safe housing without some financial assistance. Housing coaches and mobile supports coordinate with individuals to determine if a Department of Housing and Urban Development (HUD) subsidy, Housing Choice Voucher, increased personal income or roommate maybe a long-term option.
- When the civil section of Norristown State Hospital was closed to admissions, CBH focused on developing community-based resources for individuals with complex needs across multiple levels

of care. In addition to developing 216 new slots in the community, over 100 housing subsidies were provided to individuals transitioning from NSH to the community. Core services were also expanded including mobile PRS, Peer Support Services, Housing First options, tenant supports, and other EBPs.

- Franklin/Fulton promotes long-term recovery and functionality through Supportive Housing and CRS. Individuals are provided supports to overcome barriers with attending community-based services in addition to building natural supports. Franklin/Fulton reported the majority of individuals after 90 days of receiving housing supports have not accessed higher levels of care.

- Finally, many of the Beacon and CCBH counties implemented community-based housing programs and supports such as Supportive Housing, Master Leasing, Bridge Housing, and case management.

Extended Acute Care Units

The goal of an EAC unit is to provide a safe, therapeutic, and recovery-oriented environment focused on long-term needs for individuals with serious mental illness. EACs are part of the recovery-focused process that seeks to promote individual choices around care and provides opportunities for collaboration with individuals, families and their treatment teams. Within a therapeutic rich environment, EACs are multi-disciplinary and trauma-sensitive which are designed to improve an individual's role-functioning while stabilizing psychiatric symptoms.

Assertive Community Treatment

Many PCs and BH-MCOs have implemented and/or expanded ACT, an EBP to reduce the need for state hospitalization among adults with SMI. ACT is a person-centered, recovery-oriented MH service delivery model that has received substantial empirical support for facilitating community living, psychosocial rehabilitation and recovery for individuals who have not benefited from traditional OP programs. Common barriers identified included rural counties do not have the critical mass to support an ACT team, high staff turnover, hiring difficulties and maintaining specialists such as the co-occurring and vocational specialist, and limited funding. Specific initiatives are highlighted below:

- CCBH incorporates the use of motivational interviewing and trains ACT teams on supportive employment along with building Value-Based Purchasing (VBP) arrangements to reward increases in the number of individuals served employed.

- Since 2014, ACT providers in the Beacon network made significant improvements in the areas of identifying the role of a Peer Specialist, including a Peer Specialist on staff and increasing their responsibility for psychiatric services.

- Allegheny and Berks counties implemented ACT/Community Treatment Team (CTT) for Transition Age Youth programs to better meet the needs of youth and young adults.

- In 2019, Cambria County implemented an enhanced community-based intensive treatment (ECBIT) model, an alternative to ACT to enhance whole health supports to those considered to

have higher needs and early outcomes demonstrate that individuals discharged from ECBIT show an improved community integration rate by 30%.

It is important to highlight that PCs and BH-MCOs also recognized the expansion of Peer Services (CPS and CRS) which has contributed to individuals avoiding more restrictive levels of care and supporting individuals in the community. Additional services and supports include:

- Mobile psychiatric nursing and medication programs to support individuals transitioning from one level of care to another. As part of this service, nurses provide health assessment, education and medication management skills.
- Supported employment, designed to help individuals obtain and keep competitive employment.
- Psychiatric hospital liaisons in EDs to ensure individuals are linked to recommended treatment and supports in the community.
- Telehealth in rural and urban settings to provide consultation, assessments, and ongoing treatment for children and adults in the community.

Success Story: Mayview State Hospital Closure

When Mayview State Hospital closed on December 29, 2008, a total of 307 individuals had been successfully discharged to communities in Allegheny, Beaver, Greene, Lawrence, and Washington counties with detailed community support plans (CSPs). By 2011, only one former Mayview resident had been re-hospitalized in a state hospital through a civil commitment. The success in supporting people to live in communities is remarkable. Participants in a Mayview discharge study reported that they overwhelmingly preferred community living to the hospital and most felt safe and comfortable in their new residencies.[75] A large percentage of participants showed reductions in psychiatric symptoms and improved social adjustment over time.

To help sum up this amazing accomplishment, one former Mayview resident said: "the best experience has been knowing that I can make it in the real world."

Three years later in 2011, the community tenure of these individuals is a testament to their capacity to recover and to the substantial planning efforts of OMHSAS and the participating counties, BH-MCOs, providers, and stakeholders. Allegheny HealthChoices, Inc. (AHCI) facilitated a comprehensive planning process that encompassed service expansion, financial sustainability, responsiveness to stakeholder concerns, and individual CSPs for each person discharged. Key lessons learned include:

[75] Greeno, K., Estroff, S., and Colonna Kuza, C. *Mayview Discharge Study: Two-year outcome report*. Mayview Regional Service Area Plan. http://www.mayview-sap.org/documents/presentations/two%20year%20report%20mayview%20discharge%20study%209.pdf

- Peer Services were instrumental in helping members transition out of the hospital and continue to help members maintain relationships and involvement in the community.
- A large number (69%) of individuals received CTT services, modeled on ACT, in the three years since the closure.
- Across the regions, multiple factors contributed to former Mayview residents' recovery and stability: development of crisis centers, expansion of case management and service coordination, EAC programs and RTF-A.
- Since the closure, there has been significant cost savings. Individuals treated in the hospital cost $460 per day or $167,900 annually, compared to an average annual cost per person discharged of $16,400 in Washington County and $29,000 in Allegheny County, in 2010.[76]

Funding

PCs in collaboration with their BH-MCOs identified reinvestment funds to support housing initiatives, EAC programs, and supportive employment. HC Medicaid funds are used to pay for ACT services.

Monitoring/Data

PCs and BH-MCOs reported efforts to increase community-based resources including housing has resulted in positive outcomes:

- Fayette County reported over 575 households have received housing case management or rental assistance. The county formally monitors provider partners at least quarterly and in addition, utilizing data from 2013 through 2020, 789 individuals' employment goals have been funded.
- Over 30 individuals have received secure, affordable housing in Southwest Six and Northwest Three counties, and over 50 individuals have benefited from Bridge Rental subsidies.
- Over 800 individuals have benefited from housing programs in Allegheny County.

CABHC reported EAC programs have contributed to reduced State Psychiatric hospital admissions and readmissions, and improved community tenure. Even though the length of stay can range up to six months, individuals remain connected with families and case management resources. Overall, it was reported that the quality of care is strong and reflects a recovery-oriented treatment modality. In addition, a recent expansion of an EAC in a medical facility removes many barriers that individuals with comorbid conditions face to receiving psychiatric IP care. Capacity of EAC units in Beacon counties was reported to have grown to 32 individuals and has promoted individual choices around

[76] Allegheny HealthChoices, Inc. (June 2011). *Outcomes and Regional System Development for the Mayview State Hospital Service Area*. https://www.ahci.org/Documents/Mayview2yr_0611-1_HiRes.pdf

care and has provided opportunities that embrace collaboration with the individuals, families, and treatment team.

In 2008, OMHSAS conducted a study to better understand how fidelity to the ACT model impacted outcomes. The study found that high-fidelity ACT had better outcomes and was more efficient than low-fidelity programs, including having more people employed, more living independently or with families and having fewer people living in shelters, on the street or in nursing homes. As a result of this study, OMHSAS issued an ACT Bulletin in 2008 stipulating standards for developing and monitoring ACT programs. Performance monitoring is conducted at least annually and the Tool for Measurement of ACT (TMACT) is commonly used to assess fidelity to the ACT model.

Mobile medication teams in Allegheny, Erie and North/Central State Option counties have been effective with reducing IP utilization and helps individuals transition to other MH services as they develop medication management skills.

Stakeholder Interview Findings

Provider Comments

One consumer owned provider described a successful program in Berks County with state hospitals that include semiannual meetings with CPS supervisors, participation in discharge planning, and supporting the transition from the state hospital to the community with a warm hand off to a CPS. This provider group described two important components of successful discharge from a state hospital and other IP psychiatric hospitals to be:

1. The ability for the CPS to begin working with the member prior to discharge. Establishing this relationship prior to discharge increases community tenure. Currently, some state hospitals and other psychiatric hospitals collaborate with consumer owned providers, and others do not.

2. Individuals recently discharged into the community from institutional care access their CPS when they need them, including after hours. The CPS is also more available, and the individual can talk with the CPS more frequently than other clinical providers. This more intensive and flexible support also supports increased community tenure.

Other consumer-owned providers reported a fairly new model of embedding CPS in IP units. They noted that this helps to transition the culture in these institutions from a medical model to a recovery model. Furthermore, embedded CPS services allows these providers to introduce recovery tools, such as WRAPs to both member and hospital staff. Another approach is to embed a CPS in ERs, to facilitate diversion from institutionalization to community-based or OP services.

Other provider groups reported that the following developments over time in the HC-BH system have supported decreased admissions and lengths of stay in state hospitals and psychiatric IP facilities.

- Implementation of EAC programs have enabled members avoid longer psychiatric IP stays, and subsequent state hospital admission.

- SDOH emphasis provides a better quality of life for individuals at risk for hospitalization, and consequently increase community tenure.
- Placement of care managers and CPSs in hospital settings or engaged in discharge planning has created smoother transitions from IP to OP services, decreasing readmission rates.
- The growth of ACT teams has also supported increased community tenure, particularly when the facility-based provider engages this team in discharge planning and a warm hand off upon discharge. In some counties, regular meetings between the county, the IP provider and the BH-MCO are held to discuss and support individuals with particular challenges to community living. Providers reported mixed results from individuals on ACT teams.
- One provider implemented a short-term residential program for individuals coming out of criminal facilities to transition to the community and reduce recidivism.

Providers noted continued barriers to increased community tenure includes lack of continuing care when insurance lapses during treatment, and ACT staffing issues resulting in less capacity than is required.

Member Comments

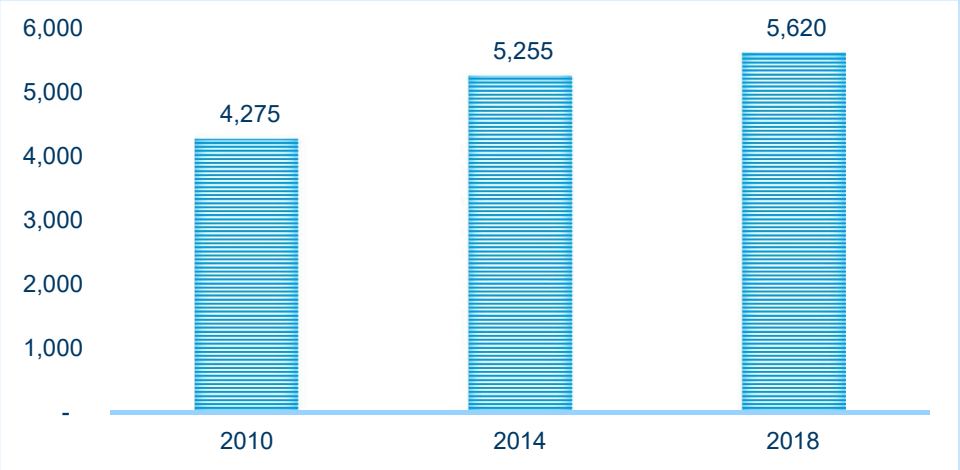
Members emphasized the importance of drop-in centers for individuals transitioning into the community. Recently, members noted that several virtual drop-in centers have been created to fill the void created by the COVID-19 pandemic. Open 24/7, these drop-in centers include Zoom Video Communications, Inc. (Zoom) meetings and has helped allow the community to stay in contact with each other.

Members also emphasized the importance of recovery planning and how it is essential to a successful transition into the community. Recovery plans should focus on the individual's triggers and how to manage them, as well as a crisis plan. Having these recovery plans in place are reported to decrease readmissions to IP and to increase community tenure. Members also highlighted the value in which peers bring during the recovery planning process and the important role they play during the transition to community support and services.

Service Trends

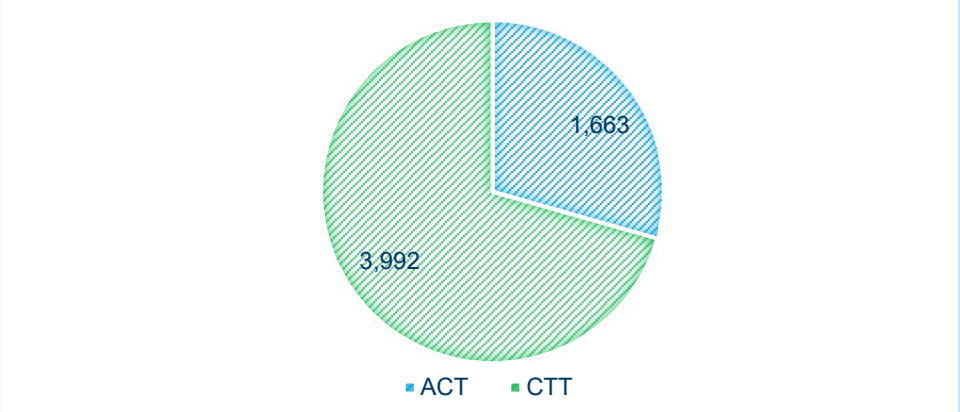
One EBP popular for helping individuals live in the community are ACT programs. The model for ACT is a multidisciplinary team of professionals with expertise in psychiatry, nursing, social work, substance abuse treatment, and employment counseling who provide intense supports and services in the community. CTTs were originally developed in Pennsylvania in 1993, based upon the ACT model, yet has a different implementation. Later, the full ACT model was implemented in the Commonwealth. Both ACT and CTT were the focus of an evaluation for fidelity to the treatment model, with a subsequent initiative to expand fidelity-based ACT and CTT programs throughout the Commonwealth. The number of unique users of ACT and CTT services between 2010 and 2014 increased by 22.9%, and by 31.5% between 2010 and 2014, as indicated in the following chart:

Chart D: Number of Unique Users of ACT and CTT Services



In 2018, 5,620 individuals received ACT/CTT services. Almost thirty percent of the users received ACT, and 71% received CTT as noted in the following chart.

Chart E: Number of Individuals who Received ACT or CTT in 2018



Individuals receiving ACT constituted 29.9% of the unique users, but 33% of the total costs for ACT and CTT. Furthermore, the cost per user is 23% more for ACT services than for CTT services. The higher cost for ACT services could be due to the more intense needs of individuals receiving ACT, or, could be due to the richer staffing model and more frequent visit requirements in the ACT model relative to the CTT model.

Table 5. Comparison of ACT and CTT Costs in 2018

	ACT	CTT	Total
Annual Cost	$ 26,011,400	$ 50,710,878	$ 76,722,279
Cost per User	$ 15,641	$ 12,703	$ 13,652

The following section highlights data tied to other community-based services that help to impact reduction of state psychiatric hospitals reliance. The information includes the number of adults receiving BH services, which increased by 23.2% between 2015 and 2018.[77] The services that were most frequently used by adults in 2018, in descending order, are:

1. OP Psychiatric (used by 68% of adults receiving BH services in 2018)
2. Other Services[78] (used by 29.5% of adults receiving BH services in 2018)
3. OP D&A (used by 23.9% of adults receiving BH services in 2018)

The following table demonstrates the increase, in every BH category of service, in adult utilization between 2015 and 2018:

Table 6. Increase in the Number of Adults Receiving BH Services between 2015 and 2018

Category of Service	2015	2018	% Change
IP D&A	2,461	3,280	33.3%
Non-Hospital D&A	30,242	41,043	35.7%
OP D&A	70,160	93,276	32.9%
IP Psychiatric	31,094	35,639	14.6%
OP Psychiatric	231,378	266,951	15.4%
Ancillary Support	29,718	36,549	23.0%
Community Support	57,579	63,553	10.4%
Other Services	83,619	115,222	37.8%
Total	**316,838**	**390,194**	**23.2%**

As a group, the D&A services has the largest and most consistent increases in the number of adults accessing these services, ranging from 32.9% (OP D&A) to 35.7% (non-hospital D&A). This uniform,

[77] This represent post Medicaid expansion growth in the number of individuals receiving BH services.

[78] "Other Services" includes lab services; Evaluation and Management Services and Healthcare Common Procedure Coding System services provided as wrap-around, in mobile crisis teams, and other community-based settings; and ACT.

post Medicaid expansion growth across all types of D&A services suggests that the expansion population drove much of this growth.

However, the category of service with the largest growth (Other Services at 37.8%) are psychiatric services provided in a variety of contexts, including community-based setting. This increase in the utilization of these services is a continuation of overall growth in services designed to support community tenure.

Literature Review and National Scan

Service Development

There has been a marked decrease in IP psychiatric beds in the US over the past 65 years. Several reasons for this decrease have been noted, including closure of state psychiatric hospitals, conversion of private psychiatric beds to more profitable medical/surgical beds, and federal emphasis on improved and expanded community-based services.[79]

In many cases, with sufficient community-based services, including access to intensive community-based supports and crisis diversion services, counties, MCOs, providers, etc. can support individuals with chronic and severe mental illness outside of an institutional setting, leading to a decreased need for IP beds.

Successful discharges from state hospitals are dependent on several factors. Some of the main elements are adequate access to SDOH, including supported housing and supported employment, access to psychotropic medication, and access to community providers. Other factors include community inclusion and natural supports.

Treatment planning for discharging individuals from a BH IP or crisis setting to the community should reflect the needs of the individual, which oftentimes may be housing or employment as a priority over treatment. By allowing individuals to be the determiners of their treatment plans and focusing on what is of import to the individual, which may not always be treatment, individuals are more engaged in the process and achieving community stability.

Housing First

Many states have turned to a Housing First model to assist in retaining individuals with severe mental illness and SUDs in the community. Without adequate housing, it is difficult to link and sustain individuals in treatment. Housing First, an evidence-based model does not require that an individual enrolls or stays in treatment to obtain housing. Housing First initiatives move individuals directly into

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[79] Fuller Torrey, E., Jaffe, D. J., Entsminger, K., Geller, J., & Stanley, J. *The Shortage of Psychiatric Hospital Beds for Mentally Ill Persons: A Report of the Treatment Advocacy Center*. Mental Illness Policy Org. https://mentalillnesspolicy.org/imd/shortage-hospital-beds.html

permanent supportive housing that offers supportive services. This approach places value on individual choice, while focusing on a harm reduction philosophy and case management.

The modality most often used to address behaviors that might be barriers to obtaining and retaining housing is harm reduction. The National Harm Reduction Coalition defines harm reduction as "a set of practical strategies and ideas aimed at reducing negative consequences associated with drug use. Harm Reduction is also a movement for social justice built on a belief in, and respect for the rights of people who use drugs". Harm reduction approaches treatment of substance use as a continuum, and works to minimize harm rather than push for total absence through methods such as needle exchange programs for intravenous drug users.[80]

In addition to harm reduction, supportive housing services include transition services as an individual prepares to move to the community and sustaining services to enable the individual to remain in the community. Transition services assist with screening and assessment to determine individual preferences and barriers to housing such as criminal records. In collaboration with the individual, a housing plan is developed. This service also assists with housing search and applications, identification of resources to cover moving expenses, and arranging the details of the move as well as a crisis plan, if housing should become jeopardized.

Tenancy supports assist in maintaining long-term housing, through services such as community integration and development of natural supports. In addition, the service addresses behaviors such as late rental payment that may jeopardize housing and reduce behaviors that may lead to eviction and other household support activities such as utility payment.

Other states have shown the success of a Housing First model. The Commonwealth of Virginia has embraced a Housing First model, and reduced overall homelessness by 31% and family homelessness by 37.6% from 2010 to 2016. In November 2015, Virginia received recognition as the first state to effectively end Veteran homelessness. Success of the program has been attributed to strong Commonwealth agency partnerships and commitment in the local communities.[81]

Massachusetts has developed an approach to Housing First in Boston, known as a surge. Individuals are provided information and enrolled in supportive service programs as well as make housing offers on site. Attendees may leave with an address and support services the very same day. The first eight surges yielded housing for more than 225 people.[82]

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[80] *National Harm Reduction Coalition*. https://harmreduction.org

[81] Kestner, P., & Robertson, K. (May 2017). *How Virginia Uses Collaboration And Coordination To End Homelessness State-Wide*. United States Interagency Council on Homelessness (USICH). https://www.usich.gov/news/how-virginia-uses-collaboration-and-coordination-to-end-homelessness-state-wide

[82] Bernstein, L., Cooper, E., Ciccarello, S., and Livingston, G. (January 2018). *Boston's Housing Surges: Helping Older Adults Experiencing Chronic Homelessness Find A Permanent Place To Call Home*. USICH.

In an evaluation of Rhode Island's Housing First program, the state placed a total of 48 individuals between 2005 and 2007. Results show:

- Individuals averaged a cost of $31,617 per person in services such as ED visits, prisons, and hospital stays, and that cost was reduced to $23,671 per person once they were placed in a Housing First home.
- Ninety-three percent of the individuals placed in the two years of the study had remained in permanent housing.
- Program case managers have been very effective in assisting with access to benefits such as Social Security Income leading to an increase in individual income, although less effective in assisting individuals in finding employment.[83]

Employment First

Similar to the Housing First Model, US Department of Labor, Office of Disability Employment Policy, provides federal support for a national movement of Employment First, with employment as the priority in the individual's treatment plan. Publicly financed employment services for individuals focus on integrated employment with commensurate wages and work sites that allow integration with individuals who do not have disabilities. Individuals should also have an opportunity for advancement in preferably full time employment. Many states have formally committed to the Employment First framework through official executive proclamation or formal legislative action.[84]

States that have adopted this framework have seen results in employment rates and stability of individuals in the community. Minnesota saw in increase of 0.5% in employed individuals in Fiscal Year (FY) 2018, with the majority earning $600 or more per month. Over 40% of individuals were employed with a competitive, integrated employer.

In Ohio, the Employment First Advisory Committee's training plan for providers took a unique approach to professional development planning by asking local communities to apply for a role as Local Leader teams. The state selected seven teams, and included members from various agencies

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https://www.usich.gov/news/bostons-housing-surges-helping-older-adults-experiencing-chronic-homelessness-find-a-permanent-place-to-call-home

[83] Hirsch, E., Glasser, I., D'Addabbo, K., and Cigna, J. (December 2008). *Rhode Island's Housing First Program Evaluation. Supportive Housing Network of New York*. https://shnny.org/uploads/Supportive_Housing_in_Rhode_Island.pdf#:~:text=Rhode%20Island%E2%80%99s%20Housing%20First%20Program%20Evaluation%20Research%20supported,and%20Jessica%20Cigna%2C%20Research%20Assistants%20December%201%2C%202008

[84] *Employment First*. U.S. Department of Labor Office of Disability Employment Policy. https://www.dol.gov/agencies/odep/initiatives/employment-first

such as county boards of developmental disabilities, self-advocates, family members, employment providers, educators, and others. Over a period of several months, the teams developed an assessment to determine needed resources in the community for integrated employment. The assessment was then used to develop a local professional development action plan, and create a local interagency agreement. The state utilized an interagency local approach to maximize buy in and optimize services available locally.[85]

Psychotropic Medication

Development of effective and safer psychotropic medication over time has led to increased utilization of management of medication in the community. Decreased negative side effects and expansion of the provider workforce have enabled more willingness for treatment and access to medication, a key component of community stabilization.

Another trend in community-based treatment is the use of long-acting injectable antipsychotics (LAIs). These medications provide individuals with therapeutic blood levels of antipsychotics for weeks to months, requiring infrequent clinic visits for new injections.

Adherence to medications is a challenge in MH care, particularly among individuals with severe mental illness. LAIs have emerged as a means of treating MH patients for longer durations, with the hope that this might help individuals lead more stable lives in the community. Available evidence suggests LAIs are as effective as oral antipsychotics and may work even better for some subsets of individuals. In 2013, a review of studies found that LAIs were significantly better than oral antipsychotics at preventing hospitalizations among patients with schizophrenia.[86]

Two states, New Mexico and Louisiana, have attempted to address the shortage of prescribers by certifying PhD psychologists to prescribe psychotropic medication. So far, those with prescribing privileges report that:

- They are getting good cooperation from physicians when an individual needs a psychotropic medication.
- Knowing more about medications in general helps prescribers talk to their clients about side effects and drug interactions.[87]

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[85] The Ohio Department of Developmental Disabilities. (February 2014). *Ohio's Path to Employment First*. https://ohioemploymentfirst.org/up_doc/Ohios_Path_to_Employment_First.pdf

[86] Morris, N. P. (January 2017). *How Community Mental Health Care Can Make a Major Difference*. Scientific American. https://blogs.scientificamerican.com/mind-guest-blog/how-community-mental-health-care-can-make-a-major-difference/

[87] Munsey, C. (February 2008). *Front-line psychopharmacology*. American Psychological Association. https://www.apa.org/monitor/feb08/frontline

Nurse practitioners (NPs) represent another option for expansion of prescribing providers. Allowing NPs to assess, diagnose, and treat individuals and families with psychiatric disorders expands the available workforce and decreases gaps in access to services.[88] As more and more doctors choose to pursue lucrative specialties rather than family medicine or primary care, the demand for NPs with continues to increase rapidly. Twenty-two states currently allow for NPs to prescribe and treat individuals with mental illness, including Alaska, Arizona, Colorado, and Connecticut.[89]

Funding Strategies

Funding for services rely on a combination of dollars, not just Medicaid. Two methods of combined funding strategies are blended funding and braided funding. In blending funding, funding is merged from individual sources into one funding stream, with each individual funding source losing its specific identity. Several agencies may provide support to a single individual, such as Medicaid for BH and PH needs, public health for food and nutritional needs, and vocational rehabilitation for employment needs. In a blended funding model, one case manager coordinates and manages the treatment plan, funding and services from different agencies including vocational rehabilitation, public health, and Medicaid.

In braided funding, stakeholders coordinate funding from individual sources, with each individual funding source keeping its specific identity. For example, some states such as North Carolina are using braided funding for supported employment. Each funding source pays for different milestones in the service, maximizing the federal dollars available for service provision. The Department of Education's vocational funding may provide for job readiness milestones such as assessment and resume preparation, Medicaid funds may provide social supports during the beginning stages of the employment process, and the state's MHBG Funding from SAMHSA may fund long-term milestones such as employment retention at six months.

Housing First

Funding for housing programs is usually a combination of resources, such as Medicaid, state and local safety net funding, foundations and other private resources and other federal agencies such as HUD.[90] Even when public sector programs, non-profit service providers and other agencies collaborate under

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[88] American Psychiatric Nurses Association. *Psychiatric-Mental Health Nurses*. https://www.apna.org/i4a/pages/index.cfm?pageid=3292

[89] *States Granting NP Full Practice Authority*. Maryville University. https://online.maryville.edu/nursing-degrees/np/states-granting-np-full-practice-authority/#:%7E:text=%2022%20States%20with%20NP%20Practice%20Autonomy%20,potential%20to%20gain%20full%20prescriptive%20authority. . .%20More%20

[90] Mandros, A. (June 2015). *What Is "Housing First"?* OPEN MINDS. https://openminds.com/market-intelligence/editorials/what-is-housing-first/

Housing First initiatives, programs struggle to cover funding for (non-MH) case management, outreach, and engagement services.

States may access tenancy support services through in a variety of ways, such as CMS waivers and federal grants.[91] Other states have found creative ways to fund community-based supports such as housing. For example, during the first year of Denver, Colorado's supportive housing Social Impact Bond initiative, the outcomes met benchmarks to trigger the first success payment of $188,349 to project investors. From January 1, 2016 to June 30, 2017, 39 individuals frequently involved with the criminal justice system remained housed for at least 365 days without any episodes away from housing lasting more than 90 days or unplanned exit from housing.[92]

In New Jersey, Horizon Blue Cross Blue Shield of New Jersey (Horizon BCBSNJ) expanded its Horizon Neighbors in Health demonstration project that addresses SDOH. The demonstration hires community health workers, who utilize a platform called NowPow to connect Horizon BCBSNJ members with an array of non-medical services such as food, housing, MH support, education, or employment opportunities; Horizon BCBSNJ funds the initiative.[93]

In North Carolina, the Department of Health and Human Services has received permission to fund SDOH Pilots via Medicaid under an 1115 waiver authority. Pilots can address housing, transportation, food insecurity, and domestic violence. In addition, the state has created a database called NCCARE360, similar to the New Jersey NowPow platform to allow care coordinators and other care managers to locate SDOH resources throughout the state. Funding for the pilots comes from waiver demonstration funds.[94] Most states are moving toward some sort of creative funding to address SDOH and to incentivize health plans to create community resources, which in turn provides better health outcomes and quality of life as well as health savings.

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[91] Mandros, A. (June 2015). *What Is "Housing First"?* OPEN MINDS. https://openminds.com/market-intelligence/editorials/what-is-housing-first/

[92] Gillespie, S., Hanson, D., Cunningham, M., and Pergamit, M. (October 2017). *Denver Supportive Housing Social Impact Bond Initiative: Housing Stability Outcomes*. Urban Institute. https://www.urban.org/research/publication/denver-supportive-housing-social-impact-bond-initiative-housing-stability-outcomes

[93] OPEN MINDS. (July 2020). *Horizon New Jersey Health Completes Expansion Of 'Neighbors In Health' Program To Address Social Determinants Of Health*. https://openminds.com/market-intelligence/news/horizon-new-jersey-health-completes-statewide-expansion-of-neighbors-in-health-program-to-address-social-determinants-of-health/

[94] NC Medicaid Division of Health Benefits. *North Carolina's Transformation to Medicaid Managed Care*. https://medicaid.ncdhhs.gov/transformation#:%7E:text=North%20Carolina%27s%20Transformation%20to%20Medicaid%20Managed%20Care%20DHHS,Medicaid%20provider%20submit%20claims%20as%20they%20do%20today

Psychotropic Medication

Medicaid does fund psychotropic medication, and is required to fund all medications with limited exceptions. Formularies are often organized into “preferred” or “non-preferred” drugs, with the “preferred” category not requiring special authorization to encourage use of drugs that have been on the market longer and have more generic options to be prescribed first. Although there are federally required rebates for Medicaid, many states also negotiate supplemental rebates from manufacturers as part of efforts to contain costs.[95]

Monitoring/Data Strategies

There have been several tools developed to monitor progress of individuals in the community. Reliable and valid surveys can be an effective method of monitoring. One survey developed by CMS is the Experience of Care (EoC) Survey, created as a part of the Testing Experience and Functional Tools demonstration. The demonstration allowed nine states to test HCBS quality management tools and develop an information technology infrastructure. After the demonstration ended in 2015, this survey was incorporated into the Consumer Assessment of Healthcare Providers and Systems (CAHPS) program as the CAHPS HCBS Survey most states deliver to long-term services and supports (LTSS) recipients.

The National Core Indicators for Aging and Disabilities is a survey that can be used in both FFS and managed care programs. A similar survey exists for individuals with developmental disabilities, and both surveys focus on quality of life and outcomes. Surveys such as these allow for qualitative measures of community living in addition to the use of more quantitative measures such as number of individuals housed. These survey results assist with monitoring quality and member satisfaction.[96]

HUD is another source of measurement of transitions for multiple populations, including Medicaid. Information is collected at the individual level, and can inform individual, agency, community, and state planning regarding strengths and opportunities for improvement. The Housing Management Information System (HMIS) can collect information such as employment and assess areas or programs where there is poor job retention as well as track placement outcomes such as placement separations due to incarceration or return to a shelter. In addition to assisting with determining

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[95] Gifford, K., Winter, A., Wiant, L., Dolan, R., Tian, M., and Garfield, R. (April 2020). *How State Medicaid Programs are Managing Prescription Drug Costs: Results from a State Medicaid Pharmacy Survey for State Fiscal Years 2019 and 2020*. Kaiser Family Foundation. https://www.kff.org/medicaid/report/how-state-medicaid-programs-are-managing-prescription-drug-costs-results-from-a-state-medicaid-pharmacy-survey-for-state-fiscal-years-2019-and-2020/

[96] Medicaid and CHIP Payment and Access Commission. (June 2018). *Managed Long-Term Services and Supports: Status of State Adoption and Areas of Program Evolution*. https://www.macpac.gov/wp-content/uploads/2018/06/Managed-Long-Term-Services-and-Supports-Status-of-State-Adoption-and-Areas-of-Program-Evolution.pdf

negative outcomes, the system can also be used for long-term planning of resources for interventions as well as prevention.[97]

Another federal source of measurement can be found from SAMHSA. The Uniform Reporting System (URS) reports annually on state and national statistics as part of the Community MHBG Program. Measures include individual's employed and unemployed, number of individuals receiving MH service in the community, number of individuals in jails or homeless, and appropriateness of service location. Although these are aggregate numbers reported, they can also assist in measuring the overall efficacy of the community system and resources to prevent state facility institutionalization.[98] For example, in FY 2019, the percentage of individuals in the US with a known living situation was 83.7%, 56.3% of which was a private residence. It is important to note that the states self-report information.

In the area of psychotropic medications, the Pharmacy Quality Alliance provides national measure sets to determine the quality and appropriate, safe use of prescription medications, both psychotropic and non-psychotropic. Several measures focus on the use of prescription opioids, such as morphine and other opioids utilized by individuals with and without cancer while others focus on areas such as the use of multiple antipsychotics in children. These measures ensure the quality and safety of the prescribing and utilization of prescription medication.[99]

Summary of Findings

The transition from state hospitals and other institutions has presented a challenge both nationwide and internationally. The main challenges presented are two fold; fear of individuals leaving institutions who may not have the skills to live independently and scarcity of resources in the community to adequately develop those skills and support a successful transition. The Commonwealth has responded to these challenges with developing services and supports such as ACT/CTT teams, EACs, and Peer Services. Services such as these offer supports to assist in developing independent living skills as well as supporting connections to natural supports in the community.

As learned from the Mayview State Hospital closure, the role of the Peer was instrumental in helping members transition out of the hospital and continue to help members maintain relationships and involvement in the community.

Other efforts to supporting individuals in the community has been housing vouchers to help supplement income for individuals who

[97] *Step Eight: Using the HMIS Data*. U.S. Department of Housing and Urban Development. https://archives.hud.gov/offices/cpd/homeless/hmis/implementation/step8.pdf

[98] *2019 Uniform Reporting System (URS) Output Tables*. (May 2020). SAMHSA. https://www.samhsa.gov/data/report/2019-uniform-reporting-system-urs-output-tables

[99] *PQA Quality Measures*. Pharmacy Quality Alliance. https://www.pqaalliance.org/pqa-measures

may not be able to cover full housing costs in the short-term as well as peer-operated drop-in centers. In addition, the importance of warm transitions from an institution to the community has been recognized. It is essential providers work with individuals prior to discharge to develop rapport and begin ensuring supports are in place before transition so that there is not a wait and the transition fails due to lack of community services.

Inadequate funding and enough resources in rural areas as well as restrictions on Medicaid funding by the federal government continue to present challenges to successful community transitions. As SDOH such as housing, employment, and transportation receive more and more national attention, the Commonwealth will have the support of other states and advocacy organizations in thinking through these challenges and assisting with creative solutions to achieve the goal of having individuals live, work, and play in their own communities with the least restrictions possible.

7

Development of a Family-Based Evidence-Based Practice Model Service Array That Supports System Transformation

Strategies Recommended in A Call for Change

Each of the following strategy areas describes strategies, goals, and activities to increase family-based services as identified in *Strategies for Promoting Recovery and Resilience and Implementing Evidence-Based Practices.*[100] Suggested activities for the development of family-based services are for consideration and are not all inclusive. Additional activities related to these strategies may have emerged in the intervening 15 years and are included in this section.

Service Development Strategy: Implement family-based services including Functional Family Therapy (FFT), Multi-systemic Therapy (MST), Multi-Dimensional Treatment Foster Care (MTFC) and Wraparound services. Also, consider implementation of Multidimensional Family Therapy (MDFT) on a more limited basis.

Activities to support the implementation of these family-based services should include the development of a supportive framework and infrastructure with a favorable culture/climate to implement and sustain these services. Administrative actions should include a standardized screening protocol (e.g., the Child and Adolescent Functional Assessment Scale [CAFAS] or Child and Adolescent Needs and Strengths [CANS]-MH) and tracking outcomes over time.

Funding Strategy: Promote and support evidence-based culture for family-based practice models through paying for transition costs, and use of financial incentives with BH-MCOs and providers.

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[100] Mercer Government Human Services Consulting. (October 2006). *Strategies for Promoting Recovery and Resilience and Implementing Evidence-Based Practices*. Pages 158–161.

Activities include paying for training and transition costs through an intermediary organization, either procured through a Request for Proposal (RFP) agency or using a quasi-governmental entity to pay for training and transition costs. Consider use of financial incentives for providers.

Monitoring/Data Strategy: Require and monitor fidelity to the treatment model with ongoing fidelity monitoring, using a standardized screening protocol, and enforcing the models' entrance criteria. In addition, monitor utilization and outcomes with the development of local and statewide data monitoring capacity, local data collection and analysis, and program outcome evaluation.

Activities include developing local and Commonwealth-wide data monitoring capacity, especially those outcomes data implemented in routine clinical practice, requiring the use of fidelity protocols to track and monitor these EBPs at local and Commonwealth level; and requiring local outcome evaluation at the local level.

Fifteen Years of Accomplishments and Trends

In 2005, OMHSAS established an overarching goal of transforming the children's BH system to one that is family-driven and youth guided. One effort to support this goal is to improve access to evidence-based and culturally relevant MH treatment. Three highly recognized programs that work within the context of the youth's support system include FFT, MST, and MTFC. All three programs help divert culturally diverse youth with severe BH issues from residential and juvenile detention placements. These three services were originally identified as family-based services in the *Strategies for Promoting Recovery and Resilience and Implementing Evidence-Based Practices* report.

Another effort to support the goal of a family-driven and youth guided system, is an initiative to establish child and family teams and implement High-Fidelity Wraparound (HFW), an evidence-based process. Joint Planning Teams (JPTs) engage and empower families to be the primary determinant of services in the treatment and recovery process. HFW was initially established in five counties and family teams were formed to reduce the use of residential placement and other intensive services. In 2009, OMHSAS received a five-year SAMHSA grant to allow 15 more counties to develop HFW. The Youth and Family Training Institute, a division of the University of Pittsburgh and Western Psychiatric Institute Clinic of UMPC provides training, support, monitoring, and evaluation of HFW in each county. Between 2009 and 2019, OMHSAS has been awarded several additional grants, which has helped support expansion including enhancements to the model, training, and evaluation efforts. HFW has served hundreds of youth and their families in 17 of the most populated counties across the Commonwealth. Reported outcomes are positive and in 2018, 1,500 youth/families were enrolled in HFW.[101]

[101] Youth and Family Training Institute. (2019). *Connecting the dots… A Ten Year Review 2009–2019*. http://antrios.wpic.pitt.edu/files/file/Ten%20Year%20Review/YFTI%20Ten%20Year%20Report.pdf

PC and BH-MCO Interviews

Service Development

Multi-systemic Therapy, Functional Family Therapy, and Multi-Dimensional Treatment Foster Care

MST, FFT, and MTFC services were consistently reported to be underutilized across the Commonwealth. PCs and BH-MCOs reported a lack of referrals and concerns with sustaining the services, implementation complexity, families' unfamiliarity with a new service, and narrow service definitions. Other challenges to the service include limited funding to dedicate to training and network expansion. To overcome challenges with FFT, CABHC collaborated with a national entity to provide training, education, and technical assistance. A prescribing algorithm was developed to identify the number of individual's eligible for FFT. Outcome reports are provided quarterly during FFT monitoring meetings and the quality of service is reported to be evidence-based and provided with fidelity to the model. Beginning in 2016, CBH developed a request for proposal to expand traditional family-based services and to focus on crisis intervention skills. Trainings and ongoing consultation opportunities are offered so providers are well positioned to provide crisis intervention that is youth-based and family centered.

High-Fidelity Wraparound

Designed to help youth and families with complex needs to live together successfully in the community, families receive support from family and youth support partners, a facilitator and supervisor/coach to develop a family-centered service and support plan. A youth support partner and family support partner play a valuable role with ensuring youth and family voice and choice, supporting confidence, and using their personal story to teach and role model through experience. In 2019, 31 youth support partners and 32 family support partners completed the credentialing process.[102] This team-based, collaborative approach enables youth and families to use their resources and help from others to overcome challenges.

Funding

As of 2019, there are 12 MST providers serving 54 counties in the Commonwealth and all programs are enrolled in MA. There are eight FFT providers serving 12 counties that have been approved by OMHSAS for MA funding.[103]

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[102] Youth and Family Training Institute. (2019). *Connecting the dots… A Ten Year Review 2009–2019*. http://antrios.wpic.pitt.edu/files/file/Ten%20Year%20Review/YFTI%20Ten%20Year%20Report.pdf

[103] Center for Mental Health Services Division of State and Community Systems Development. (2019). *Pennsylvania FY 2020/2021 Community Mental Health Services Block Grant Plan*. https://www.paproviders.org/wp-content/uploads/2019/07/FY20-21-CMHSBG-Application-Public-Comment-Draft-003.pdf

Pennsylvania has primarily utilized Medicaid to finance all related costs of providing and measuring HFW. Medicaid 42 CFR 438.208 authority allows BH-MCOs to perform joint treatment planning involving identification, assessment and development of individual service plans, for high need individuals with special health care needs. JPT is the term for HFW financed with Medicaid funds through this authority.[104] Several counties have also used reinvestment funds to provide JPT services. For example, in York County, over 35 youth and their families have received JPT through reinvestment funds. Fayette County has also used reinvestment funds since the initiative's inception in 2008. A few counties use funds from county children and youth agencies to pay for HFW teams to work with youth involved in the child welfare system.

Monitoring/Data

FFT, MST, MTFC, and HFW have established fidelity monitoring protocols available that are required, tracked and monitored both at the local and state level. The Youth and Family Training Institute is responsible for fidelity and outcome monitoring of the HFW workforce. Since implementation of a data collecting process in 2013, the Youth and Family Training Institute had collected data on over 1,800 youth and families. Reported outcomes of HFW include reductions in intensive levels of care including RTF, Partial Hospitalization, and IP Psychiatric Hospitalization as well as reductions in other child-serving systems of juvenile justice, child welfare, and D&A.[105]

The OMHSAS Children's Bureau in conjunction with OMHSAS field offices have conducted site reviews of FFT providers. The reviews are based on an extensive survey tool that assesses compliance with FFT practices and with Commonwealth regulations and policies.

Stakeholder Interview Findings

Provider Comments

All provider groups agreed that FBMH services have increased collaboration to create more successful transitions between levels of care, as well as supporting IP diversions. Facility-based providers reported that FBMH has reduced IP and RTF admissions and lengths of stay, and is routinely prescribed for youth with IP readmissions. Providers maintained that removing prescriptive regulatory and managed care restrictions has provided more flexibility and enabled family teams to address family needs in real time.

School- and community-based providers described MST and FFT as very successful, although these services are not as available in rural areas of the Commonwealth. These providers did note that there

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[104] *HFW Outcome and Cost-Effectiveness Analysis*. Youth and Family Training Institute. http://antrios.wpic.pitt.edu/pages/hfw-outcome-and-cost-effectiveness-analysis-

[105] Youth and Family Training Institute. (2019). *Connecting the dots… A Ten Year Review 2009–2019*. http://antrios.wpic.pitt.edu/files/file/Ten%20Year%20Review/YFTI%20Ten%20Year%20Report.pdf

is a gap in services between the more intensive services (e.g., FBMH and intensive behavioral health services [IBHS]) and standard OP services. These providers reported a need for an intermediate step down service that supports the youth and family in their movement towards less intensive services.

Member Comments

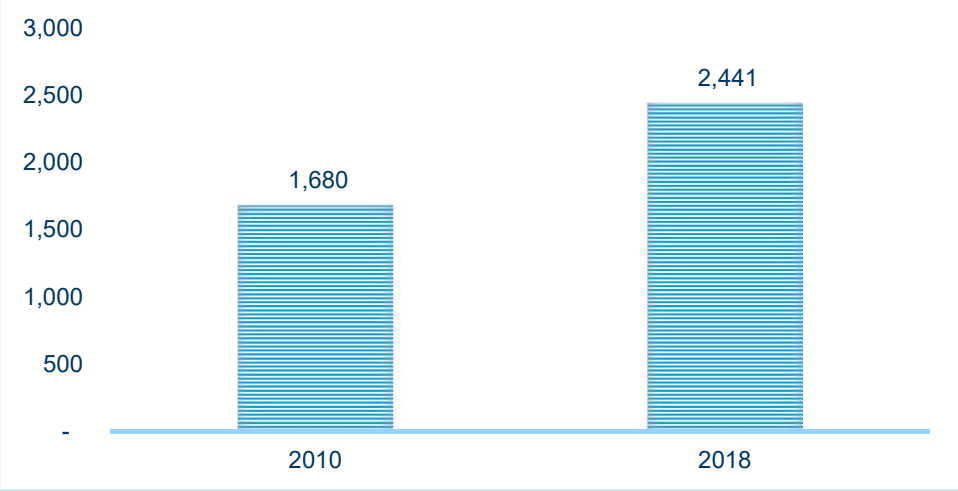
Family members of youth reported that they have had variable experiences with FBMH services. Some family members reported that the team did not arrive at their home, or arrived during meal times, and created so much inconvenience for the parent that the parent refused to continue with FBMH services. Other members in more rural areas of the Commonwealth said that FBMH services are not available and rural areas are about "10 years behind" areas that are more populated.

However, despite some of the reported barriers, some family members reported very positive experiences with FBMH services. They identified that FBMH services excelled at crisis management. An additional benefit the family members identified is that the team approach for FBMH services eliminated the need for 5–7 appointments a week, making BH services more family friendly and manageable. Another family member described how beneficial FBMH services are and how her child and family feel as though they are being listened to.

Service Trends

The number of individuals and their families who received FFT and MST services increased from 1,680 to 2,441, an increase of 43.5%, as indicated in the following chart. This increase in recipients represents a change from 0.1% to 0.2% penetration rate.

Chart F: Increase in the Number of Families Receiving FFT and MST between 2010 and 2018



Costs associated with these services are reflected in the following table:

Table 7. Change in Costs for FFT and MST

FFT and MST Users	2010	2018	% Change
Annual Cost	$ 8,308,544.00	$ 12,337,533.00	48.5%
Cost per User	$ 4,945.56	$ 5,054.29	2.2%

Increases in costs between 2010 and 2018 reflect the increased utilization of these services rather than an increase in frequency of sessions or LOS. Fidelity to the EBP models of FFT and MST require that those who receive these services meet relatively narrow entrance criteria and that the service is implemented as described. Meeting these requirements accounts for the relatively low number of recipients as well as the stability of cost per user across time.

Literature Review and National Scan

The goals of intensive community-based EBPs are to keep youth in their communities and to avoid more restrictive placements such as IP and residential care; these EBPs also offer cost savings when compared to residential placements. These goals align with the goals of the Family First Prevention Services Act (FFPSA), which are: 1) to keep families together, 2) prevent abuse and neglect, and 3) support research-based services for families. FFPSA amends Title IV-E to provide more federal resources for evidence-based prevention services and limits the use of federal funds for placing children and youth in congregate care placements.[106] The FFPSA allows the use of Title IV-E funding to pay for services provided to children and youth (and their families) who are at risk of entering foster care.

Service Development

Multisystemic Therapy

MST is an evidence-based, community-based, and family-based intervention that was originally developed for youth with behavioral problems and has more recently been adapted by the developer to be used with youth experiencing child maltreatment, serious emotional disorders, problem sexual behavior, substance abuse, and chronic health conditions.[107] This intervention focuses on creating an environment that supports adaptive behaviors while addressing different areas of a youth and their

[106] The Children's Defense Fund. (2018). *The Family First Prevention Services Act*. https://www.childrensdefense.org/wp-content/uploads/2018/08/family-first-detailed-summary.pdf

[107] Henggeler, S. W., & Schaeffer, C. M. (2016). Multisystemic Therapy®: Clinical Overview, Outcomes, and Implementation Research. *Family Process*, 55(3), 514–528. https://doi.org/10.1111/famp.12232

caregiver's lives. MST has been provided in 34 states to over 200,000 youth.[108] Compared to other interventions for high-risk youth, MST has the largest body of data, with results replicated by independent research teams. Outcomes for juvenile offenders include 54% fewer arrests: youth with juvenile justice involvement have had 54% fewer arrests over the last 14 years, 75% fewer violent felony arrests over 22 years, and 54% fewer out-of-home placements (median across all studies).[109]

Virginia set out to reform how its Department of Juvenile Justice responded to court system-involved youth and in 2017, used savings from the closing of Beaumont Juvenile Correctional Center to provide MST and FFT to court-involved youth in underserved areas of the Commonwealth.[110] By 2019, MST and FFT programs were in 97% of the Commonwealth's cities and counties.[111] Another effort to implement MST in Virginia was through its Department of Social Services (VDSS). VDSS implemented the Three Branch Model approach (legislative, judicial, and executive) to address child welfare issues and integrate FFPSA into its practices. VDSS is providing training in MST (ranked as a well-supported intervention) as part of its efforts to implement FFPSA.

Louisiana adopted MST early when state researchers who were impressed by its outcomes advocated for adoption of the model in the state. The first MST team was funded through a criminal justice grant in 1995 and through support from the court system; the model has continued to grow.[112] In 2001, the Louisiana Supreme Court provided enough funding to the Jefferson Parish Human Services Authority (JPHSA) to allow JPHSA to offer MST to every youth who was involved in the state's drug court system. Demand for MST across the state increased after drug court standards were revised to implement a requirement for evidence-based treatment programs for youth.

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[108] MST® Services. *What Makes MST® Such an Effective Intervention?* https://f.hubspotusercontent30.net/hubfs/295885/MST%20Redesign/White%20Paper/What%20Makes%20MST%20an%20Effective%20Intervention%3F.pdf?__hstc=220415175.3a0aa6e18fd88c8d156d0cb01bfc6eb7.1612564821558.1612800884521.1612805629481.5&__hssc=220415175.2.1612805629481&__hsfp=3541130711

[109] *Proven Results*. MST® Services. https://www.mstservices.com/proven-results

[110] Virginia Department of Juvenile Justice. *DJJ INVESTS SAVINGS FROM FACILITY CLOSURES INTO NEW EVIDENCE-BASED FAMILY THERAPY PROGRAMS ACROSS VIRGINIA*. http://www.djj.virginia.gov/pdf/admin/Newsroom/News/101017%20DJJ%20Implements%20MST.pdf

[111] Virginia Department of Juvenile Justice. *DJJ TRANSFORMATION UPDATE REPORTS RECORD LOWS IN NUMBERS OF YOUTH ENTERING COURT SYSTEM*. http://www.djj.virginia.gov/pdf/admin/Newsroom/News/121819%20DJJ%20Transformation%20Plan%20Update%20--%20FINAL.pdf

[112] MST® Services. *MST® Services State Success Guides*. https://f.hubspotusercontent30.net/hubfs/295885/MST%20Redesign/Marketing%20Collateral/Guides/State%20Success%20Guides.pdf?__hstc=220415175.3a0aa6e18fd88c8d156d0cb01bfc6eb7.1612564821558.1612800884521.1612805629481.5&__hssc=220415175.1.1612805629481&__hsfp=3541130711

A challenge Louisiana faced in implementing MST was that Medicaid does not cover start-up costs and administrative activities. This challenge, which required providers to make investments while starting up teams before they could bill for services, was overcome when the state championed the long-term model outcomes and positive impact MST has on youth.

Functional Family Therapy

FFT is a short-term, home and community-based program for youth ages 11 to 18 years old who struggle with behavioral and emotional challenges. This strength-based intervention focuses on risk and protective factors within and outside the youth's family. The FFT model is built on a foundation of acceptance and respect and has five major components — engagement, motivation, relational assessment, behavioral change, and generalization; each component has its own goals and intervention strategies.[113] FFT is being implemented at multiple sites across 10 countries. Almost 200 sites are authorized to implement FFT in the US.[114] Virginia, Florida, and Georgia allocated state funding to develop and support the use of EBPs, including FFT, to decrease the number of youth detained, committed to the Department of Juvenile Justice, or placed in short-term residential programs.

Wraparound

Wraparound is a comprehensive and holistic planning process for children and youth experiencing serious MH or behavioral challenges. The youth and family decide on the vision and goals, which leads to the development of an individualized treatment plan. Organizations that provide Wraparound implementation are required to support this practice by ensuring that staff receive the training they need to carry out their roles, have reasonable caseloads, and are adequately compensated; and collect and analyze data to monitor quality and outcomes. It also requires collaboration and coordination with child serving systems to provide access to flexible resources and an array of services in the community.[115] Many states, including Maine, New Mexico, Ohio, Oregon, and the Commonwealth of Virginia, have implemented Wraparound through SAMHSA grants.

New Mexico Children, Youth & Families Department's (CYFD's) Behavioral Health Services provides HFW, through internal and external structures, for children ages 4 to 21 years who have complex behavioral needs.[116] Wraparound is implemented internally by Juvenile Justice Service's staff and

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[113] Functional Family Therapy LLC. *Clinical Model*. https://www.fftllc.com/about-fft-training/clinical-model.html

[114] Functional Family Therapy LLC. *Authorized FFT Sites. https://www.fftllc.com/sites/?country=Australia&state=*

[115] National Wraparound Initiative. (2019). *WRAPAROUND BASICS: FREQUENTLY ASKED QUESTIONS*. https://nwi.pdx.edu/pdf/wraparound-basics.pdf

[116] S SAMHSA. (June 2019). *Intensive Care Coordination for Children and Youth with Complex Mental and Substance Use Disorders: STATE AND COMMUNITY PROFILES*. https://store.samhsa.gov/product/Intensive-Care-Coordination-for-

externally by a MCO and a community provider through a demonstration of a Wraparound service delivery and financing model for CYFD-involved children and youth (and their families) with high needs. In April 2018, New Mexico began implementing Wraparound in two health homes, which are part of the CareLink New Mexico program that coordinates care integration for Medicaid beneficiaries who have a diagnosis of serious emotional disturbance (SED) or SMI.

Oregon passed House Bill 2144 in 2009, which provided statutory direction for the Statewide Systems of Care and Wraparound Initiative (SOCWI) and required an advisory committee and biennial report on the SOCWI's progress and the cost of its implementation. The lead administrative agencies were the Department of Human Services (DHS) and Oregon Health Authority, with collaboration from the Department of Education, the Oregon Youth Authority, the Oregon Commission on Children and Families, and other agencies involved with the SOC. The pilot started with three MH organizations in eight counties and expanded to 13 Coordinated Care Organizations across 30 counties. All Coordinated Care Organizations have been implementing Wraparound since January 2017. Youth ages 0 to 17 years who experience complex MH issues and are involved with a MH agency and one additional child serving system are eligible for Wraparound.[117] Youth may receive services through age 25, once they are eligible for Wraparound. Medicaid eligible youth who are enrolled in secure placements funded by the Oregon Health Authority's Health Systems Division (HSD) are eligible for Wraparound services. Providers of Wraparound programs need to be trained in trauma-informed and culturally responsive treatment services; Youth and Family Partner services must be offered to the youth and family. Youth with a primary diagnosis of autism spectrum disorder (ASD) have been eligible for Wraparound since January 2020.

Louisiana developed a Coordinated System of Care (CSoC), which creates a single point of entry for children ages 5 to 20 who have complex BH needs and are at-risk of out-of-home placement or are in placement. Youth and their families receive intensive, individualized services and develop a plan that meets their needs. The coordinated plan allows for improved communication and collaboration between families, youth, state agencies, providers, and families' natural supports.[118] Families are able to receive Wraparound facilitation, parent support and training, youth support and training, short-term respite and independent living skills, skills building, and all services available through Medicaid. Children and youth receiving MST cannot be concurrently enrolled in CSoC. A CANS brief assessment is used to determine eligibility.

Children-and-Youth-with-Complex-Mental-and-Substance-Use-Disorders-STATE-AND-COMMUNITY-PROFILES/PEP19-04-01-001

[117] Oregon Health Authority Child and Family Behavioral Health. *Intensive Services: Overview*. Oregon Health Authority. https://www.oregon.gov/oha/HSD/BH-Child-Family/Pages/Intensive-Services.aspx

[118] Louisiana Department of Health. *About Louisiana's Coordinated System of Care (CSoC)*. https://ldh.la.gov/index.cfm/page/1335

Treatment Foster Care Oregon

Treatment Foster Care Oregon (TFCO), formerly known as Multidimensional Treatment Foster Care (MTFC), creates opportunities for children and youth with serious emotional and behavioral disorders to live in a family setting as an alternative to institutional, residential, and group care.[119] TFCO for Preschoolers (TFCO-P) is for children ages 3 to 6, TFCO for Childhood (TFCO-C) is for children ages 7 to 11, and TFCO for Adolescents (TFCO-A) is for youth ages 12 to 17. Parents or another relative caregiver are provided effective parenting resources as part of the intervention. Children or youth live in a TFCO treatment home for about nine months while parents receive initial and ongoing training, daily monitoring, weekly support groups, and coaching. Youth receive individualized skills training and support to navigate the program and practice coping skills and problem-solving skills. The program is available 24 hours a day, seven days a week in order to respond to any situation or behavioral issue.

Multidimensional Family Therapy

MDFT is a comprehensive and family-based program for children and youth ages 9 to 26 that treats problem behaviors, including substance use, delinquency, and antisocial and aggressive behaviors. It can be implemented in MH/SUD treatment program, juvenile justice, child welfare systems, and juvenile justice courts.[120] Interventions focus on improving family functioning and children and youth's coping, problem-solving, and decision-making skills. MDFT has 30 years of supporting research and is categorized as a supported practice in the Title IV-E Prevention Services Clearinghouse.[121] Certification training and licensing is available for teams of three clinicians. In 2019, 59 programs were operating in 13 states. The South Carolina Department of Mental Health adopted MDFT for its MH clinics.[122] MDFT services are part of Connecticut's DCF Intensive Home-Based Services continuum and referrals are received from DCF offices, SOC collaboratives, juvenile justice staff and other community providers.[123]

Funding Strategies

MST and FFT

Family First Virginia (FFV), an initiative of the VDSS, has identified FFT and MST as EBPs that can be provided to children and youth (and their parents or relative caregivers) who are at imminent risk of

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[119] *Treatment Foster Care Oregon*. Treatment Foster Care Oregon. https://www.tfcoregon.com/

[120] *MDFT Program*. Multidimensional Family Therapy. https://www.mdft.org/MDFT-Program/What-is-MDFT

[121] *Multidimensional Family Therapy*. Title IV- E Prevention Services Clearinghouse. https://preventionservices.abtsites.com/programs/244/show

[122] Multidimensional Family Therapy. (n.d.). *Annual U.S. Program Implementation Report 2019*. https://www.mdft.org/mdft/media/files/Documents/2019-Annual-Report.pdf

[123] *Intensive Home Based Services*. Connecticut State Department of Children and Families. https://portal.ct.gov/DCF/Behavioral-Health-Partnership/Intensive-Home-Based-Services

entering foster care.[124] FFV uses a three-branch model to allocate the responsibility of child welfare to all branches of government and child-serving institutes. A three-branch leadership team comprising six leaders from the three branches of government oversees four work groups including finance and evidence-based services is designed around the priorities of the FFPSA. Each work group comprises senior level decision-makers from across the Commonwealth. FFV expects to begin utilizing federal title IV-E funds to fund MST and FFT services in July 2021.[125]

In Louisiana, the over 50 MST teams in JPHSA's network are funded through a combination of Medicaid and state Supreme Court Juvenile Drug Court funding. The Louisiana Department of Children & Family Services also collaborates with this network.

Wraparound

Wraparound in New Mexico is funded through a PMPM rate that is paid to providers. This rate includes a package of specific services and covers the cost of intensive care coordination and related activities. Other children and youth who meet eligibility criteria are included in this model.[126] MCOs offer a tiered care coordination model, but the highest level does not meet the intensity of services to meet the needs of high-risk, high-need youth who are involved with multiple systems. Family Peer Support Worker services are covered through Medicaid and integrated into the PMPM MCO rate, and the health home CareLink New Mexico rate. HFW is in the 1115 waiver renewal for a capitated case rate (PMPM). In Oregon, Medicaid covers Wraparound and a Wraparound payment process has been created for Certified Community Behavioral Health Clinics (CCBHCs).[127]

In Louisiana, CSoC provides the Medicaid State Plan and HCBS waiver, and Louisiana Medicaid determines financial eligibility.[128] Louisiana's CSoC combines resources from the Department of Health, the DCF Services, the Department of Education, and the Office of Juvenile Justice. Youth must be eligible for Medicaid to receive CSoC services.[129]

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[124] *What are Evidence-Based Programs?* Family First Virginia. https://familyfirstvirginia.com/prevserv/evbased.html

[125] *Family First News.* Family First Virginia. https://familyfirstvirginia.com/resources/news.html#implementation

[126] Substance Abuse and Mental Health Services Administration. (2019). *Intensive Care Coordination for Children and Youth with Complex Mental and Substance Use Disorders.* https://store.samhsa.gov/sites/default/files/d7/priv/samhsa-state-community-profiles-05222019-redact.pdf

[127] Oregon Health Authority. (September 2017). *Certified Community Behavioral Health Clinics*. https://www.oregon.gov/oha/HSD/BHP/CCBHC%20Documents/CCBHC-Wraparound-Guide.pdf

[128] Louisiana Department of Health. (March 2020). *Louisiana Coordinated System of Care: Standard Operating Procedures*. https://ldh.la.gov/assets/csoc/Documents/SOPManual/CSoC_SOP_3-2020.pdf

[129] Louisiana Department of Health. *Coordinated System of Care: For Reference*. https://ldh.la.gov/index.cfm/page/1342

MDFT in Connecticut is funded through Medicaid, insurance, and Child Welfare and Juvenile Court Systems. In 2017, the Connecticut DCF and Wisconsin Department of Health Services (DHS) received SAMHSA State Youth Treatment-Implementation initiative funding and used them to add MDFT services.[130] Connecticut DHS used its funding to develop Project ASSERT (AccesS, Screening and Engagement, Recovery Support, and Treatment) for youth ages 12 to 21 with SUDs. The program integrates MDFT with MAT for youth with opioid problems.[131]

Treatment Foster Care Oregon

TFCO can be funded as a foster care program by entitlement funding (Title IV-E) through state funds for youth placed by a court, or as a Medicaid State Plan service or HCBS waiver program.[132] Local general revenue, MH block grant funds, foundation grants, and public-private partnerships can also be used as funding sources. Although foster care is not a specific Medicaid benefit, services that are a part of therapeutic foster care can be covered by Medicaid.[133] States have identified therapeutic foster care as a Medicaid State Plan rehabilitative service of Targeted Case Management (TCM), and Medicaid may reimburse for clinical and therapeutic services. Room and board, and training and supervision of foster parents are not Medicaid covered services.

Monitoring/Data Strategies

Multisystemic Therapy

Consistent application of the MST model to all cases is achieved through intensive supervision and clinical consultation.[134] Fidelity to the model is monitored through the administration of the Therapist Adherence Measure-Revised (TAM-R) and the Supervisor Adherence Measure (SAM). The primary caregiver completes the TAM-R during the second week of treatment and every four weeks after that. The supervisor and therapist review the results. The SAM is completed every two months by MST therapists and results are shared during a consultation meeting with the MST clinical supervisor. Both instruments are entered into an MST Institute online database, which also collects case-specific

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[130] Multidimensional Family Therapy International. (June 2017). RCT: MDFT PREVENTS AND REDUCES CRIMINALITY. https://www.mdft.org/mdft/media/files/Newsletter/MDFT-Newsletter-June2017.pdf

[131] *AccesS, Screening and Engagement, Recovery Support, and Treatment (ASSERT)*. UConn Health School of Medicine Department of Public Health Sciences. https://health.uconn.edu/public-health-sciences/programs/health-services-research-unit/assert/

[132] *Treatment Foster Care Oregon*. Blueprints for Healthy Youth Development. https://www.blueprintsprograms.org/programs/31999999/treatment-foster-care-oregon/print/

[133] Medicaid and CHIP Payment and Access Commission. (June 2019). *Report to Congress on Medicaid and CHIP*. https://www.macpac.gov/wp-content/uploads/2019/06/June-2019-Report-to-Congress-on-Medicaid-and-CHIP.pdf

[134] Louisiana Medicaid Program. (June 2017). *APPENDIX E-4: EVIDENCED BASED PRACTICES (EBPs) POLICY – MULTI-SYSTEMIC THERAPY*. https://www.lamedicaid.com/provweb1/Providermanuals/manuals/BHS/BHS_E-4_06-09-17.pdf

information, including successful completion rates. Program implementation reviews are completed every six months to monitor fidelity to the model and identify areas for improvement. MST Services was licensed by the Medical University of South Carolina to distribute MST while preserving the treatment model's integrity to ensure positive youth and family outcomes.

Functional Family Therapy

The FFT implementation and certification processes ensure the fidelity of FFT program replication.[135] Georgia Criminal Justice Coordinating Council employs two Model Fidelity Coordinators to assess the fidelity of FFT implementation and provide coaching and technical assistance. The Fidelity Coordinator monitors program fidelity by reviewing program materials, interviewing program staff, examining case files, observing group sessions, and surveying participants. Program reviews are also completed for each program during their annual site visit. Florida's Department of Juvenile Justice, Office of Accountability and Program Support has an established set of monitoring and quality improvement standards that address fidelity monitoring of all Redirection Services EBPs, including FFT. Sites are reviewed annually.

Wraparound

In New Mexico, CANS is used to screen for Wraparound eligibility; it is also implemented in the MCO/provider demonstration project. Facilitators enroll in the Wraparound CARES Facilitator Immersion Program, which includes training, coaching, and feedback. Program participants qualify to test for the New Mexico Wraparound Facilitator certification through the Credentialing Board for Behavioral Health Professionals. MCOs are responsible for utilization management. Fidelity is measured through the use of the Wraparound Fidelity Index Short Form (WFI-EZ) and the Team Observation Measure.

The Oregon Health Authority HSD provides program rules that address eligibility; training needs; caseload size; implementation requirements; and responsibilities of youth, caregivers, and staff who deliver Wraparound.[136] Oregon Wraparound provides workforce development, training, and system support for implementation of high quality, HFW across the state.[137] Coordinated Care Organizations or delegated entities utilize National Wraparound Initiative fidelity tools, including the WFI-EZ and the Team Observation Measure, which are part of the Wraparound Fidelity Assessment System. CANS is used in child and family teams to inform the plan of care.

In Louisiana's CSoC, the Wraparound Agency is responsible for the completion of the CANS Comprehensive and Independent Behavioral Health Assessment (IBHA), which need to be conducted

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[135] *About FFT Training*. Functional Family Therapy. https://www.fftllc.com/about-fft-training/implementing-fft.html

[136] *Health Systems Division: Behavioral Health Services - Chapter 309*. Oregon Health Authority. https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=265700

[137] *Training, coaching, and resources*. Oregon Wraparound. https://oregonwraparound.org/

by licensed MH professionals with CANS certification. The Wraparound Fidelity Assessment System is a component of quality assurance processes. The CSoC Wraparound Agency contracts with the National Wraparound Initiative to conduct annual fidelity monitoring activities.[138]

MDFT quality assurance activities include certification of the therapist and supervisor, booster training, rating and feedback of supervision, bi-annual reviews of Therapist Development Plans and Clinical Portal Reports, and a review of compliance with site requirements.[139]

Treatment Foster Care Oregon

TFCO program fidelity is important to youth and family outcomes. TFCO provides standardized measurement of program model components and standards that must be met for a program to be certified. TFCO programs receive detailed feedback on their strengths and areas in need of improvement. The certification process involves an evaluation of several TFCO program components. Program certifications are valid for two years and re-certifications are valid for three years.[140] TFC Consultants, Inc. provides training in the model and sites can be operational within a year.

Summary of Findings

Although reported outcomes are positive, PCs, BH-MCOs, and providers reported that MST, FFT, and MTFC are underutilized. These stakeholders identified various challenges with implementing and sustaining these services. HFW, available in 17 counties across the Commonwealth is reported to have contributed to reductions in intensive levels of care and supporting youth in the community. Many additional children and youth initiatives and accomplishments are highlighted in Section 8 of this report.

[138] Louisiana Department of Health. (March 2020). *Louisiana Coordinated System of Care: Standard Operating Procedures*. https://ldh.la.gov/assets/csoc/Documents/SOPManual/CSoC_SOP_3-2020.pdf

[139] *Training*. Multidimensional Family Therapy. https://www.mdft.org/Training-Program/3-Levels-of-Training/Level-2-Certification

[140] *Treatment Foster Care Oregon*. Treatment Foster Care Oregon. https://www.tfcoregon.com/

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Strategies for the Development of Early Childhood Services and Transformation of the Children's BH System

Strategies Recommended in the Transformation of the Children's Behavioral Health System in Pennsylvania

Each of the following strategy areas describes strategies, goals and activities for the development of early childhood services as identified in *Strategies for Promoting Recovery and Resilience and Implementing Evidence-Based Practices.*[141] The transformation of the children's BH services is described in the draft *A Support Document for the Call for Change: Transformation of the Children's Behavioral Health System in Pennsylvania*.[142] Suggested activities for the development of early childhood services and the transformation of the children's BH system are for consideration and are not all-inclusive. Additional activities related to these strategies may have emerged in the intervening years and are included in this section.

Service Development Strategy: Develop an early childhood MH consultation service and other types of early childhood interventions such as PCIT. Develop a service system that is family-driven, youth-guided, and improve and expand EBPs, including school-based EBPs. In addition, expand services for youth with co-occurring issues (e.g., SUD, IDD) and for transition aged youth to meet the special needs of these populations.

Activities to support the development of early childhood MH consultation services include use of pilot programs to assess early childhood MH consultation service implementation and efficacy. Along with, developing outreach mechanisms to other entities to identify children and families in need of early childhood MH interventions. Activities to support transformation of the children's BH delivery system

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[141] Mercer Government Human Services Consulting. (October 2006). *Strategies for Promoting Recovery and Resilience and Implementing Evidence-Based Practices*. Pages 142–144.

[142] Mercer Government Human Services Consulting. (November 2010). *A Support Document for the Call for Change: Transformation of the Children's Behavioral Health System in Pennsylvania*. Pages 44–46.

includes utilizing a tiered, public health approach to screening and intervention, and to reduce residential treatment by expanding family and community-based services.

Funding Strategy: Coordinate and support services from other agencies and incorporate changes from healthcare reform from the ACA that allow expansion of services (e.g., community- and school-based services).

Activities to develop funding for early childhood consultation include exploration of grants, Medicaid, and Commonwealth funding. Activities for supporting the ongoing transformation of the children's BH delivery system include supporting the development of braided funding across agency partners such as the DPW.

Monitoring/Data Strategy: Require and monitor fidelity to EBP models as well as monitor utilization and outcomes utilizing existing data collection methods.

Activities to support the development of early childhood MH consultation includes the development of consultant qualifications, training, resources, and develop a strong evaluation component for this service. As family- and community-based services are implemented, develop data collection systems and fidelity monitoring activities for those services.

Fifteen Years of Accomplishments and Trends

The Commonwealth has taken on a comprehensive approach to serving children from birth to 21 years of age, and to transition the children's BH system to a youth-guided and family-driven system. The Commonwealth has launched a broad array of initiatives to work towards system transformation. A few key initiatives are highlighted below:

- An approach began in June of 2004 with the development of the Integrated Children's Services Plan.[143] The goal of the Integrated Children's Services Plan is to promote the design and implementation of an integrated system of services and resources (long-term prevention, early intervention and services that support family stability, child safety, community protection, and healthy child development), which supports positive outcomes for the healthy growth and development of children. Although there is not a single directed model for integration across the Commonwealth, counties have developed individualized approaches to achieving the elements of integration.

- There is evidence that, in many situations, children and youth can be more effectively served in their homes and communities instead of in RTFs. Furthermore, home- and family-based treatment often yields superior outcomes at lower cost. Beginning in 2007, OMHSAS supported the goal to reduce RTF utilization by 50%.

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[143] Pennsylvania Department of Human Services. *Integrated Children's Services*. https://www.dhs.pa.gov/Services/Children/Pages/Integrated-Children%27s-Services.aspx

- In 2008, Pennsylvania was a recipient of a federal grant to address youth suicide prevention. In 2014, OMHSAS was awarded its third Garrett Lee Smith Youth Suicide Prevention grant from SAMHSA to implement prevention and early intervention strategies for youth across the Commonwealth. This was a five-year grant known as the "Suicide Prevention in Pennsylvania Schools and Colleges Initiative".

- In 2009, Pennsylvania was awarded a six year SAMHSA SOC grant to develop systems of care in 15 counties to serve youth and families of youth with multi-system involvement and are in or at-risk of out of home placement. The 15 counties were identified to establish and build an infrastructure to work with youth and family, integrate professional services, and utilize natural supports in the community.

- In 2009, in partnership with the Bureau of Autism Services, OMHSAS developed guidelines for facilitating service delivery to child and adolescents with ASD and supported trainings of clinicians to provide functional behavioral assessments. In 2019, OMHSAS established new regulations to replace Behavioral Health Rehabilitation Services (BHRS) with IBHS for children and young adults in need of treatment for ASD or behavioral disorders.

- Also in 2009, OMHSAS created a Transition Age Youth Sub-Committee of the OMHSAS Advisory Committee. In addition, a training curriculum for Peer Specialists who work with transition age youth was created.

- In 2014, OMHSAS was awarded a Project LAUNCH (Linking Actions for Unmet Needs in Children's Health Grant Program), with a goal to create an infrastructure to support services for children from conception to eight years of age and their families. Allegheny County was selected as the project site.

- Over the years, the Commonwealth recognized that services alone are insufficient and that it is critical to develop school cultures that are supportive of emotional, social and behavioral development. Counties, BH-MCOs, and providers have partnered with school districts throughout Pennsylvania to develop an array of school-based BH services, including OP services and one-to-one support.

All of these initiatives highlight the commitment of the Commonwealth, providers, counties, BH-MCOs, and other stakeholders to transition the children's BH system to a youth-guided and family-driven system.

PC and BH-MCO Interviews

Service Development

Interviews with the PCs and BH-MCOs yielded a variety of efforts and accomplishments for the development of early childhood services and transformation of the children's BH system. Although many innovative services and effective interventions were identified in specific counties and geographic areas, themes identified include school-based interventions, expansion of PCIT, and reductions in RTF LOSs and improved quality of care in RTFs. Highlights of the initiatives and accomplishments are described below:

Guided by CASSP and recovery principals, the CSBBH team consists of master's level clinicians and bachelor's level staff designed to focus on the family as a whole with sensitivity to trauma issues and the importance of a positive approach to behavioral support.

School-Based Interventions

School-based BH brings together schools, county MH programs, and community resources to develop a continuum of services that empower children to have educational and MH needs met within their school districts. Since 2009, PC's in collaboration with CCBH have expanded Community and School Based Behavioral Health (CSBBH) Teams. Teams are based in the school to provide optimal access for youth and families but also delivers services in home and community settings, as needed. The flexible model includes clinical interventions, crisis intervention, case management, consultation, and training to school staff and others involved in the child's care as well as summer therapeutic programming. Additional examples of school-based interventions are highlighted below:

- Positive Behavioral Interventions and Supports (PBIS), an evidence-based three-tiered framework to improve and integrate systems and outcomes impacting students daily has been implemented in Cumberland, Dauphin, Lancaster, Lebanon, and Perry Counties. Four preschools and three elementary schools are currently operational.
- DBHIDS and CBH collaborated with providers and some schools to implement Cognitive Behavioral Intervention for Trauma in Schools (CBITS), a skills-based intervention aimed at relieving symptoms of PTSD, depression, and general anxiety among children exposed to trauma. CBITS also includes parent and teacher education sessions.
- Some counties have implemented school-based OP MH clinics to provide services onsite to youth who need OP services but have experienced barriers related to access (e.g., transportation, parental chronic illness, cultural preference). Program goals include expanding access to routine OP services, providing preventive support, preventing the need for more intensive services, and reducing barriers to accessing community services.

Parent-Child Interaction Therapy

OMHSAS has encouraged the counties, BH-MCOs, and providers to develop and expand EBPs that specifically help families keep children in the home and community. The PCs and BH-MCO's highlighted expansion of PCIT, an EBP designed for young children (ages 2.5 to 7) and their families with behavioral challenges. PCIT emphasizes changing and improving parent-child interactions, helping parents form nurturing relationships with their child, and coaching parents on how to shape their child's behavior to decrease negative behavior and increase prosocial behavior. As a low cost OP evidence-based service, PCIT helps children stay with their families. Along with positive outcomes of PCIT, common barriers include transportation to and from the service and the time intensity required from the child and family, which has contributed to underutilization of the EBP in some counties. Examples are highlighted below to overcome barriers:

MEMBER STORY

PCIT helped cultivate a connection between a mother and her 6-year-old son, whom successfully completed PCIT. The mother adopted her son and credits PCIT as the single most helpful tool she learned as a foster parent!

Mother is an active advocate within the DBHIDS/CBH System of Care Family Member Committee, participates in PCIT RFA Consensus Review and multiple speaking events.

- One of PerformCare's PCIT provider physically embedded a clinic within a Head Start program. PerformCare reported this has created a beautiful marriage and is the most successful PCIT provider.
- To increase the awareness, capacity and referrals to PCIT, Beacon developed an online library for clinical staff, conducted many trainings, developed a PCIT fidelity tool with consultation from PCIT experts, and continued to collaborate with Commonwealth and counties to bring new PCIT providers into the network.
- Another solution for delivery of PCIT has been to incorporate interventions into IBHS in-home and community settings. Implementation of a mobile, home-based model through the Early Childhood Wellness initiative began in 2016 with providers in Allegheny and Erie Counties with subsequent expansion to Chester County and the Northeast contract.[144] Teams of intensively trained Mobile Therapists and bachelor's level staff use PCIT PRIDE (Praise, Reflect, Imitate, Describe, and Enthusiasm) and parent coaching skills, along with standardized PCIT evaluation tools. Families report reductions in externalizing behaviors, improved social interactions in their child and mastery of positive behavioral management skills as parents.

[144] Lackawanna, Luzerne, Susquehanna, Wyoming counties.

The program has continued to grow and expand, and demonstrated outcomes that included shorter LOSs and faster reunification with families through community-based mental health services and natural supports. A key component of this model is delivering the therapy in the home.

Residential Treatment Facility Transformation

Steady progress in tailoring services to the specialized needs of children and their families has helped OMHSAS achieve progress in reducing RTF utilization, as demonstrated by various initiatives.

An approach to reduce the time in residential treatment is to change the goals and structure of the service from long-term placements to more targeted interventions with the goal of quickly returning the child/adolescent to his or her family. In 2009, Lehigh and Northampton Counties developed an Intensive Residential Treatment Facility (IRTF) program to provide brief, intensive placements (30 to 120 days) with continued connection to the community such as school and after school programs and support groups, and family involvement.

In 2015, DBHIDS received a SAMHSA grant for continued system enhancements via the implementation of the Philadelphia SOC with a specific focus on reducing the utilization and LOS in RTFs. Additional efforts were focused to improve the quality of care, including the reduction of the use of restraints for children and youth in RTFs. Quality RTF activities involved many stakeholders including peers and family and youth representatives. In 2018, all RTF providers were invited to attend a two-day training and providers developed strategic plans to implement Building Bridges' Six Core Strategies© to reduce the use of restraint and seclusion, and promote trauma-informed and family-driven/youth-guided services. Other quality efforts involve training RTF providers in EBPs including DBT, development of clinical performance standards aligning with CASSP and SOC principles, and creation of a HFW team to support family and youth voice and choice.

Beacon facilitates complex case meetings to build an integrated approach to meet the individualized needs of the child and family. These meetings serve children/youth including those who have been discharged from Psychiatric Residential Treatment Facilities (PRTFs), to ensure children/youth are able to access community-based services and those services are sufficient to maintain the child/youth in the home and community. Complex issues are addressed during meetings with all child-serving systems including County Juvenile Probation Officers, Children and Youth Services, County Behavioral Health and IDD agencies, CASSP coordinators, Office of Developmental Programs (ODP), PH-MCOs, and Family and Youth Advocacy Organizations.

CCBH has sponsored PRTF learning collaboratives to improve family engagement, enhance community integration, implement best practice medication prescribing and management, and to continue to develop the workforce. In Allegheny County, a pay-for-performance initiative was designed to focus on reducing elevated body mass index (BMI) scores among youth with five RTF providers. As a result of the initiative, RTF providers adopted health-promoting policies and over half of youth with a high BMI showed improvement over time. In addition, nutritional guidelines were changed, youth vote on snack options, and activities such as running clubs and yoga are offered.

Other highlights from early childhood and BH children's system transformation initiatives are highlighted below:

- PerformCare utilizes the CANS to identify available and relevant EBPs for children.
- Beginning in 2016, with input from families, providers and other stakeholders, CBH developed high-quality Applied Behavior Analysis (ABA) standards to support an ABA provider designation process. The network of ABA providers has expanded by 20 providers in Philadelphia and dramatically reduced the waitlist for ABA services.
- Fayette County formed Family Advocates/Family Engagement Specialists to provide support to parents and caregivers raising children/adolescents with social, emotional or behavioral problems and/or problems with substance use. In addition, a County Leadership Team comprised of five child/family serving system partners, youth and family leaders to provide input and feedback on development of new programming and current programs/processes. Family and youth are encouraged to be leaders and have a voice.

Family advocates in Fayette County have personal experience raising a child that has used services and the advocates strive for parent/caregiver education and self-empowerment.

- Across CCBH counties, a cross-system Robert Wood Johnson Foundation grant was implemented to train early local intervention service coordinators to implement parental/caregiver depression screenings.
- Montgomery County created a BH services resource guide for children, adolescents, and families to assist with navigating the children's system.[145] A copy of the most recent children's community-based supports and services guide is available online.[146]

[145] Montgomery County Department of Health and Human Services Office of Mental Health/Developmental Disabilities/Early Intervention. *A Guide To Behavioral Health Services For Children, Adolescents, & Families Montgomery County, Pa*. https://www.montcopa.org/DocumentCenter/View/28748/Childrens-Behavioral-Health-Services-Guide-Feb-20-Electronic-Version

[146] *Children's Mental Health Supports and Services*. Montgomery County, Pennsylvania. https://www.montcopa.org/2039/Childrens-Mental-Health-Supports-and-Ser

- A Children's Services Integration Framework (CSIF) was implemented across CCBH counties to promote recovery, resilience, and wellness. In collaboration with stakeholders including families, the core principals of CSIF include true affirmation of young people and families; a clinical model; a clinical home; workforce development; wellness with BH and PH integration; and evaluation, fidelity and outcomes. CSIF brings a consistent philosophy and holistic approach to all children's programs.

- Bucks County, in collaboration with MBH, launched a Transition to Independence Process (TIP) initiative and later expanded to Cambria, Delaware, Montgomery, Lehigh, and Northampton Counties. TIP is an evidence supported model that prepares young adults aged 16–26 for adulthood and supports them in the areas of planning for employment, higher education, independent living, personal wellbeing, and community life functioning. TIP facilitators meet with young adults in the home or community and also provide access to Peer Support Specialists.

Youth-driven and strength-based, TIP helps young adults become more independent and in control of their own future.

Funding

Funding for development of early childhood services and transformation of the children's BH system draws from several different sources including reinvestment, grant, and HC funds. A few examples are described below.

Reinvestment dollars for start-up/ramp-up costs was used for CSBBH and payment is now through HC via a shared risk arrangement. Financial incentives are provided to improve performance and established performance measures must be met such as 30% of the services must be delivered in the home/community and a reduction medical spend in alternative/additional services.

In Allegheny County, reinvestment funds are used to support youth transitioning from RTFs to permanent, supportive housing. Reinvestment funds are also used to provide rent subsidies and housing support services to youth, during the transition to affordable, independent living in the community. The permanent supported housing program has been able to expand through the use of reinvestment funds when a second mobile treatment team began.

In 2010, the Commonwealth received a two-year grant to assist with the goal of implementing PCIT in Pennsylvania. Eight providers originally received grant financial assistance to receive training in PCIT. Additional grant and reinvestment funds have supported considerable training, supervision, and equipment costs for providers across the Commonwealth. Some PCs and BH-MCOs reported offering enhanced rates.

Reinvestment funds were used to support the initial development of blended case management (BCM) programs to serve as TIP providers, intensive training of TIP facilitators within each program and implementation of this person-centered model.

Monitoring/Data

Monitoring activities include review of youth medical records, clinical case reviews, onsite monitoring, meetings with team and supervisory staff, stakeholder advisory meetings, and school satisfaction surveys.

The monitoring and outcomes of early childhood and children's system transformation efforts have generally demonstrated positive results. A few examples are described below:

CSBBH has expanded to 82 teams, 20 providers, 69 school districts, and in 159 school buildings across 25 counties. In CY 2020, over 9,000 children and youth received services through CSBBH teams. The model is evaluated annually for cost effectiveness and clinical outcomes. The Child Outcomes Survey and Strengths and Difficulties Questionnaire tracks youth and family functioning and family perception of how the treatment is progressing. CCBH also conducts random quarterly performance measure reviews. Significant improvements have been reported in child and family functioning, reductions in difficulties in the home and school and an increase in pro-social behaviors in the home, school, and community. School districts report decreases in infractions, truancy, and restraints as well as improvements in academics, and better partnerships for the child's benefit by supporting communication between school and family.

Over 325 OP therapists are trained in PCIT in over 125 agencies serving 62 counties in Pennsylvania. BH-MCOs and PCs reported positive outcomes for children and families who completed treatment including a decrease in child behavior problems and improvement in parent-child relationship. The service is consistently reported underutilized due to barriers identified in the previous section (transportation issues, time required from parents).

In conclusion, family-based services continue to be the preferred aftercare plan for children discharged from the service and natural supports are key to successful discharge plan.

The longitudinal effects of the IRTF program were evaluated in 2012 with a two-plus year outcome study that compared services received before and after being involved in the IRTF program. Data was submitted monthly by providers including EBPs, community supports, and discharge level of care. Data was also collected at 12 months post-discharge including ancillary contacts and admissions to 24-hour levels of care. The study found a 48% decrease in youth being admitted to acute IP facilities for the 12 months post-discharge from the IRTF program, and a 73% decrease in acute IP days. Only 18% were admitted to traditional RTFs after the program.[147]

[147] Lees, J., & Hunt, P. *An Innovative Approach to Residential Treatment: Shorter Stays & Better Outcomes!* Magellan Behavioral Health/ACMHA: The College for Behavioral Health Leadership.

In Philadelphia, between 2016 to 2019, the number of restraints in RTFs decreased in both accredited and non-accredited RTFs and continues to trend downward. Since 2006, the number of youth in RTFs trended downward, including use of out-of-state RTFs.[148] CBH reported data has demonstrated a trend in downward utilization from 1,834 youths in RTFs in 2006 to 396 youths in RTFs in 2016.

MBH completed an implementation audit (i.e., chart reviews, claims audits, overall compliance with program, and network expectations) with each TIP program within six months of start-up and annually, fidelity assessments occur. A specialized information system was developed to support the TIP assessment process and to track outcomes. Data is submitted annually and multiple outcomes indicators are assessed through the Tailored Adaptive Personality Assessment System (TAPAS) at entry and at discharge from TIP, such as employment, education, living situation, personal effectiveness/wellbeing, and community life functioning. Outcomes demonstrate a decrease in IP admissions when comparing the 180-days prior to TIP to 180 days-post TIP and a decrease in PMPM spending.

Stakeholder Findings

Provider Comments

School- and community-based providers reported a greater emphasis on youth and family voice and choice, with the inclusion of youth and parents, as foundational to children's services. However, these providers did suggest that this change is not as pervasive in children's services as in adult services. Providers suggested a few policy changes that might enhance the spread of youth-centered care include changing the age for psych rehab services to 14, and developing youth CPS certification and roles.

School- and community-based providers reported that several child and youth promising practices and EBPs have been notably successful. These successful approaches include PCIT for very young children and their families, in-home intensive family coaching, TIC, particularly TF-CBT and the Sanctuary Model used in RTFs, ABA for children with ASD, DBT, and MST. One school- and community-based provider has witnessed a "surge of children's EBPs" in the HC-BH system.

Ongoing barriers to children and youth services include a decreasing number of IP beds, FBMH services and OP services, particularly in the western part of the Commonwealth and rural areas. Staff recruitment and retention issues have intensified. In some areas, facilities and programs have been created but providers have been unable to staff these programs. Other providers noted challenges in developing and retaining a workforce for children services due to inadequate reimbursement. Like

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https://www.magellanhealthcare.com/documents/2020/04/an-innovative-approach-to-residential-treatment-shorter-stays-and-better-outcomes-handout-1.pdf/

[148] Prior to placing any child/youth in an out-of-state RTF, OMHSAS requires the BH-MCOs to submit many policies as part of the request including a copy of the restraint and seclusion policy.

other provider types, these children providers noted that early career clinicians use these positions as stepping-stones for experience and as stepping stones in career development. Also noted is the significant need for medical transportation in the rural areas, and expressed concern that this service will no longer be reimbursed.

Integrated clinic providers reported that the lack of FBMH and school-based services in rural areas create significant challenges to these clinics as they attempt to coordinate care for BH needs. Integrated clinic providers from other areas of the Commonwealth report an increased availability of FBMH and school-based services. This additional capacity has resulted in the elimination of wait lists and increases care coordination by the integrated care clinics.

Some children's providers stated they are not being heard by decision makers and identified some instances in which providers felt they were excluded from conversations about policy and licensing changes (e.g., changes in BHRS delivery system and establishment of IBHS services).

Providers of children's services suggested the creation of a universal outcome system for children's services, with standard outcome measures. Other recommendations include increase bed availability for children/adolescents and create channels for coordinating with IDD services for individuals with dual BH/IDD services.

Member Comments

Some family members of youth receiving HC-BH services reported seeing a significant shift to a strengths-based approach to assessment and treatment. However, family members also reported that decisions are made prior to conversations with parents or guardians. Family members stated that providers have good intentions and are open to working with family and family support, and that working with peers is helpful. PCs/BH-MCOs have family advisory committees, but often times lack youth and family member involvement.

Family members reported generally positive experiences with school-based services, and welcomed the growth of these services. One family member called these services a "one stop shop" in which the youth and family can receive an array of needed services. Another parent reported that when her daughter struggled to adjust to a larger school, school-based services helped her make that adjustment. In addition to a noticeable growth of school-based services, members noted how the service provides referrals and access to other supports and services within the community.

A family member who had children and grandchildren receiving services from HC-BH for some time noted the welcome change in the treatment model for RTFs, resulting in much shorter stays. She said that when her daughter was in an RTF 10 or 12 years ago, the average length of stay was 18 to 24 months.

This family member reported that her daughter was in a "holding pattern" for much of that time in a RTF, and appreciates the transition to shorter and more IRTF stays along with ensuring her child and family members have support in the home.

Family members recognized an increase of providers trained in TIC over the years, although this varies among counties. In one area, a family member noted only two well-known providers are equipped to treat trauma in children and youth.

Although family voice was unheard of 15 years ago, the general consensus is the HC-BH delivery system requires more development of being family driven and youth guided.

Finally, some family members reported confusion and challenges associated with navigating the HC-BH children's system. They suggested an increase in the number of family partners and family CPSs to support families with young children. Family members also reported frustrations with a shortage of child psychiatrists, provider turnover and changes with providers coming into the member's home.

Service Trends

As the following table demonstrates, the number of children and youth eligible for Medicaid services increased from 1,267,637 to 1,406,629 (11%) between 2010 and 2018. The number of children and youth who received BH services during the same time period increased from 185,460 to 213,898, or 15.3%. The latter increase resulted in an increase in BH services penetration from 14.63% to 15.21%.

Table 8. Change in Children and Youth BH Service Utilization between 2010 and 2018

	2010	2018	% Change
Number of Eligible Children/Youth	1,267,637	1,406,629	11.0%
Number of Children/Youth who Received BH Services	185,460	213,898	15.3%
Penetration Rate for BH services	14.63%	15.21%	3.9%

The most frequently utilized category of BH services which are used by the highest number of children and youth (in descending order) in 2018 are:

1. OP Psychiatric (76.3% of BH services utilizers)
2. BHRS (29% of BH services utilizers)
3. Community Support (17.7% of BH services utilizers)

4. Other Services[149] (17.4% of BH services utilizers)

The least frequently utilized BH services in 2018, in ascending order, are:

1. IP and non-hospital D&A (1% of BH services utilizers)
2. Accredited and non-accredited RTF (1.2% of BH service utilizers)
3. Ancillary Support[150] (1.4% of BH service utilizers)

Changes across all service utilizers between 2010 and 2018 are displayed in the following table:

Table 9. Changes in the Number of Children and Youth Receiving BH Services between 2010 and 2018

Category of Service	2010	2018	% Change
IP D&A	73	12	-83.6%
Non-Hospital D&A	4,461	2,094	-53.1%
OP D&A	10,896	5,952	-45.4%
IP Psychiatric	12,961	11,975	-7.6%
OP Psychiatric	135,438	163,305	20.6%
BHRS	60,820	62,264	2.4%
RTF (Accredited and Non-Accredited)	4,350	2,642	-39.3%
Ancillary Support	6,512	3,024	-53.6%
Community Support	36,033	37,941	5.3%
Other Services	32,402	37,194	14.8%
Total	**185,460**	**213,898**	**15.3%**

The notable decrease in the facility-based and OP D&A services may be due a change in status of individuals age 21 from “child” to “adult” made in 2015 with the advent of Medicaid expansion. These older young adults may have been responsible for much of the D&A utilization in 2010, and are counted as an “adult” in the 2018 data. On a related issue, the decrease of ancillary support may be due to a change in billing for D&A laboratory related support, in addition to the general decrease in D&A service recipients.

[149] “Other Services” includes lab services; Evaluation and Management Services and Healthcare Common Procedure Coding System services provided as wrap-around, in mobile crisis teams, and other community-based settings.

[150] “Ancillary Support” services are diagnostic laboratory and radiology services.

The 7.6% decrease in IP psychiatric utilization coupled the 5.3% increase in community support services and 14.8% increase in "other services" (which includes mobile and community support) may reflect successful diversion from hospitalization with mobile crisis, community and family-based services. These diversions resulted in decreased utilization of IP Psychiatric and RTFs.

In general, the larger increases of OP (clinic-based) services, BHRS (community-based) services, and community support services coupled with decreases in utilization of the more restrictive facility-based services (IP psychiatric and RTF), coupled with the 3.9% increased penetration rate, is congruent with a health delivery system that is transitioning from a restrictive, medical model to a recovery oriented, community-based health delivery systems.

A Support Document for the Call for Change: Transformation of the Children's Behavioral Health System in Pennsylvania draft document recommends that residential treatment be provided less often, with a goal of a 50% reduction from baseline trends. Further, the recommendations stated that residential treatment be more intensive, short-term, clinically effective, and community-based. The final recommendation was that supportive efforts, such as TIC, alternatives to coercive techniques and reduction of out-of-state placement be essential components in the transformation of residential treatment.[151] The following table provides a closer view of RTF services and summarizes the changes in utilization and costs in the years since this strategy was articulated in 2010.

Table 10. Changes in RTF Utilization and Costs between 2010 and 2018

	2010	2018	% Change
Number of Children/Youth Receiving RTF Services	4,350	2,642	-39.3%
Annual Costs	$ 208,485,665	$ 163,861,511	-21.4%
Cost per User	$ 47,928	$ 62,022	29.4%

The 39.3% decrease in RTF utilization in 2018 represents substantial progress towards the goal of a 50% reduction. Annual RTF costs decreased by 21.4%, while cost per user increased by 29.4%. One explanation for the increased cost per user that shrank 39.3% is that those children and youth receiving services in 2018 had significant MH conditions and may have required, on average, longer lengths of stay. Alternatively, the costs of developing more intensive programming, and programming for specialty populations (e.g., children and youth with co-occurring clinical conditions) may account for a significant increase in cost per user.

As almost 30% of all children and youth receiving BH services receive BHRS, this service has a significant impact on this health delivery system. Between 2010 and 2018, the number of BHRS

[151] Mercer Government Human Services Consulting. (November 2010). *A Support Document for the Call for Change: Transformation of the Children's Behavioral Health System in Pennsylvania*.

recipients increased a modest 2.4%. However, as the following table demonstrates, the annual cost for BHRS services decreased 20.8%, and the cost per user decreased 22.6%.

Table 11. Changes in BHRS Utilization Compared with Changes in Costs between 2010 and 2018

	2010	2018	% Change
Number of Children/Youth Receiving BHRS Services	60,820	62,264	2.4%
Annual Cost	$ 603,522,583	$ 478,277,972	-20.8%
Cost per User	$ 9,923	$ 7,681	-22.6%

Literature Review and National Scan

A service continuum that addresses child and youth needs across developmental stages ensures that needs can be identified and addressed early in different settings, and that services are individualized and directly address those needs. The following section provides a description of the service arrays for each developmental stage (infants to early childhood, school-age children and youth) for children and youth with the most complex needs.

Service Development

Infant and Early Childhood MH Service Array

IECMH is the capacity of a child from birth to 5 years of age to: 1) develop secure relationships with adults and peers; 2) experience, regulate, and express emotions in socially acceptable ways; and 3) explore their environment and learn within the context of the family and culture they live in.[152] IECMH provides the foundation for all future social and emotional development. Early and accurate identification and appropriate treatment of MH or developmental disorders in infants and young children can have a positive impact their overall health and development. *The DC: 0-5™: Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood* is a system of developmentally appropriate diagnostic criteria. The DC: 0-5 helps clinicians accurately diagnose and classify IECMH disorders. When adopted, the DC: 0-5 can improve access to IECMH services and supports and improve outcomes for children.[153]

[152] ZERO TO THREE. (2017). *The Basics of Infant and Early Childhood Mental Health: A Briefing Paper*. https://www.cdhd.idaho.gov/pdfs/mental%20health/zero-to-three-iecmh-basics.pdf

[153] Ahlers, T., Cohen, J., Oser, C., & Szekely, A. (July 2018). *Advancing Infant and Early Childhood Mental Health: The Integration of DC:0–5TM Into State Policy and Systems*. ZERO TO THREE. https://www.zerotothree.org/resources/2343-advancing-infant-and-early-childhood-mental-health-the-integration-of-dc-0-5-into-state-policy-and-systems#downloads

Meeting the social and emotional needs of infants and young children requires a comprehensive, targeted array of promotion, prevention, and treatment strategies.[154] Few, if any, service delivery systems that serve infants and young children have adequate capacity to implement the full continuum of care described below. Wisconsin is an example of a state that has developed a comprehensive plan to address IECMH. Key strategies in this plan include raising public awareness, securing funding, developing a state IECMH workforce, and recognizing DC: 0-3R codes for Medicaid. BrightStart — Louisiana's Early Childhood Advisory Council — builds, maintains, and strengthens a comprehensive and integrated early childhood system.[155]

IECMH Comprehensive Service Array Overview

IECMH Universal or Promotion Strategies**,** which are targeted to parents, support social and emotional wellness of infants and very young children. Examples of IECMH promotion include infant and early childhood MH awareness campaigns, "warm lines" that answer questions on child development and typical behaviors, and social and emotional screenings during well child visits.[156]

IECMH Prevention Services target the child/caregiver relationship. They include parent education programs (Circle of Security, Incredible Years, Nurturing Parent Program), home visiting services (Parents as Teachers, Nurse-Family Partnership, Health Families America, the Pyramid Model), and Infant and Early Childhood Mental Health Consultation (IECMHC). A system of IECMHC can be integrated into and strengthen all prevention and early intervention services as well as primary care.[157] IECMHC is a problem-solving, capacity-building evidence-based approach that supports the healthy social and emotional development of young children ages birth to six years. The goal of IECMHC is to increase the capacity of staff, family, programs, and systems to prevent, identify, treat, and reduce MH problems in infants and young children.[158]

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[154] ZERO to THREE. (May 2016). *Planting seeds in fertile ground: Actions every policymaker should take to advance infant and early childhood mental health.* https://www.zerotothree.org/resources/1221-planting-seeds-in-fertile-ground-steps-every-policymaker-should-take-to-advance-infant-and-early-childhood-mental-health

[155] ZERO TO THREE. (February 2013). *Nurturing Change: State Strategies for Improving Infant and Early Childhood Mental Health*. https://www.zerotothree.org/resources/122-nurturing-change-state-strategies-for-improving-infant-and-early-childhood-mental-health

[156] ZERO TO THREE. (February 2016). *Infant-Early Childhood Mental Health*. https://www.zerotothree.org/resources/110-infant-early-childhood-mental-health

[157] Ahlers, T., Cohen, J., Oser, C., & Szekely, A. (July 2018). *Advancing Infant and Early Childhood Mental Health: The Integration of DC:0–5TM Into State Policy and Systems*. ZERO TO THREE. https://www.zerotothree.org/resources/2343-advancing-infant-and-early-childhood-mental-health-the-integration-of-dc-0-5-into-state-policy-and-systems#downloads

[158] Le, L. T., Lavin, K., Aquino, A. K., Shivers, E. M., Perry, D. F., & Horen, N. M. (December 2018). *WHAT'S WORKING? A Study of the Intersection of Family, Friend, and Neighbor Networks and Early Childhood Mental Health Consultation*.

Many states have expanded the role of existing early childhood advisory councils or Project LAUNCH, young child wellness councils to oversee and coordinate IECMHC efforts. Others have formed new groups. Illinois identified funding and developed training and technical assistance capacity to expand IECMHC statewide. The Illinois Early Childhood Mental Health Consultation Initiative is led by the Illinois Children's Mental Health Partnership, a statewide public/private partnership of policymakers and advocates.[159] The Arkansas Department of Health and Human Services/Division of Childcare and Early Childhood Education funds Project PLAY (Positive Learning for Arkansas's Youngest). In FY 2018–2019, Project PLAY provided IECMHC to 87 early childcare and education providers located in 35 counties in Arkansas.

IECMH Treatment Services involve the infant or young child's parent or primary caregiver in treatment and directly target the infant or young child's MH disorder. Evidence-based MH treatments for infants and young children include Attachment and Biobehavioral Catch-Up, Child-Parent Psychotherapy, PCIT, Positive Parenting Program (Triple P), and Infant-Parent Psychotherapy. Arkansas, California, and Minnesota Medicaid reimburse providers for dyadic therapies that treat infants and their caregivers in the context of their relationship.

A Comprehensive Array of MH Services for Children, Youth, and Their Families — System of Care

A SOC is a coordinated and organized network of an array of broad, flexible, and effective services and supports for an identified population, often children who have a SED and their families. Services are typically HCBS. A SOC incorporates care planning and management across multiple levels, is culturally and linguistically competent, and incorporates family and youth voice in service delivery and at management and policy levels. It is data-driven and includes a supportive policy and management infrastructure.[160] Family and child or youth strengths and needs determine the individualized services they receive to address the child or youth's physical, emotional, social, and educational needs. Services and supports include traditional and non-traditional services as well as informal and natural supports.[161]

Georgetown University Center for Child and Human Development. https://gucchd.georgetown.edu/products/ECMHCWorkingStudy_Report_F.pdf

[159] The Center of Excellence for Infant and Early Childhood Mental Health Consultation. *Illinois's Approach to Building and Sustaining Infant and Early Childhood Mental Health Consultation*. https://www.iecmhc.org/documents/il-approach-building-sustaining-iecmhc.pdf

[160] Pires, S. (2010). *Building systems of care: A primer, 2nd Edition.* Human Service Collaborative for Georgetown University National Technical Assistance Center for Children's Mental Health.

[161] Stroul, B., Blau, G., & Friedman, R., (2010). *Updating the System of Care Concept and Philosophy.* Georgetown University Center for Child and Human Development, National Technical Assistance Center for Children's Mental Health. https://gucchd.georgetown.edu/products/Toolkit_SOC_Resource1.pdf

Burlington County in New Jersey received a SAMHSA SOC grant in 1999. A statewide reform initiative began in 2000 to use the SOC approach and restructure the delivery system for children and youth with behavioral needs started. By 2006, this initiative was fully implemented in all counties.[162] Through reorganization and service alignment, all children's services and divisions were housed in the DCF, which is responsible for serving at-risk children and youth and their families. All children's services and divisions are in this department in order to enhance care through an integrated approach to care and service coordination. The Children's System of Care provides need-based services in a family-centered, community-based environment to children, youth, and young adults under age 21 who have emotional and BH needs, IDDs, or substance use needs. Components of New Jersey's SOC include a contracted system administrator that serves as the single point of access, mobile response and stabilization services, family support organizations, youth partnerships, and Care Management Organizations (CMOs).[163] Services include intensive community-based services, out-of-home services, intensive in-home supports for children and youth with IDDs, family support services, and substance use treatment services.[164]

Connecting the Array of Community- and School-Based MH, Social and Emotional Services and Supports — The Interconnected Systems Framework

Multi-tiered frameworks provide a continuum of instructional and behavioral supports that are targeted to meet the individual needs of all students. They also create a foundation and structure for providing a range of evidence-based MH interventions, increasing the likelihood that a student will have access to these supports. The common elements of multi-tiered frameworks include: 1) universal screening, 2) data-driven decision-making by an identified school leadership team, 3) continuous monitoring of progress, 4) a continuum of EBPs, and 5) a focus on fidelity of implementation.[165]

Multi-tiered system of support (MTSS) models are built on a prevention framework that organizes school-level resources to address each student's academic and behavioral needs within three

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[162] SAMHSA. (2015). *The Comprehensive Community Mental Health Services for Children with Serious Emotional Disturbances Program: Report to Congress 2015*. https://www.samhsa.gov/sites/default/files/programs_campaigns/nitt-ta/2015-report-to-congress.pdf

[163] Blake, A. (2017). *Care Management Organization Policy Manual*. New Jersey Department of Children and Families. https://www.state.nj.us/dcf/policy_manuals/CMOManual.pdf

[164] Davis, W., Sawyer, M. J., & Gargan, L. (June 2018). *New Jersey Children's System of Care: Peer Support in an Integrated System of Care* [Slides]. SAMHSA. https://www.nasmhpd.org/sites/default/files/NJSOC%20SAMSHA%20Webinar.pdf

[165] Morrison, J. Q., Russell, C., Dyer, S., Metcalf, T., & Rahschulte, R. L. (2014, July). *Organizational Structures and Processes to Support and Sustain Effective Technical Assistance in a State-wide Multi-Tiered System of Support Initiative*. Journal of Education and Training Studies. https://files.eric.ed.gov/fulltext/EJ1055441.pdf

intervention tiers that vary in intensity.[166] MTSS aids school professionals in the early identification of students who are at risk for being academically unsuccessful or have difficulties with challenging behaviors. The progressively intensive tiers represent a continuum of supports that are available to students. School implementation teams regularly review school data to identify student needs across the tiers. Providers of services regularly collect and review data on student progress and provide this information to the school implementation team as part of a continuous quality monitoring process. This feedback loop ensures that the implementation team has information about student progress and can determine what supports are needed and whether supports are addressing the identified needs.

PBIS is an evidence-based multi-tiered framework for maximizing the use of evidence-based interventions. PBIS prevents inappropriate behaviors from occurring by improving the link between EBPs and the environments in which teaching and learning occur.[167] Within the PBIS framework, intensive services can be provided through partnerships between the school- and community-based MH providers for students with the most complex behavioral needs. Colorado's framework has expanded from a PBIS to a full MTSS framework and identifies ten SBMHS best practice principles.[168]

Most schools offer some array of SBMHS-direct and indirect MH services, consultations, contacts, and supports that are provided in the schools. SBMHS: 1) include multidisciplinary treatment plans developed and implemented by a team of community MH, school-employed MH, and education professionals; 2) rely on cross-discipline collaboration and communication, including case management; and 3) involve students and parents in planning services and reinforce parent participation in services.[169]

SBMHS can help ensure that students who need MH services and supports receive them. When effectively implemented, SBMHS increase access to care, reduce stigma, and foster academic success. However, there is little evidence that these services improve student outcomes when they lack administrative support for implementation, they are separated from other behavioral supports, or

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[166] *Tiered Framework*. Positive Behavioral Interventions & Supports (PBIS). https://www.pbis.org/pbis/tiered-framework

[167] OSEP Technical Assistance Center on Positive Behavioral Interventions and Supports. (2018). *PBIS FAQs*.

[168] Positive Behavioral Interventions and Supports (PBIS). Colorado Department of Education. https://www.cde.state.co.us/mtss/pbis

[169] Knoff, H. M. (2007). *The Seven Sure Solutions to School-Based Mental Health Services Success – The Necessary Collaboration between School and Community Providers*. In Evans, S. W., Weist, M. D., & Serpell, Z. N. (Eds.), *Advances in school-based mental health interventions: Best practices and program models, Vol. 2* (pp. 6-1–6-21). Civic Research Institute

there is minimal coordination between community-based MH providers, school staff, and administrators.[170]

When SBMHS and PBIS are not coordinated, schools struggle to develop a continuum of interventions that meet the complex needs of students.[171] When SBMHS and PBIS practices and resources are integrated within an MTSS, SBMHS moves from a reactive, individual approach to an approach that is preventative; promotes social, emotional, and MH and wellness for all; and facilitates positive outcomes for students.[172] Wisconsin anchored its SBMHS framework in its PBIS framework and applied all the same foundational principles to its MH structure.[173]

The Interconnected Systems Framework (ISF) is an implementation framework that merges education and community MH supports into a single, multi-tiered prevention system that promotes the success and mental wellbeing of all students. ISF incorporates a board range of partners and a wide range of data to expand MH interventions. The impact of ISF is measured by student outcomes rather than access to services. The core features of MTSS are essential to implementing ISF.[174] ISF serves as the bridge between a school's MTSS framework and a community's MH continuum. The ISF utilizes the multi-tiered framework to integrate and coordinate school and community-based MH and wellness supports. The models build on the school's and the community's strengths to enhance the school's capacity to meet the academic, MH, and wellness needs of all students.

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[170] Dowdy, E., Ritchey, K., & Kamphaus, R. W. (April 27, 2010). *School-Based Screening: A Population-Based Approach to Inform and Monitor Children's Mental Health Needs*. *School Mental Health, 2*, 166–176. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2957575/pdf/12310_2010_Article_9036.pdf

[171] Barry, S., Barrett, S., & Perales, K. (December 2016). *PBIS Forum 16 Practices Brief: Embedding Mental Health Into School-wide System of PBIS: Interconnected Systems Framework Practice Guide*. https://assets-global.website-files.com/5d3725188825e071f1670246/5d80123d059b38ba0510bf33_RDQ%206%20Brief%20-%20Mental%20Health.pdf

[172] Perales, K., Pohlman, K., Eber, L., & Barret, S. (December 2017). *PBIS Forum in Brief: Aligning and Integrating Mental Health and PBIS to Build Priority for Wellness*. https://assets-global.website-files.com/5d3725188825e071f1670246/5d8011be6a2ce76e34b8d002_RDQ%202%20Brief%20-%20Mental%20Health.pdf

[173] Wisconsin Department of Public Instruction. (December 2015). *The Wisconsin School Mental Health Framework: Integrating School Mental Health with Positive Behavioral Interventions & Supports.* Bulletin No. 16050. https://dpi.wi.gov/sites/default/files/imce/sspw/pdf/mhframework.pdf

[174] Eber, L., Barrett, S., Perales, K., Jeffrey-Pearsall, J., Pohlman, K., Putnam, R., & Splett, J. (September 2020). *Advancing Education Effectiveness: Interconnecting School Mental Health and School-Wide PBIS, Volume 2: An Implementation Guide*. Positive Behavioral Interventions & Supports (PBIS). https://assets-global.website-files.com/5d3725188825e071f1670246/5f6914a88117c9834d0638f8_ISF%20v2%20Implementation%20Guide.pdf

Funding Strategies

Infant and Early Childhood MH Service Array

Wisconsin secured funding from private foundations and state contracts to launch small projects to show the effectiveness of IECMH services and raise public awareness about these services. The state used federal funding from Project LAUNCH and Early Childhood Comprehensive Systems to infuse IECMH services into communities and to create changes in practice and policy. In 2007, Wisconsin Medicaid recognized DC: 0-3R diagnostic codes to bill in-home MH services.[175]

In 1996, Illinois used Part C Early Intervention and general revenue funds to support the placement of MH consultants at every early intervention site across the state. The state also used Child Care and Development Block grant quality set-aside funding to pilot test a regional MH consultation model in 2003. In 2006, the State Board of Education supported MH consultation in Preschool for All and Prevention Initiative sites. Funding sources that support IECMHC include a Preschool for All Expansion Grant; DHS; the Department of Public Health; Maternal, Infant, and Early Childhood Home Visiting funds; the State Board of Education; and foundation and non-profit support.[176]

A Behavioral Health Transformation package implemented in Arkansas in 2017 included changes to Medicaid and revisions of OP BH rules that required providers to use the DC: 0-3R (and subsequent versions). The aim of this package was to improve diagnosis and referral of young children to evidence-based services. Dyadic therapies were also included for Medicaid reimbursement.[177]

A Comprehensive Array of MH Services for Children, Youth, and their Families — System of Care

SAMHSA began funding SOC demonstration grants and cooperative agreements in states, territories, counties, and federally recognized tribal entities in 1993, and began offering expansion and sustainability grants in 2012.[178] New Jersey received a SAMHSA grant in 1999 that resulted in statewide implementation of a SOC by 2006.

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[175] ZERO TO THREE. (February 2013). *Nurturing Change: State Strategies for Improving Infant and Early Childhood Mental Health*. https://www.zerotothree.org/resources/122-nurturing-change-state-strategies-for-improving-infant-and-early-childhood-mental-health

[176] Center of Excellence for Infant and Early Childhood Mental Health Consultation. https://www.iecmhc.org/documents/il-approach-building-sustaining-iecmhc.pdf

[177] Ahlers, T., Cohen, J., Oser, C., & Szekely, A. (July 2018). *Advancing Infant and Early Childhood Mental Health: The Integration of DC:0–5TM Into State Policy and Systems*. ZERO TO THREE. https://www.zerotothree.org/resources/2343-advancing-infant-and-early-childhood-mental-health-the-integration-of-dc-0-5-into-state-policy-and-systems#downloads

[178] SAMHSA. (2015). *The Comprehensive Community Mental Health Services for Children with Serious Emotional Disturbances Program: Report to Congress 2015*. https://www.samhsa.gov/sites/default/files/programs_campaigns/nitt-ta/2015-report-to-congress.pdf

New Jersey's SOC is funded through Medicaid as a single-payer entity with multiple, blended funding sources, which include Medicaid, state Children's Health Insurance Program, waivers, and block grants, and child welfare, IDDs, and SUD funding. It coordinates with PCPs through a Medicaid Health Home SPA as a core component of the system. CMOs throughout the state use a Wraparound approach for care management.[179] They bill for services through the DHS' fiscal agent. Family support organizations offer peer support funding through Medicaid administrative funds and fixed contracts. Although the SPA covers intensive care coordination (Wraparound), an 1115 waiver pays for transition life skills, non-medical transportation, and youth support training. Mobile crisis response and stabilization services are funded through Medicaid and state dollars.

Connecting the Array of Community and School-Based MH and Social and Emotional Services and Supports — The Interconnected Systems Framework

Funding approaches for ISF include examining how BH and MH efforts within a school or district are funded, and discussing what would need to change to connect education and community agency staff. The resulting shared funding plan, with reallocation of existing resources and blended and/or braided funding, allows for more flexibility. Long-term investment is sustained by moving from short-term funding streams to stable institutional funding. Charleston, South Carolina, offers an example of blended or braided funding, where school-based clinicians are funded (by school district) by the Department of Mental Health. Schools provide a portion of the position funding so that the clinician can be involved on the MTSS team.[180]

Monitoring/Data Strategies

The IECMHC leadership team in Illinois uses data and needs assessments to identify the need for IECMHC, address gaps in service needs, and identify funding opportunities. The data are also used to support workforce development and identify needs for training on children's MH and social and emotional learning.[181]

The COE for IECMHC was established by SAMHSA, the Health Resources and Services Administration (HRSA), and the Administration for Children and Families to support states, tribes, and communities in providing IECMHC services. The COE for IECMHC offers a toolbox that includes the

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[179] Simons, D., Pires, S. A., Hendricks, T., & Lipper, J. (July 2014). *Intensive Care Coordination Using High-Quality Wraparound for Children with Serious Behavioral Health Needs STATE AND COMMUNITY PROFILES*. Center for Health Care Strategies, Inc. http://www.chcs.org/media/ICC-Wraparound-State-and-Community-Profiles1.pdf

[180] Eber, L., Barrett, S., Perales, K., Jeffrey-Pearsall, J., Pohlman, K., Putnam, R., & Splett, J. (September 2020). *Advancing Education Effectiveness: Interconnecting School Mental Health and School-Wide PBIS, Volume 2: An Implementation Guide*. Positive Behavioral Interventions & Supports (PBIS). https://assets-global.website-files.com/5d3725188825e071f1670246/5f6914a88117c9834d0638f8_ISF%20v2%20Implementation%20Guide.pdf

[181] Center of Excellence for Infant and Early Childhood Mental Health Consultation. https://www.iecmhc.org/documents/il-approach-building-sustaining-iecmhc.pdf

latest research and best practices in home visiting and early care and education programs. It also provides resources and strategies for addressing gaps in knowledge and implementing IECMHC.[182]

Quality assessment and performance improvement activities in New Jersey rely on documentation of all care management activities and include youth outcomes and satisfaction. Wraparound Fidelity Index measures can be used by the CMOs to assess fidelity to the Wraparound model. In addition, CMOs are required to report unusual incidents. A system review process assesses the CSoC's strengths, areas for improvement in youth outcomes, and the system's fidelity to the Wraparound model.[183]

In the ISF model, student progress is monitored in order to evaluate intervention effectiveness and move beyond tracking access to services. The academic and community data that the team agreed to monitor (e.g., academic outcomes, discipline data, and ER visits) is reviewed to determine whether the student is learning new skills and using them across different settings. Teams are also responsible for monitoring the fidelity of specific interventions that are being provided. The effectiveness of the overall approach can be monitored through the Implementation Inventory (Version 3), a school-level fidelity instrument.[184]

Summary of Findings

In the past 15 years, progress has been made to transform the children's BH system. Efforts to develop school-based interventions, reduce RTF utilization, and expand access to early childhood EBPs such as PCIT has resulted in positive outcomes. A variety of funds including reinvestment, grant and HC funds have supported efforts. Over time, there has been a greater emphasis on youth and family voice and choice. Members recognized an increase in trauma-informed children's providers as well as the concentrated efforts to reduce length of stay in RTFs and reduce the use of seclusion and restraint.

Family members and caretakers expressed challenges with navigating the children's system, in particular with families new to the system or with young children. Access to children's EBPs vary by

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[182] The Center of Excellence for Infant and Early Childhood Mental Health Consultation. *Development of the Center of Excellence IECMHC Toolbox: Purpose, Process, and Contributors*. https://www.samhsa.gov/sites/default/files/programs_campaigns/IECMHC/development-center-excellence-iecmhc-toolbox.pdf

[183] Blake, A. (2017). *Care Management Organization Policy Manual*. New Jersey Department of Children and Families. https://www.state.nj.us/dcf/policy_manuals/CMOManual.pdf

[184] Eber, L., Barrett, S., Perales, K., Jeffrey-Pearsall, J., Pohlman, K., Putnam, R., & Splett, J. (September 2020). *Advancing Education Effectiveness: Interconnecting School Mental Health and School-Wide PBIS, Volume 2: An Implementation Guide*. Positive Behavioral Interventions & Supports (PBIS). https://assets-global.website-files.com/5d3725188825e071f1670246/5f6914a88117c9834d0638f8_ISF%20v2%20Implementation%20Guide.pdf

county and is more limited in rural areas. Similar to other states, providers have experienced challenges with staff recruitment and retention. Informed by national research and comparison to the current children's BH system in the Commonwealth, OMHSAS is leading efforts to continue to identify the ideal array of BH services to ensure the most appropriate BH services are available in communities in which children, youth and families live.

9

Enhancing Integrated Health Care

Strategies for Enhancing Integrated Health Care

Although strategies for enhancing integrated care were embedded in other strategies throughout all three guidance documents, the focus on integrated care as a stand-alone topic of interest emerged within the last 10 years. Because of its current importance to the future of the HC-BH system, it is offered as a new area of focus and activity. Each of the following areas describes strategies, goals and activities to enhance integrated health care. Suggested activities for integrated care are for consideration and not all-inclusive. Additional activities related to these strategies may have emerged in the last 10 years and are included in this section.

Service Development Strategy: Develop additional programming, provider network and services to support MH/SUD service integration, co-occurring BH and IDDs, and BH and PH integration.

Activities may include the creation of dual MH/SUD residential, partial hospital and intensive OP programming that provides treatment for both type of conditions; the development of developmentally appropriate BH services (e.g., Dual Diagnosis Treatment Teams [DDTTs]); and embedding primary care into community BH agencies (e.g., CCBHCs) or creating a system of health navigators and/or for care coordination.

Funding Strategy: Develop structures and incentives to integrate services for individuals with co-occurring BH and IDDs, and BH and PH.

Activities may include directed payments to providers who meet case management standards (e.g., COE for MAT), value added health navigator services, development of grant money to support WRAP services.

Monitoring/Data Strategy: Develop processes and procedures to collect data to inform ongoing monitoring of integrated care. This should include identification of data metrics in collaboration with the counties, BH-MCOs, and providers.

Activities include requiring utilization and outcome measures to track and trend care coordination activities from BH-MCOs; ongoing monitoring of case management activities; and quality reporting requirements from clinics and other services providing some type of integrated health care.

Recent Accomplishments and Trends

The Commonwealth has multiple initiatives to advance integrated care. For example, beginning in 2014, DHS implemented a BH-MCO and PH-MCO pay for performance program for integration and coordination of BH and PH services with a goal to improve the quality of healthcare, reduce expenditures, and reduce hospitalizations and inappropriate ER visits through enhanced care coordination among PH-MCOs, BH-MCOs, and providers. Integrated care plans to address the holistic needs of individuals 18 and older who have SMI are developed and the BH-MCO and PH-MCO share responsibility for notifying each other of IP PH or psychiatric hospital admissions and ER visits. Five quality performance measures were also established such as initiation and engagement of substance use treatment; adherence to antipsychotic medications; and combined BH/PH IP utilization for individuals with serious and persistent mental illness (SPMI).

In 2017, Pennsylvania was one of the first states to launch a SAMHSA-funded CCBHCs Demonstration Project for two years to develop and test an inclusive prospective payment system (PPS) model for community clinics to integrate BH and PH services. The model focused on provision of nine core services provided directly by the CCBHCs. To receive certification, CCBHCs had to provide a minimum set of EBPs centered on recovery-oriented care and support for children, youth, and adults. In 2020, OMHSAS required the PCs and/or its BH-MCO to contract with each ICWC (formally known as CCBHCs) and ICWC's must offer care that is person- and family-centered, trauma-informed, recovery oriented and that the integration of BH and PH care serves the "whole person".

PC and BH-MCO Interviews

Service Development

PCs and BH-MCOs highlighted integrated care activities. During the interviews, three main themes emerged including efforts to coordinate between BH and PH providers; programming to coordinate between BH and IDD providers; and efforts to increase smoking cessation. Highlights of the integrated care initiatives and accomplishments are described below:

BH and PH Coordination

The primary methods for developing integrated BH and PH continuums consist of co-locating BH and PH practitioners and developing community-based teams focused on implementing integrated care plans. Co-location and integrated care coordination team models vary by county and include specific structuring to meet the needs of the local landscape while keeping a focus on the behavioral and physical needs of the individuals.

Since 2009, the Behavioral Health Home Plus (BHHP) expanded to over 64 BH providers across 27 counties as part of recovery for adults living with SMI, individuals with OUD, adolescents participating in BH services, and youth in treatment in PRTFs. The BHHP is a comprehensive population health model that enhances capacity of BH providers to help individuals identify and address PH and wellness challenges along with empowering individuals to become more informed and effective

managers of their health. Case managers and peer support staff are trained as wellness coaches and nurses are utilized for their expertise in PH management. Self-management toolkits are also utilized by individuals for weight-loss, healthy diet, physical activity, tobacco cessation, and medication adherence.

Originally implemented in 2009 in Montgomery County and since expanded to Lehigh, Northampton and Delaware counties, MBH utilizes a similar coordinated staffing model through Wellness Recovery Teams (WRTs). The Teams include a RN, a BH clinician, and administrative navigator to focus on coordinating care, supporting individuals, and developing relationships with PCPs and medical specialists to help with care coordination. The team focuses on individuals 18 years or older diagnosed with SPMI, working to minimize fragmented services and support members and caregivers with self-care skills.

MEMBER STORY

A member in OP services and Peer Support who engaged with his team and wellness coaching and achieved his goal related to physical health — wanting to be able to ride roller coasters with family again and he not only achieved that goal, but also other recovery goals including getting a car, employment and others.

Beacon also focuses on an integrated care coordination model to address whole person health. Beacon participates in collaboration rounds with PH-MCOs and during treatment planning with individuals, BH and PH goals are identified.

CBH has continued to expand access to FQHCs and FQHC Look-Alike's since 2008. As part of a co-location initiative, BH consultants in the FQHC offer brief consultations and provide individuals with psychosocial support using evidence-based intervention such as CBT and motivational interviewing. SAMHSA's standard framework for six levels of integration (as described in the literature review and national scan section) along with an Integrated Practice Assessment Tool (IPAT) is designed to place practices on the level of collaboration/integration. By 2018, approximately 47 sites delivered BH services.

PCs in collaboration with PerformCare embedded MH clinicians in primary care, pediatric, and PH specialty offices as well as offering BH services in FQHCs. Efforts to embed MH clinicians has been driven by providers, and again in keeping with the SAMHSA/HRSA model, OP clinics and providers have been involved in PH practices, whether it be increased communication or full co-location.

This recovery-oriented approach helps identify and address underlying physical, behavioral, environmental, and psychosocial factors contributing to instability in community settings.

BH/IDD Coordination

In addition to integrating care between BH and PH providers, the Commonwealth focused on integrating care to support adults with co-occurring MH disorders and intellectual disabilities, another area where care is often fragmented. DDTTs employs a community-based, multi-disciplinary treatment team including a recovery coordinator with a focus on crisis intervention, community stabilization and diversion from the criminal justice system

and IP hospitalization as well as a step-down service from higher levels of care. Since 2012, the DDTT program has expanded from the North/Central State Option counties to two DDTT providers with teams serving members in most HC contracts across the Commonwealth.

Tobacco Cessation

Another overarching integrated care theme was in the area of tobacco cessation. For MBH, the Tobacco Cessation Plan program focuses on improving community tobacco cessation support and education. Trainings have been offered to providers, community, and clinical staff at two PH-MCOs. To assist in the promotion of tobacco free campuses, MBH has developed incentive programs as well as piloting member access to Clickotine®, a digital therapeutics solution.

Beginning in 2013, CBH, DBHIDS, Philadelphia Department of Public Health and PENN focused efforts to reduce tobacco use and tobacco-related morbidity and mortality among those with BH problems in Philadelphia. Training and technical assistance to providers on screening and diagnosis tobacco use disorder was offered and providers implemented tobacco-free policies.

Individuals now have access to tobacco-tree treatment environments and evidence-based tobacco use disorder treatment across all levels of care.

Additional integrated care initiatives include:

- To better serve and address the multifaceted needs of older adults, the Northwest Three and Southwest Six counties partnered with an expert in Gerontology to develop and facilitate an Older Adult Learning Community. Over 100 MH/SUD clinicians completed 25 hours of free training and achieved a Geriatric Competent Clinician designation.
- Delaware and Bucks counties have embedded nurse navigators within a BH clinic who are responsible for collaborating care across an individual's services and supports, assessing PH status and collaborating with agencies including pharmacy and specialty services to promote holistic care.

Funding

Funding for integrated care initiatives draws from several different sources and in some cases, changing to new funding, as sources are made available. Medicaid and Medicare reimburse FQHCs with an all-inclusive rate, which includes the brief BH interventions noted above. Some FQHCs are also part of VBP arrangements through HC. WRTs received funding as supplemental services until DHS deemed integrated care a mainstream requirement and a responsibility of the PH plans as well.

BHHP receives funding as a VBP arrangement under HC funding. Performance measures target retaining a RN as the agency's lead health navigator, completion of a Wellness Outcomes Tool for 80% of individuals, completion of a PCP visit or other specialist for 70% of individuals, and scoring at least 80% on a fidelity review.

Since the original DDTT was established, multiple counties sought OMHSAS approval to use reinvestment funds to develop and implement DDTT as an innovative, cost effective alternative to address the unique needs of the targeted population. Once the reinvestment plan service demonstrated cost-offset or cost value, DDTT was eligible for approval as a supplemental service. These DDTT services are no longer supported by reinvestment funds, as costs are covered as a Medicaid medical expense and factored into the capitation rates.

Each ICWC is paid a monthly PPS rate and the PC and/or BH-MCO pays each ICWC in its network the PPS rate for its enrolled ICWC members for the nine core services. The PPS rate is incorporated into the capitation rates.

Monitoring/Data

The monitoring and outcomes of integrated care efforts have demonstrated positive results. Examples are highlighted below:

The BHHP model has been evaluated by funding from the Patient-Centered Outcomes Research Institute (PCORI). Key findings from the PCORI evaluations over two years include:

- Improved engagement in primary care (approximately 40% increase in number of visits)
- Improved patient activation in care
- Increased overall community-based ambulatory PH service use (40%–50%)
- Decreased PMPM total cost (15%)
- Decreased behavioral and medical IP use (30%–40%) and cost (20%–25%)
- Decreased case management cost (17%)

WRT's demonstrated positive results for both IP utilization and financial outcomes. Members in Montgomery County saw a 53% decrease in PMPM MH IP admissions and a decrease of 25% in PMPM spending from pre- to post-intervention. Members also saw an overall improvement by 14 points in their Health and Wellness Questionnaire results after being involved or completing WRT. Members served in the Lehigh and Northampton WRT program saw an 80% decrease PMPM MH IP admissions and members in Delaware County's WRT program also experienced a decrease in spending. Bucks County Nurse Navigator program has also demonstrated positive outcomes for members including a decrease in IP utilization.

As part of evaluating integrated health initiatives, the PCs and MBH monitors specific data points including members served and/or engaged, rates of hospitalization/re-hospitalization, community tenure, crisis service utilization, medication trends, lab results, SDOH, etc.

Franklin/Fulton utilizes a VBP arrangement with a FQHC and monitors and tracks data including access to care, ER utilization, IP hospital admission, and readmissions. CBH conducts consumer satisfaction surveys and the Integrated Practice Assessment Tool (IPAT) is utilized to assess the degree of integration across FQHCs.

Monitoring and oversight activities of DDTT typically include clinical and peer review during the authorization process, utilization monitoring including discharge status (successful or otherwise), quality monitoring including complaints, grievances and significant member incidents, and clinical and compliance audits. BH-MCOs and PCs have reported reduction in use of IP services post-DDTT along with a reduction in hospital costs.

Stakeholder Findings

Provider Comments

Creation of BCM has allowed care managers more flexibility to provide more individualized services and to work with members based upon their needs. They reported that BCM also allows the care manager to continue to provide services as symptoms become more or less acute.

Integrated care providers reported that significant advances have been made in sharing of data and clinical information with other local hospitals and other providers. They report receiving clinical information more quickly, which has enhanced the quality of their work and coordination of care. Providers noted that PCPs are now more aware of the benefits of integrated care, and more open to sharing information with BH providers. Providers also noted that they would like to have more BH navigators in their own integrated clinics.

CCBHC providers reported that additional funding has allowed clinics to hire additional BH staff and to provide more services. Prior to this additional funding, these clinics either contracted with clinicians based on a FFS model, or referred clinic members to a BH provider. By hiring additional staff, these providers reported they are able to provide better integration of BH and PH services.

One provider noted that the HC-BH service delivery system provides better coordination of care and includes creative programming with targeted situations. This provider expressed concerns over a risk of HC-BH becoming the “catch all” from other systems (e.g., individuals with MH challenges associated with TBI, IDD, and dementia with behavioral disruptions).

Integrated care providers also reported significant inequities between services addressing BH and PH. For example, individuals with BH issues do not receive nurse navigators. Although intervening in BH issues decreases PH costs, BH providers do not receive incentives of benefits from this cost reduction.

Additional barriers to effective integrated care identified by this provider group included challenges associated with provider enrollment in the Medicaid Program and contracting with HC BH-MCOs. They noted that the process of getting clinicians certified, credentialed and enrolled in the BH-MCO can take six months. Some of these providers expressed concerns over the initiatives to integrate BH and PH services without a plan or roadmap for integration.

Member Comments

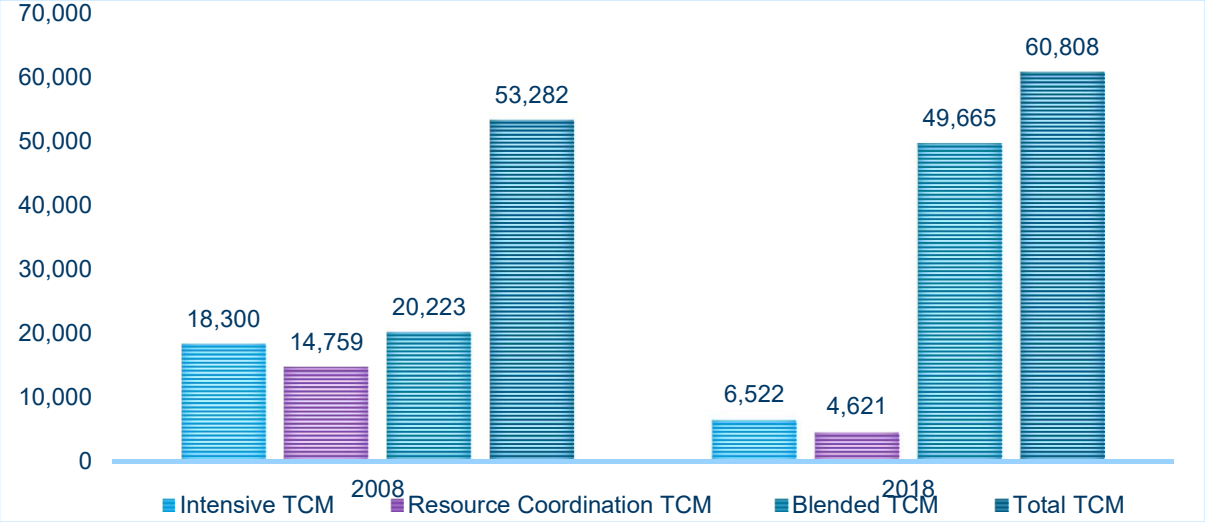
Many adults either had no experience with integrated care clinics, or only learned of integrated care recently. Adults noted that having nurse navigators has been very helpful. One individual reported the benefits of using an integrated care clinic for all healthcare services meant that her PH physician was alert to possible medication side effects. Another member noted that these clinics represent a significant advance over his past experience in which the family PCP reached out to the individual's psychiatrist to coordinate services due to a contraindication of a medication prescribed by the psychiatrist. The member reported that his psychiatrist refused to communicate with the PCP.

Members expressed much enthusiasm for more integrated services, either through an integrated care clinic or more care coordination.

Service Trends

TCM is one vehicle used to coordinate and integrate care. The following table displays changes in the number of individuals who received various types of TCM between 2008[185] and 2018.

Chart G: Changes in TCM Utilization between 2008 and 2018



[185] Mercer had user counts readily available for the three TCM groupings, beginning in 2008.

As noted in this chart, the total number of individuals who received some type of TCM increased 14% between 2008 and 2018. However, the type of TCM the majority of individuals received shifted significantly due to policy changes.

Historically, Intensive TCM included acuity and frequency criteria that resulted in individuals moving in to and out of this service level as their clinical conditions fluctuated. Policy changes allowed Blended TCM care managers to continue working with individuals, even as their symptoms were exacerbated or stabilized. This change resulted in the TCM service recipients receiving more person-centered blended TCM.

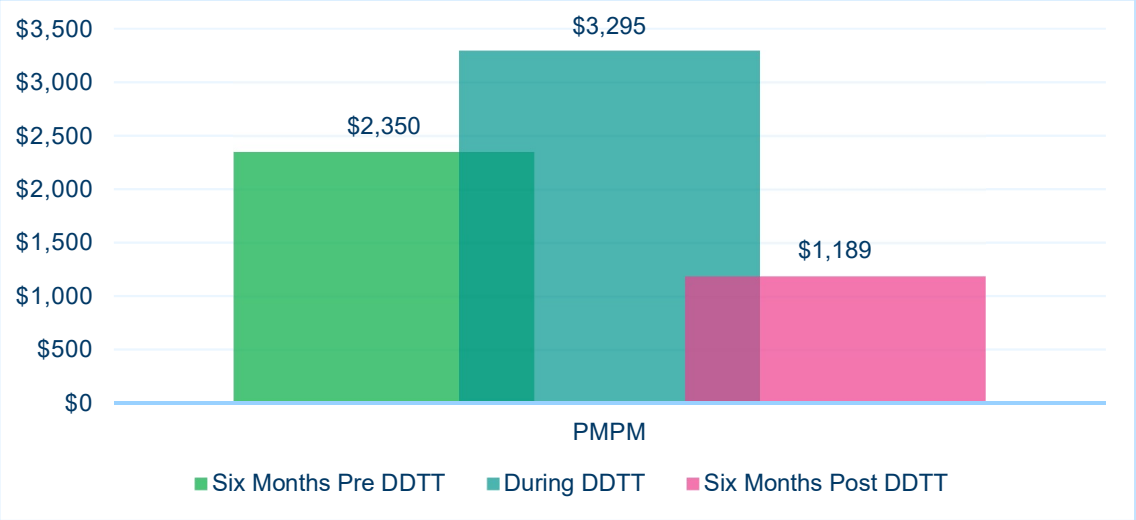
Another OMHSAS initiative specific to the service integration for MH and IDD care is the DDTT. Conducted in 2020, a mixed method analysis of outcomes that compared pre-DDTT with post-DDTT utilization indicated that individuals utilized more community-based services and fewer resources during the post DDTT phase of the study period. Specific outcomes are as follows:

- Sixty percent fewer individuals received facility-based care[186] in the post-DDTT stage than in the pre-DDTT stage, and the total number of unique users for all clinic and community-based services stayed the same across pre-DDTT, during DDTT, and post-DDTT phases of the study.
- Total community and clinic PMPM during the post-DDTT phase is 21.5% less than community and clinic PMPM during the pre-DDTT PMPM.
- The PMPM costs for all MH services six months post-DDTT services decreased by 64% from the during-DDTT study phase, and by almost one-half relative to the six-month costs prior to DDTT services.

This pattern of utilization suggests that DDTT services are meeting the DDTT service goals of decreasing facility-based care and increasing community tenure.

[186] Facility-based care includes IP Acute Psychiatric, Residential Psychiatric for Transition Age Youth 18–22, and Adult Residential Treatment Facility.

Chart H: Total MH Service PMPM of Sample Pre-DDTT, During DDTT and Post-DDTT Services



Literature Review and National Scan

The World Health Organization defines integrated care as "integrated people-centered health services putting individuals and communities, not diseases, at the center of health systems, and empowering individuals to take charge of their own health rather than being passive recipients of services".[187] The APA defines integrated healthcare as "often referred to as inter-professional health care, as an approach characterized by a high degree of collaboration and communication among health professionals".[188] Integrated care definitions include two components: the needs of the individual requiring services and the availability of coordinated services to meet those needs.

State efforts to enhance person-centered, integrated healthcare services have focused upon organizational and structural integration at various levels of the healthcare delivery system. For example, some states carve-in BH services into MCO contracts. In FY 2019, 44 states had one or more delivery system or payment reform initiatives in place in (most often Patient-Centered Medical Homes or ACA Health Homes) that target the provider level for integration of care. In addition to

[187] World Health Organization. *Service delivery and safety: What are integrated people-centered health services?* https://www.who.int/servicedeliverysafety/areas/people-centred-care/ipchs-what/en/

[188] American Psychological Association. *Integrated Health Care*. https://www.apa.org/health/integrated-health-care#:~:text=Integrated%20health%20care%2C%20often%20referred%20to%20as%20interprofessional,degree%20of%20collaboration%20and%20communication%20among%20health%20professionals

CCBHCs and Health Homes, states utilize other models, especially Primary Care Case Management (PCCM), as a best practice to ensure integration of care.[189]

SAMHSA and HRSA created a Center for Integrated Health Solutions (CIHS) dedicated to planning and development of integration of primary and behavioral healthcare for individuals with mental illness and/or SUDs and PH conditions, whether seen in specialty MH or primary care settings. CIHS identifies the six levels of integration at the provider level and core competencies for health integration in each of the stages. This framework helps provider organizations improve outcomes by helping them understand where they are on the integration continuum.[190]

Table 12. CIHS Continuum of Collaboration/Integration

Coordinated Key Element: Communication		Co-Located Key Element: Physical Proximity		Integrated Key Element: Practice Change	
Level 1	**Level 2**	**Level 3**	**Level 3**	**Level 5**	**Level 6**
Minimal Collaboration	Basic Collaboration at a Distance	Basic Collaboration Onsite	Close Collaboration Onsite with Some System Integration	Close Collaboration Approaching an Integrated Practice	Full Collaboration in a Transformed/ Merged Integrated Practice

Care Management and Care Coordination Models of Integrating Care

Many states use care management and care coordination models to decrease fragmentation and enhance integrated care.

North Carolina created a coordination model between Local Management Entity/MCOs, a BH managed care carve out, and 14 PCCM local networks, called the Community Care North Carolina (CCNC). The intent is to coordinate care between BH and PH providers with two types of activities. Individual-level care coordination occurs when staff from both organizations meet as an interdisciplinary team to discuss complex cases. Meetings occur on at least a monthly basis and cover complex cases such as individuals with schizophrenia and diabetes or Chronic Obstructive Pulmonary

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[189] Gifford, K., Ellis, E., Lashbrook, A., Nardone, M., Hinton, E., Rudowitz, R., Diaz, M., & Tian, M. (2019, October). *A View from the States: Key Medicaid Policy Changes: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2019 and 2020*. KAISER FAMILY FOUNDATION. https://www.kff.org/report-section/a-view-from-the-states-key-medicaid-policy-changes-delivery-systems/

[190] SAMHSA-HRSA Center for Integrated Health Solutions. (n.d.). *Table 1. Six Levels of Collaboration/Integration (Core Descriptions)*. https://www.thenationalcouncil.org/wp-content/uploads/2020/01/CIHS_Framework_Final_charts.pdf?daf=375ateTbd56

Disease. CCNC also encourages system-level care coordination with the development of initiatives that integrate physical and behavioral healthcare. A current initiative is the assessment of the current incorporation of BH need in primary care treatment planning, and to build capacity for primary behavioral healthcare.[191]

The Indiana Care Select PCCM program began in 2008, building on a successful chronic disease management program for individuals with diabetes or congestive heart failure. The Care Select program includes those individuals eligible for certain categories of Medicaid FFS, as well as HCBS waiver enrollees. The program has expanded since its creation to include other special health needs, including SMI and SED. Physicians assume responsibility for providing or coordinating members' care, with the assistance of two managed care entities (MCEs). The MCEs develop care plans for enrollees, using an assessment tool developed jointly by the MCEs and the state.[192]

Arkansas has a care coordination program called "Provider-led Arkansas Shared Savings Entity" (PASSE) that coordinates BH and PH needs. A PASSE care coordinator manages an integrated plan of care for individuals with BH needs, medication management and counseling, or who are in need of developmental disability services.[193]

Sharing Clinical Information in Integrating Care

Physical and organizational structures can also be integrated by sharing clinical information. Electronic Health Records (EHRs) are the basic building blocks in sharing clinical information and integrating healthcare. However, the use of EHRs by MH/SUD providers lag behind that of medical providers. The Health Information Technology for Economic and Clinical Health Act (HITECH) of 2009, provided billions of dollars in subsidies for medical providers to purchase and maintain EHRs. Unfortunately, the act did not make incentive payments available for MH/SUD providers.[194]

The Bipartisan Policy Center recently released a report titled *Integrating Clinical and Mental Health: Challenges and Opportunities*, in which sharing clinical information was noted to be necessary in order

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[191] U.S. Department of Health and Human Services Assistant Secretary for Planning and Evaluation Office of Disability, Aging and Long-Term Care Policy. (January 1, 2014). *Strategies for Integrating and Coordinating Care for Behavioral Health Populations: Case Studies of Four States*. https://aspe.hhs.gov/system/files/pdf/76991/4CaseStud.pdf

[192] Agency for Healthcare Research and Quality. *Designing and Implementing Medicaid Disease and Care Management Programs*. https://www.ahrq.gov/patient-safety/settings/long-term-care/resource/hcbs/medicaidmgmt/mm3.html

[193] https://humanservices.arkansas.gov/divisions-shared-services/medical-services/healthcare-programs/passe/

[194] McGregor, B., Mack, D., Wrenn, G., Shim, R. S., Holden, K., & Satcher, D. (2015). Improving Service Coordination and Reducing Mental Health Disparities Through Adoption of Electronic Health Records. *Psychiatric Services*, 66(9), 985–987. https://ps.psychiatryonline.org/doi/pdf/10.1176/appi.ps.201400095

to integrate healthcare services. The authors recommend that states encourage or require MH providers to use EHRs.[195]

A statewide electronic Health Information Exchange (HIE) allows providers, pharmacists, other health care providers and individuals receiving healthcare services to access and share clinical information electronically.[196] Although states differ in type and content of HIEs, some states have used HIEs to integrate care not only across providers, but across payers as well. For example, Arizona's HIE was originally designed for Medicaid providers, but now supports multiple payers (Medicaid, Medicare, and Commercial). Arizona's HIE includes BH providers, medical providers, hospitals, and labs.[197] Although regulatory and organizational barriers can exist to sharing information, integrated care requires that data reside in EHRs and shared across the healthcare delivery system.

Funding Strategies

Care Management and Care Coordination Models of Integrating Care

Integrating care through care management and care coordination programs use a variety of funding sources. For example, North Carolina funds CCNC through their State Plan, as well as state and federal grants for piloting new initiatives. Medicaid funds CCNC's work through a PMPM fee. CCNC passes a portion of the PMPM fee to the local CCNC networks to fund their activities. CCNC's two largest but most critical costs relate to training and the development of its data and information systems.[198]

The Indiana Care Select PCCM program is funded by Medicaid care management fees of approximately $25 PMPM. Participating physicians receive an administrative fee of $15 PMPM, as well as $40 per patient for participating in care coordination conferences with the CMO. Twenty percent of the payment to the CMOs is contingent on their performance on a series of quality-related

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[195] Bipartisan Policy Center. (January 2019). *Integrating Clinical and Mental Health: Challenges and Opportunities*. https://bipartisanpolicy.org/wp-content/uploads/2019/01/Integrating-Clinical-and-Mental-Health-Challenges-and-Opportunities.pdf

[196] HealthIT.gov. *What is HIE?* https://www.healthit.gov/topic/health-it-and-health-information-exchange-basics/what-hie

[197] *Health Information Exchange (HIE)*. AHCCCS. https://www.azahcccs.gov/AHCCCS/Initiatives/HIT/HIE.html

[198] U.S. Department of Health and Human Services Assistant Secretary for Planning and Evaluation Office of Disability, Aging and Long-Term Care Policy. (January 1, 2014). *Strategies for Integrating and Coordinating Care for Behavioral Health Populations: Case Studies of Four States*. https://aspe.hhs.gov/system/files/pdf/76991/4CaseStud.pdf

measures, such as avoidable hospitalizations, breast cancer screening, antidepressant management, and other care management activities.[199]

The Arkansas PASSE program operates under a 1915(b) waiver, and payment is made from Medicaid funds to the provider-led entities by the state on a PMPM basis. Actuarially sound rates are developed annually. Providers must own at least 51% of the organization, and are at financial risk to deliver services within the capitation amount provided.[200]

Sharing Clinical Information in Integrating Care

Integrating care by sharing clinical information is also funded by multiple sources. HIEs are funded through state funds, state and federal grants, and Medicaid funds. For example, the Arizona HIE was launched by a two-year $11.5 million Medicaid Transformation Grant as well as state funds to support the design and implementation of its HIE. Managed by the state Medicaid agency, the Arizona HIE grew from Medicaid providers to encompass all payer providers.[201]

The US Department of Health and Human Services recently provided grants through the STAR HIE Program (Strengthening the Technical Advancement & Readiness of Public Health via Health Information Exchange Program) to improve interoperability of health data in the face of escalating needs posed by the COVID-19 pandemic.[202] Grant recipients included Arizona and Pennsylvania.

Monitoring/Data Strategies

Multiple organizations have developed quality measures for integrated care. For example, the Agency for Healthcare Research and Quality (AHRQ) has developed an Atlas of Integrated Behavioral Health Care (IBHC) Quality Measures to identify appropriate measures for integration and to help identify gaps in integration efforts. Core measures include items such as assessment of chronic illness care, BH integration checklist, consumer assessment of health care and provider systems (clinician and group), and young adult healthcare survey measures.

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[199] Mathematica Policy Research, Inc., Verdier, J. M., Byrd, V., & Stone, C. (2009, September). Enhanced Primary Care Case Management Programs in Medicaid: Issues and Options for States. Center for Health Care Strategies, Inc. https://www.chcs.org/media/EPCCM_Full_Report.pdf

[200] Provider-led Arkansas Shared Savings Entity (PASSE) Risk-Based Provider Organizations Under Title XIX Section 1915(b) Authority

[201] *Health Information Exchange (HIE)*. AHCCCS. https://www.azahcccs.gov/AHCCCS/Initiatives/HIT/HIE.html

[202] U.S. Department of Health and Human Services. (September 29, 2020). *HHS Announces Funding for Health Information Exchanges to Support Public Health Agencies – STAR HIE Program Funds Five Organizations to Improve Interoperability of Health Data*. https://www.hhs.gov/about/news/2020/09/30/hhs-announces-funding-for-health-information-exchanges-to-support-public-health-agencies.html

Eleven functional domains divide and organize the IBHC Framework for measuring integration of BH care into high-level functions or actions. The clinical functions necessary for integrated behavioral healthcare include care team expertise, clinical workflow, patient identification and patient and family engagement. The operational/enabling functions that support integrated care include treatment monitoring, leadership alignment, operational reliability, business model sustainability and data collection and use. The third functions are the outcomes, limited to patient experience at this time.

A key domain in the operational/enabling function is treatment monitoring. This measure assesses if clinical information such as registry and outreach is readily available in the EHR, with documented follow-up workflows. Business model sustainability is another measure in the operational function. The domain determines if the business model will sustain the practice, and its providers. Sustainability for patients includes copays, time off work required for appointments, driving and transportation costs in time and money as well as health care premiums.[203]

Some models for monitoring integrated care are integrated into a service delivery model. For example, the Centers for Health Care Strategies developed integrated care models for primary, acute, BH, and LTSS, with recommended measures of functional status, care coordination, care transitions, BH, and safety. Measures include domains such as improvements in patient satisfaction, prevention, access to care, and functional status. Data collection methodologies include consumer and provider surveys and chart reviews as well as claims data.[204]

Another example of an integrated service delivery model with concurrent reporting and monitoring requirements are the CCBHCs. In order to be certified as a CCBHC, the original demonstration required that the clinics comply with standards for comprehensive, integrated healthcare, as well as the capacity to calculate and report a standardized list of performance measures. Additionally, the CCBHC was required to submit specified data to the state, who was required to calculate and report an additional set of standardized performance measures.[205] The advantage of integrated service delivery models that include quality measure reporting requirements is that the measures are organic to the model of delivery, which allows for more precise interpretation of the results.

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[203] Agency for Healthcare Research and Quality. *Atlas of Integrated Behavioral Health Care Quality Measures*. https://integrationacademy.ahrq.gov/products/behavioral-health-measures-atlas

[204] Center for Health Care Strategies, Palmer, L., LLanos, K., & Bella, M. (June 2006). *Integrated Care Program: Performance Measures Recommendations*. Center for Health Care Strategies, Inc. http://www.chcs.org/media/ICP_Resource_Paper.pdf

[205] SAMHSA. *Section 223 Demonstration Program for Certified Community Behavioral Health Clinics*. https://www.samhsa.gov/section-223

Summary of Findings

The Commonwealth has acted upon opportunities to integrate care. OMHSAS, counties, BH-MCOs and providers have led various initiatives to co-locate BH and PH providers, implement integrated care plans, and participate in collaboration rounds involving both BH-MCOs and PH-MCOs. Members identified the benefits of being able to see multiple providers in one location, which can mitigate SDOH challenges such as transportation and childcare. DDTT has supported adults in the community with co-occurring MH disorders and intellectual disabilities and reported outcomes are positive. Other integrated care efforts have focused on creating access to tobacco-free environments. Integrated care initiatives vary by county across the Commonwealth and some providers expressed concern there is not a clear roadmap or plan for integration. One area for needed integration is the treatment of co-occurring MH/SUD along with efforts to develop the provider workforce to address the dual needs of individuals. Although advancements have been made to share clinical information and data with hospitals and providers, there are potential opportunities to use EHR's by MH/SUD providers.

10

Crisis System

The Increasing Importance of a Robust BH Crisis System

As state hospital officials and other public health officials realized that many individuals could thrive with less restrictive, community-based services, the Commonwealth and other states closed state hospitals, decreasing the number of psychiatric hospital beds. With the decline in the number of psychiatric beds, a comprehensive and robust BH crisis system became more important over the past 15 years.[206] The COVID-19 pandemic has exacerbated the need for crisis services, as behavioral health services have been disrupted by the Public Health Emergency mitigation efforts. Consequently, this supplementary section on Pennsylvania's BH crisis system is included in *A Call for Change: 15 Years of Progress in HC-BH.*

MH crisis intervention services are required in all counties in Pennsylvania under the Mental Health and Intellectual Disability Act of 1966.[207] Counties are to ensure that emergency MH services are available twenty-four hours a day, seven days a week and be accessible to any individual in the community.[208] Efforts have focused on expansion of community-based crisis services including telephone, mobile, medical-mobile, walk-in, and crisis residential programs to prevent unnecessary psychiatric hospitalizations and to stabilize individuals in the community.

A responsive crisis system reduces the intensity and duration of distress for individuals experiencing a BH crisis, and provides a less restrictive option for keeping the individual safe. SAMHSA's National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit defines crisis services as crisis level safety net services and a comprehensive and integrated crisis network that serves **anyone, anywhere and anytime.**[209] The toolkit identifies the core elements of a comprehensive and integrated crisis network as (1) crisis lines accepting all calls and dispatching support based on the assessed need of

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[206] Raphelson, S. (November 30, 2017). *How The Loss Of U.S. Psychiatric Hospitals Led To A Mental Health Crisis*. NPR. https://choice.npr.org/index.html?origin=https://www.npr.org/2017/11/30/567477160/how-the-loss-of-u-s-psychiatric-hospitals-led-to-a-mental-health-crisis

[207] Pennsylvania General Assembly. (January 1967). *Mental Health and Intellectual Disability Act of 1966*. https://www.legis.state.pa.us/WU01/LI/LI/US/PDF/1966/3/0006..PDF

[208] Pennsylvania Department of Human Services. *Crisis Intervention*. https://www.dhs.pa.gov/Services/Mental-Health-In-PA/Pages/Crisis-Intervention.aspx

[209] SAMHSA. (2020). *National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit*. https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf

the caller, (2) mobile crisis teams dispatched to wherever the need is in the community (not hospital emergency departments), and (3) crisis receiving and stabilization facilities.

Provider and Member Experience with the Current Crisis System

Providers and members shared their observations of the Commonwealth's crisis system, and PC's, BH-MCO's and providers reported local initiatives to divert individuals in crisis away from jails and ERs.

Provider and Member Observations

In the provider and member stakeholder groups, crisis providers noted that the adoption of the R/R model has increased a focus on mobile crisis services that can help divert individuals from the ER, and has encouraged the development of less restrictive services. Providers also noted that mobile crisis services have resulted in a reduction of the use of seclusion and restraints in crisis and emergency settings. Multiple stakeholder groups reported that connecting individuals with a CPS or CRS in the community and developing relationships helps prevent BH issues from escalating into a crisis situation.

Crisis providers reported the effectiveness of developing a collaborative relationship with FBMH providers. They noted that in those instances in which a youth already has a FBMH team, that team provides more effective leadership, because they already have a relationship with the family and youth. The crisis providers also routinely refer youth in crisis to FBMH services instead of higher levels of care. These providers noted that they have more referrals to FBMH services than provider capacity, which may result in a delay of services as the youth is placed on a wait list.

Various provider groups also observed that locating crisis services within easy access to individuals (i.e., on a bus route, near a highly utilized IP facility or ER) contributes to the successes of a crisis diversion program. However, they also noted that individuals who are prematurely discharged from a state hospital or psychiatric IP struggle in a community setting and frequently rely on crisis services. They reported that these individuals spend much of their time in an ER or acute care setting.

Providers emphasized the importance of a strong safety net for individuals during transition from a state hospital or IP setting to ensure that community services are quickly established and easily accessed to increase community tenure. Consumer-owned providers noted that embedding CPSs in state hospitals as well as other psychiatric hospitals helps to establish community supports upon discharge, and can mitigate subsequent need for crisis services.

Members reported that drop-in programs and peer run respite programs are very important in the transition from IP services to the community. The members stated that these programs allow individuals who do not require a medication change, but are experiencing a crisis, receive 24/7 support in a less restrictive setting. Disrupting the cycle of crisis and hospitalization allows the individual to work on building skills rather than being routed through the BH system.

The provider and member highlights of the significance of R/R principles and peer services in crisis services aligns with OMHSAS' current and future plans for enhancing the crisis services system.

Examples of Crisis Initiatives in the Commonwealth

PCs, BH-MCOs, and providers recounted several initiatives that support the crisis system in Pennsylvania. One BH-MCO and PC described an initiative to divert individuals from IP care as well as improve follow-up with individuals after a crisis.

One BH-MCO reported creating community-based comprehensive crisis services include telephonic, mobile, walk-in and crisis residential programs. The BH-MCO implemented a VBP for Crisis programming across five contracts with six crisis providers. The goal is to improve follow-up post crisis event and diversion from IP psychiatric care.

Montgomery County offers a peer support talk line and teen text and call line that provides a preventive approach to reduce the number of crisis situations, concurrent law enforcement activity and hospitalizations.

Philadelphia has expanded access to the children's crisis continuum by developing services that focus on rapid response, crisis stabilization, resolution-focused treatment and family driven care. Children's mobile crisis teams provide 24/7 face-to-face, crisis stabilization in the home, school, or community. In 2018, a Children's Crisis Stabilization Unit opened, which was designed for young people in acute distress. The goal of this unit is to stabilize and return to the home/community setting. CBH reported that the trend in acute psychiatric IP utilization and Partial Hospitalization has decreased post implementation of crisis services and the Family Peer Specialist has improved family engagement in services.

Law Enforcement as a Component of the Commonwealth's Crisis System

Other programs include working with law enforcement. In one initiative, a dedicated telephone line was installed for providers to reach out to individuals who became involved with the police, and to engage them in BH services. A consumer owned provider group developed a team of forensic CPSs who work with individuals in the county jail. This provider reports significant reductions in recidivism as a result of the jail program.

Several providers described programming designed to divert individuals from incarceration. One provider created a four-bed diversion unit in which law enforcement could bring individuals for short-term residential treatment rather than the county jail. Another provider developed a program in which police can bring individuals to a BH clinic to assess for MH services as an alternative to taking them to the local jail.

Other initiatives work directly with law enforcement. For example, some counties have developed crisis intervention teams to co-respond to crises in the community. The crisis intervention teams

including care managers, social workers, and CPSs that are dispatched to a crisis situation with local police.

In another initiative, police and providers conduct “hub meetings” to discuss the needs of individuals who may be attracting police attention. Providers suggest types of BH services and reach out to the individual to provide them with support. Providers report that the police officers in these discussions are highly engaged with the people they encounter and in ways to support them.

All provider groups interviewed reported training programs available to some or all of the police departments within their geographical purview. These trainings were described as “life changing” for some police officers in their perspective and approach to answering calls for help. They noted that each police department is different across the Commonwealth. Some departments require that all officers receive BH training, others make training optional, and some departments do not engage in BH training at all.

Training initiatives include Crisis Intervention Training (CIT), which emphasizes principles of violence prevention, de-escalation, and community collaboration. One provider stated that they have heard that many police officers report back to their department that CIT training should be mandatory, as the skills learned in CIT can be used on a daily basis. Providers agreed that CIT provides many benefits to law enforcement.

Mental Health First Aid was also recognized to help local law enforcement identify, understand and respond to signs of mental illness and SUDs in individuals they encounter. Another training program, Premise Alert (promoted by Speak, Unlimited) helps law enforcement be prepared for encounters with children who have special needs. In Pennsylvania, the response is initiated with the police by the parents. In areas where this program has been implemented, police and parents report broad acceptance and satisfaction. In discussions with providers, several providers suggested expanding BH training to other parts of the justice system.

Although providers noted that relationships between local law enforcement and providers have improved “light years” in 15 years, issues remain in a culture clash between MH and law enforcement. Providers described law enforcement culture as valuing an immediate outcome (e.g., take to the hospital), whereas MH professionals would rather work with the individual to develop alternatives (e.g., create a safety plan). Further, law enforcement culture and values were described as focused on the use of force, which is at odds with individual choice, the foundational assumption of recovery culture.

Members reported that interactions with law enforcement were mixed. Some member stakeholders reported bad experiences with law enforcement. In one instance, a member attempted to de-escalate an encounter with a police officer, but was met with indifference. When this member attempted to bring the incident to the attention of law enforcement leadership, he was told to leave.

Other members reported observing significant positive changes in law enforcement due to the training the police have received. One member, stated, “I can’t say enough good things” about the changes from the 1990s. All members agreed that there are notable differences between police departments

across the Commonwealth in the quality of interactions, and that more education and training is recommended.

National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit: Building a More Comprehensive Crisis Services System

SAMHSA's National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit notes that an inadequate crisis service system results in escalating costs with an overdependence on restrictive, longer-term hospital stays, hospital readmissions, and an overuse of law enforcement.[210] A comprehensive crisis network, on the other hand, provides crisis lines and mobile crisis teams to replace many of the interventions currently provided by first responders. Instead of ERs and jail, a comprehensive crisis service system diverts individuals in crisis into crisis stabilization services. Using the SAMHSA Toolkit model as a template, OMHSAS has developed a strategy to fill current gaps in the crisis network, and obtain grant funding to enhance the Commonwealth's ability to respond to crises without overburdening first responders and costly IP hospital services.

OMHSAS is pursuing federal funds for two initiatives to support justice-involved individuals with BH conditions. One grant is to support the development of a community-based forensic program bed registry in the southeast region of the Commonwealth. The intent of the bed registry is to allow providers to consider all available services for care coordination of justice-involved individuals with BH needs. The registry is designed to display real time information about available services to support provider and court system diversion and stepdown activities from jails and IP facilities by displaying immediately available alternative services.

The second initiative that OMHSAS will support with federal funding is specialized response training for law enforcement when interacting with individuals with behavioral health conditions. The target audience for these trainings include law enforcement officers (municipal, state, county sheriffs, constables), county jail staff, county adult probation, and any other identified justice practitioners as part of the specialized response training initiative. Two training curriculums will be funded: CIT training and Mental Health First. These trainings will allow expansion of current law enforcement training to support ongoing diversion of individuals with BH conditions from the ERs and jails.

Expanding the Commonwealth's Crisis Network

OMHSAS recently conducted an analysis of the Commonwealth's Crisis Network in conjunction with applications for the 9-8-8 Implementation Grant, the FY 2021 COVID-19 Supplemental Community Mental Health Services Block Grant (CMHSBG) funds, the CMHSBG 5% crisis services set-aside funds, in addition to other funding sources. OMHSAS identified goals for each component to create a

[210] SAMHSA. (2020). *National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit*. https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf

more robust crisis system. The first three categories on the crisis system utilizes SAMHSA's model of a comprehensive crisis system:

1. Someone to **Talk** to (Crisis Call Centers). This service accepts all calls and dispatches support based on the assessed need of the caller.

2. Someone to **Respond** (Crisis Mobile Team Response). These teams are dispatched to wherever the need is in the community (not hospital emergency departments).

3. Somewhere to **Go** (Crisis Stabilization Walk-in/drop-off centers, Respite, Residential). Crisis receiving and stabilization facilities.

In addition, OMHSAS has identified a post-crisis category of services that function as a bridge to follow-up care post crisis. The following table outlines the current status and future goals for Pennsylvania's crisis service system.

Table 13. Assessment of Crisis Services in Pennsylvania[211]

	Crisis Call Centers	Mobile Crisis **Response**	**Crisis Stabilization**	Post **Crisis Services**
Existing Services	Many different local crisis call numbers. Some divert to 9-1-1, emergency services, and other third parties during weekends and non-business hours.	Inconsistency in availability and delivery of services across the Commonwealth. Heavy reliance on law enforcement and first responders for crisis response. Local policies and resources do not meet federal standards.	Inconsistency in availability and delivery of services across the Commonwealth. Some services are not available in all locations across the Commonwealth.	Few services exist across the Commonwealth that bridge individuals in post-crisis to follow-up care.
Goals	A single access point with one national number, 9-8-8 (screen calls, complete initial assessments, triage, deploy mobile response, provide information & referral services, and follow-up).	Implement mobile crisis teams, reduce reliance on law enforcement and first responders, ensure availability of services for every individual across the state, regardless of location, and meet federal standards.	Ensure availability of crisis stabilization services across the state, reduce emergency department utilization, and meet federal standards.	Post-crisis services include in-home & out-of-home options for brief services after the crisis response. Follow-up phone contact with all who interact with the crisis system.

OMHSAS grant applications include funding for all four levels of the crisis services system, with increased allocation of funds for Mobile Crisis teams. Although county mental health programs are

[211] Commonwealth of Pennsylvania Department of Human Services. 9-8-8 Advisory Board Kickoff Meeting Presentation, Slides 8-12.

required to provide 24/7 telephone crisis intervention services and 24/7 emergency services, many counties do not have a mobile crisis team.[212] OMHSAS hopes to help counties fill the gap in this important service by offering mobile crisis team planning and capacity building grants.

[212] The Commonwealth currently has 39 licensed telephone crisis intervention programs, 44 mobile crisis intervention programs, 5 medical mobile programs, 49 walk-in crisis intervention programs, and 15 crisis residential programs.

11

Recommended Areas for Next Steps

Progress has been made in the HC-BH system to promote R/R since the *A Call for Change* report and subsequent documents, and provides a foundation for continued enhancement and refinement while responding to community and member needs. This section outlines areas to consider as stakeholders and OMHSAS launch Phase II, in which OMHSAS leadership and stakeholder groups will develop specific recommendations and action plans for moving the HC-BH system forward. In addition to these areas, additional conversation topics will emerge during stakeholder conversations.

The COVID-19 pandemic has disrupted healthcare delivery systems and state revenue, while also creating increased need for publicly funded behavioral healthcare services. This combination of increased need coupled with decreased resources provides the backdrop for all discussions about recommended next steps, and will require careful consideration in prioritizing next steps in the evolution of the HC-BH delivery system.

In order to leverage resources to most efficiently achieve recovery-oriented goals, it will be important to identify and prioritize the most critical recommendations. For example, services that do not currently have promising outcomes may not be the best use of efforts at this time when funding is limited. It is disappointing that all recommendations may not be prioritized. However, realistic recommendations that are more immediately actionable and impactful are more likely to receive funding and to be implemented.

As recommendations are vetted and prioritized, it is equally important that this is done in partnership with the stakeholder community. Stakeholder groups are best served when diverse groups of members (i.e., children, youth, young adults, adults, older adults, and family members), as well as providers, PCs, and BH-MCOs are involved in the process to develop recommendations.

Mercer suggests that the following considerations be incorporated into the development of recommendations.

- Funding and payment mechanisms (Medicaid, Reinvestment dollars, VBP arrangements, Block grants, etc.).
- Potential Regulatory authority (OMHSAS Bulletins, Medicaid SPA, waivers, etc.) changes needed to expedite the ongoing development of the HC-BH service delivery system.

- How emerging practices and business models in commercial healthcare (e.g., telephonic, digital delivery and the use of digital treatment enhancements) can be modified and adopted to leverage funds to provide more services to more people for less cost.
- How data could be used to monitor and evaluate the outcomes and efficacy of initiatives and services. Including availability and ease of data collection.
- If the service or initiative is a promising practice or evidence-based and supports R/R. As well as the cost and sustainability of those practices.
- How the recommendation supports the overall goal of an R/R oriented HC-BH system.

Once specific recommendations are developed and prioritized in Phase II, Mercer recommends an action plan be developed to implement the selected recommendations. The following section describes areas for consideration in Phase II.

Increase Access and Enhance Quality of Services

BH Workforce

OMHSAS leadership, providers, PCs, BH-MCOs, and members all expressed concerns over the availability of the BH workforce, as well as their capacity to provide EBPs to members. Like many states, Pennsylvania is experiencing a shortage of direct service licensed clinicians and para professionals.[213] A recent report from the Government Accountability Office (GAO) indicates that the COVID-19 pandemic has exacerbated direct service workforce shortages.[214]

OMHSAS leadership, providers, PCs and members, identified a primary reason for the shortage of front line clinicians in the workforce as low reimbursement rates/inadequate compensation coupled with few career advancement opportunities. Given the importance and urgency of this issue, Mercer suggests prioritizing workforce issues in Phase II conversations.

Some topics to consider might include a Commonwealth-wide assessment of type and location of shortages and corresponding reimbursement rates, the use of “clinical extenders” such as NPs, MH/SUD coaches, virtually or digitally augmented treatment approaches, the adoption of emerging online services, and collaborating with other Commonwealth institutions to develop “fast track” educational and training programs. A primary focus should include how reimbursement rates can be increased, as well as the development of career ladders for clinicians who provide direct services.

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[213] Joint State Government Commission General Assembly of the Commonwealth Of Pennsylvania. (June 2020). *Pennsylvania Mental Health Care Workforce Shortage: Challenges and Solutions, A Staff Study*. http://jsg.legis.state.pa.us/resources/documents/ftp/publications/2020-06-04%20HR193_Mental%20Health%20Workforce.pdf

[214] Dicken, J. E. (March 31, 2021). *Behavioral Health: Patient Access, Provider Claims Payment, and the Effect of the COVID-19 Pandemic*. U.S. Government Accountability Office. https://www.gao.gov/assets/gao-21-437r.pdf

Currently, most career pathways remove clinicians from direct service provision into management and administrative roles.

Training and EBPs

Another area of concern pertaining to the workforce is related to maintaining and increasing access to EBPs and other effective treatment approaches by building and sustaining a well-trained, experienced workforce. For example, EBP training and monitoring require significant costs. Yet once trained (and after a significant investment on the part of the provider), providers report that many direct clinical staff leave for better paying positions in the commercial sector. Members also reported that many clinicians are inexperienced, having recently graduated.

A specific area of concern is the training to address trauma across all age groups. Phase II conversations should align and be coordinated with the Commonwealth's current efforts, including the "Trauma-Informed PA" plan.[215]

Another area noted to require special consideration is to ensure that everyone at all levels of the HC-BH delivery system have a solid understanding of R/R principles, how they apply to everyday situations, and the need to help every individual thrive in the community. Opportunities should explore R/R training, oversight, and monitoring. Another component could include standards for specialty CPS training and the expansion of Family Peer Support. Other significant practices to consider are the expansion of FEP treatment, the utilization of advanced directives to decrease assisted OP treatment, expanded mobile MH services and shorter-term opportunities for case management.

Telehealth

The pandemic has fostered the rapid expansion of telehealth services, allowing members more choices in how and where they receive services. Telehealth not only provides members with more choices, it also offers opportunities for expanding accessibility. Phase II conversations should align and be coordinated with OMHSAS current efforts to further expand access to telehealth services and enhance member choice. Considerations may include regulatory initiatives to allow audio-only/ telephone-only as a service delivery option after COVID-19 and allow practitioners in other states to provide telehealth services in the Commonwealth.

Youth-Specific Areas for Considerations for Increasing Access and Enhancing Quality

A good approach to child and youth specific considerations for next steps in a Children's SOC in Phase II is to review the steps identified in the development of an ideal array of BH services for youth

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[215] *Wolf Administration Releases 'Trauma-Informed PA' Plan with Recommendations and Steps for the Commonwealth and Providers to Become Trauma-Informed*. (July 2020). Commonwealth of Pennsylvania. https://www.governor.pa.gov/newsroom/wolf-administration-releases-trauma-informed-pa-plan-with-recommendations-and-steps-for-the-commonwealth-and-providers-to-become-trauma-informed/

and families as outlined in *A Support Document for the Call for Change: Transformation of the Children's Behavioral Health System in Pennsylvania* as well as the *Children's Mental Health Services Scan Report*, drafted in 2020.[216] Stakeholders may prioritize 5–6 critical "next steps", based upon current experience.

A more specific area for conversation is to consider providers' suggestion of choosing a universal instrument to assess a child's needs and determine appropriate services. CANS is a frequently used assessment tool for this purpose. To continue the transformation of children's services, the scores from this assessment could be required reporting. The resulting scores across time could be used for monitoring overall effectiveness of the HC-BH health delivery system. The resulting database could also be used in a variety of Commonwealth-wide quality initiatives.

Member's reported that when MH and/or developmental delay issues emerge during early childhood, parents and caregivers are not able to identify what their child needs, how they can access resources, or what resources they should access. Phase II conversations could address the development of a cross-system document or online app to help new parents and caretakers identify how to access services that may be provided through different state agencies. Efficient access to early interventions can help prevent the development of more intense issues, and provides support parents and caretakers.

Enhance Integrated Care

One area with a growing need for integration is in the treatment of co-occurring MH/SUD. Several issues could be the focus of Phase II conversation. One area is increased coordination between MH/SUD providers, with increased dialogue and more coordinated treatment. With the relaxation of information sharing as a result of the CARES Act, the challenge post-pandemic will be to preserve the confidentiality of individuals with SUD diagnoses while allowing needed information to be shared to make both MH/SUD services more effective.

MH/SUD service coordination includes a shared understanding of "recovery" and how CPSs and recovery coaches can work together to support R/R in the HC-BH service delivery system. A final consideration may include the development of a workforce that can address the dual needs of individuals with both MH/SUD conditions.

Another area of growing recognition of the need for the integration of SDOH into BH services. Since Medicaid does not provide direct funding for SDOH, Phase II should explore options associated with the assessment, funding and management of SDOH, and how SDOH can be integrated into BH services to enhance recovery. Phase II conversations should consider current Commonwealth integrated care initiatives including VBP arrangements to help address SDOH. Initiatives such as the CBCM program, focused on PC and BH-MCO partnerships with Community-Based Organizations

[216] The Children's Mental Health Services Scan is currently a Draft document for OMHSAS internal use.

(CBOs) and providers, integrating a holistic approach to patient care and education on key SDOH areas such as transportation, housing instability/homelessness, and food insecurity. In addition, alignment with Regional Accountable Health Councils (RAHC), which will lead efforts to address SDOH, reduce health disparities and promote equity and value in healthcare.[217]

As noted in the OMHSAS leadership interviews, Commonwealth regulations governing how and when MH, SUD, and PH information can be shared across providers and other entities are more stringent than those on the federal level and many other states. To make significant strides in integrating care in Pennsylvania, Phase II conversations should review current regulations that are barriers to integrated care, and opportunities for revising them to align with best practices.

An important area that should be explored during Phase II is the integration of services across payers as well as type of service by building an HIE, at least for individuals with complex cases. A thorough review of options could include:

- A review of the use of an EHR by all significant BH providers (e.g., MAT COEs, psychiatric IP units, state hospitals).
- Consider how to mandate and/or incentive these important providers to implement an EHR and a system to ask individuals for permission to upload their health information to the HIE.
- How the HIE can be expanded across payers to be able provide integrated care even for individuals who maybe transition between different payers.

Lastly, Mercer encourages Phase II conversations to explore greater integration and coordination between the BH and PH services.

The Crisis System

The rise in deaths due to suicide and substance overdose, in addition to MH crises that can lead to institutionalization or higher levels of care indicates that the crisis system requires ongoing enhancement. Phase II conversations should consider OMHSAS findings on the current crisis-response system, gaps or opportunities for enhancement, and opportunities to coordinate responses with other Commonwealth agencies.

Topics to consider include the ongoing integration of the National Suicide Prevention Lifeline with crisis providers and the increasing role of mobile crisis providers to divert individuals from ERs and jails. Members, consumer-owned and crisis providers, as well as OMHSAS leadership noted that increasing the use of peer services in every aspect of the crisis response system supports community

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[217] *Wolf Administration Launches Regional Accountable Health Councils Focused on Promoting Health Equity and Reducing Disparities Across Pennsylvania*. (March 2021). Commonwealth of Pennsylvania. https://www.media.pa.gov/pages/DHS_details.aspx?newsid=673

tenure and resiliency that helps individuals avoid ERs, IP stays and jail sentences. In addition to the incorporation of peer services throughout the crisis response system, peer-run respite services were identified as particularly efficacious in helping individuals avoid hospitalization and incarceration, and remaining in the community. Using the OMHSAS analysis and initiatives, as well as stakeholder observations, as a basis, areas of Phase II conversation about enhancing the crisis response system could include:

- Identification of mobile crisis teams that are successful in diverting individuals from ERs and jails, identification of factors that lead to those success, and how those elements can be replicated in other teams.
- Possible initiatives to identify current peer services in the various crisis system providers, and how those services can be increased within the crisis system. Enhance CPS training, funding and specialized certifications should be considered.
- The funding, expertise and outcomes of peer-run respite programs (e.g. the Living Room model) should be explored, including how agencies, first responders, and providers might cooperate to support diversion initiatives.

Financing and Regulatory Considerations

Counties have not received an increase in base funds since 2009, and are understandably reluctant to use those funds for administrative purposes. However, this situation has created a barrier for counties, who do not have the ability to capture data required to support requests for additional funding for services. Counties are not able to collect and submit the encounter data to demonstrate the need for funding. This conundrum exacerbates counties' needs for additional funding.

As a result, there are significant differences among counties to offer BH services. Particularly, the smaller or more rural counties cannot support more expensive services such as ACT or CRR. Phase II conversations should address this issue and consider ways to provide more funding to counties, such that they can collect the data necessary to demonstrate the need for additional funds.

Both program and fiscal regulations require lengthy amounts of time to be changed, resulting in less flexibility. For example, licensing requirements for CPSs and other providers may not be similar across regions. Phase II conversations could focus on creating ways to create regulatory consistency across regions to support the R/R model similarly in every region of the Commonwealth.

Stakeholder Community Leadership Development

A final area of focus for possible recommendations to support the goals in *A Call for Change* is how to expand the diversity in consumer groups to represent the diversity and complexity of the consumer community. This effort could be supported by intentional outreach to engage a broader range of individuals to serve in consumer groups, as well as ensuring that new individuals become involved in stakeholder groups over time.

Another aspect of the development of the stakeholder community is how this community could become more effective as a whole. Recommendations could focus on communication, coordination and the development of an overall strategy that addresses all aspects of the HC-BH health delivery system. Strategies might include monitoring relevant impending legislation and positioning community members to advocate on behalf of the consumer community through the development of service evaluation initiatives, the creation of advocacy groups and committees, as well as strategic planning to pursue agreed upon goals to that furthers the goals outlined in *A Call for Change.*

These areas are offered as initial suggestions to launch conversations during Phase II. Mercer anticipates that additional areas of recommendations with emerge.

Appendix A

OMHSAS Leadership Review and Assessment Interviews

Bureau or Role	Name(s)
Current Deputy Secretary	Kristen Houser
Director(s) of Eastern and Western Operations	Jason De Manincor, Kellie Mainzer
Bureau of Policy, Planning and Program Development	Jamey Welty, Benny Varghese, Jill Stemple
Bureau of Children's Behavioral Health Services	Scott Talley
Bureau of Quality, Data and Clinical Review	Amanda Roth
Bureau of Financial Management and Administration	Dawn Hamme
Bureau of Community and Hospital Operations	Phil Mader
Chief Medical Officer	Dale K. Adair, MD
Chief of Staff	Kendra Snuffer
Executive Assistant to the Deputy Secretary	Dwaneen A. Hicks
Former Deputy Secretary	Joan Erney, J.D.

Appendix B

Primary Contractor's, Counties, and BH-MCOs

The Commonwealth has 67 counties that are divided into six zones: Lehigh/Capital, North/Central County Option, North/Central State Option, Northeast, Southeast, and Southwest. There are five BH-MCOs that are contracted either with the PCs of individual counties or directly with the Commonwealth. The five BH-MCOs include CBH, CCBH, MBH, PerformCare, and Beacon Health Options.[218]

Primary Contractors and Counties	BH-MCO
23 Counties of the Behavioral Health Alliance of Rural PA (BHARP) Bradford/Sullivan, Cameron/Elk, Centre, Clarion, Clearfield/Jefferson, Columbia/Montour/Snyder/Union, Forest/Warren, Huntingdon/Mifflin/Juniata, McKean, Northumberland, Potter, Schuylkill, Tioga, Wayne	CCBH
Allegheny HealthChoices, Inc. Allegheny	CCBH
Beaver	Beacon
Behavioral Health Services of Somerset and Bedford Counties, Inc. Bedford/Somerset	CCBH
Berks	CCBH
Blair	CCBH
Bucks	MBH
Cambria	MBH
Capital Area Behavioral Health Collaborative (CABHC) Cumberland, Dauphin, Lancaster, Lebanon, Perry	PerformCare
Carbon/Monroe/Pike	CCBH
Chester	CCBH
Delaware	MBH

[218] The following list is from January 1, 2021. Some PCs and their contracted BH-MCOs have changed since *A Call for Change.*

Primary Contractors and Counties	BH-MCO
Erie	CCBH
Fayette County Behavioral Health Administration (FCBHA) Fayette	Beacon
Tuscarora Managed Care Alliance (TMCA) Franklin/Fulton	PerformCare
Greene	Beacon
Lehigh	MBH
Lycoming/Clinton	CCBH
Montgomery	MBH
Northampton	MBH
Northeast Behavioral Health Care Consortium (NBHCC) Lackawanna, Luzerne, Susquehanna, Wyoming	CCBH
Northwest Three (Northwest Behavioral Health Partnership, Inc.,) Crawford, Mercer, Venango	Beacon
DBHIDS Philadelphia	CBH
Southwest Six (Southwest Behavioral Health Management, Inc.) Armstrong, Butler, Indiana, Lawrence, Washington, Westmoreland	Beacon
York/Adams	CCBH

Appendix C

Funding Authority for Peer Support Services by State[219]

State	Mental Health	SUD	Family/Youth [220,221] (Waivers)	Funding	Comment[222]
AL					State has an 1115 waiver pending with CMS that would provide peer support services for mental health and addiction.
AK			X	State Plan	
AR			X Parent Aid	State Plan	
AZ	X	X	X Parent Partner; Family Support Partner	State Plan	
CA	X			1115 Waiver	Only available in counties that elect to participate in demonstration.
CO	X			1915(b)	
CT	X			1915(c)	

[219] Videka, L., Neale, J., Page, C., Buche, J., Beck, A., Wayment, C., & Gaiser, M. (August 2019). *National Analysis of Peer Support Providers: Practice Settings, Requirements, Roles, and Reimbursement*. University of Michigan School of Public Health Behavioral Health Workforce Research Center. https://behavioralhealthworkforce.org/wp-content/uploads/2019/10/BHWRC-Peer-Workforce-Full-Report.pdf

[220] As of 2012.

[221] Simons, D., & Mahadevan, R. (May 2012). *Medicaid Financing for Family and Youth Peer Support: A Scan of State Programs*. Center for Health Care Strategies. https://www.chcs.org/resource/medicaid-financing-for-family-and-youth-peer-support-a-scan-of-state-programs-3/

[222] *State Medicaid Reimbursement For Peer Support Service: An OPEN MINDS Reference Guide*. (March 2018). OPEN MINDS. https://openminds.com/market-intelligence/reference-guide/state-medicaid-reimbursement-for-peer-support-service/

State	Mental Health	SUD	Family/Youth [220,221] (Waivers)	Funding	Comment[222]
DE	X	X		1115 Waiver	Only available through PROMISE program.
FL	X	X		State Plan	State has a proposed 1115 waiver that would implement pilots to provide peer support to individuals with addiction. Currently, peer support for addiction is covered under the county Medicaid match program.
GA	X	X	X Family Training and Support Services	State Plan	
HI	X	X		State Plan	
IA	X	X		1915(b)	Services only available to non-expansion population.
ID					The BH organization, offers peer support as a value-add service, and does not receive Medicaid reimbursement.
IL	X			State Plan	Peer support specialists are qualified members of ACT teams, but state does not cover peer support services independently.
IN	X	X	X Training and support for unpaid caregivers (1915(c) HCBS PRTF waiver)	State Plan and 1915(c)	

State	Mental Health	SUD	Family/Youth [220,221] (Waivers)	Funding	Comment[222]
KS	X		X Parent Support and Training (1915(c) HCBS SED waiver)[223]	State Plan	
KY	X	X	X Parent to Parent Support	State Plan	
MA	X		X Family Support and Training; Family Partner	1115 Waiver	
ME	X	X		State Plan	Peer support specialists are qualified providers under the state's health home programs.
MI	X	X	X Family Support and Training	1915(c)	
MN	X			State Plan	Proposing to cover for addiction as part of 1115 waiver.
MO	X			State Plan	Peer support specialists are qualified providers, but state does not cover peer support services independently.
MS	X			State Plan	
NC	X			State Plan	Peer support specialists are qualified providers, but state does not cover peer support services independently.
NE	X			State Plan	
NH	X	X		State Plan	
NJ	X			1115 Waiver	
NM	X	X		1115 Waiver	Only available to managed care enrollees.

[223] Provides attendant care, independent living/skills building, short-term respite care, parent support and training, professional resource family care, wraparound facilitation for individuals with SED, age 4–18.

State	Mental Health	SUD	Family/Youth [220,221] (Waivers)	Funding	Comment[222]
NV	X	X		State Plan	
NY	X			1115 Waiver	Only available to individuals with SMI enrolled in Health and Recovery Plans (HARPs).
OH	X	X		State Plan	
OK	X	X	X Family Support Provider	State Plan	
OR	X	X		State Plan	
PA	X	X		State Plan	MH peer support is covered via state plan, for addiction treatment, peer support is an “in lieu” of service.
RI	X	X		1115 Waiver	
SC	X	X	X Caregiver Peer Support (1915(c) HCBS PRTF Waiver)	State Plan	
TX	X			State Plan	Peer support specialists are qualified providers, but state does not cover peer support services independently.
UT	X	X		State Plan	
VA	X	X		State Plan	
VT	X	X		1115 Waiver	
WA	X		X Peer Counselor	State Plan	
WI	X			State Plan	
WV	X			1115 Waiver	
WY	X	X		State Plan	

Appendix D

Peer Worker Training and Credentials Required by State

State	Credential Title	Education Hours	Practice Hours	Supervision Hours	Renewal Period Months	Continued Education Hours
AK	Peer Support Specialist	N/A	N/A	N/A	N/A	N/A
AL	Certified Recovery Support Specialist	40	N/A	N/A	12	16
AR	Peer Recovery	46	500	40	N/A	20
AZ	Peer Recovery Support Specialist	N/A	N/A	N/A	N/A	N/A
CA	Certified Peer Recovery Specialist	100	500	25	24	10
CO	Certified Peer and Family Specialist	60	500	25	24	30
CT	Certified Peer Recovery Specialist	50	500	25	12	10
D.C.	Certified Peer Specialist	N/A	N/A	80	NA	NA
DE	Certified Peer Recovery Specialist	46	1,000	25	24	20
FL	Certified Recovery Support Specialist	75	1,000	24	12	10
FL	Certified Recovery Peer Specialist	40	500	N/A	12	10
GA	Certified Peer Specialist	N/A	N/A	N/A	12	12
HI	Hawai'i Certified Peer Specialist	N/A	N/A	N/A	12	16
IA	Certified Mental Health Peer Support	40	100	10	24	24
IA	Certified Peer Recovery Specialist	46	500	25	24	20
ID	Certified Peer Recovery Coach	46	500	25	24	20
ID	Certified Recovery Coach	46	500	25	24	20

State	Credential Title	Education Hours	Practice Hours	Supervision Hours	Renewal Period Months	Continued Education Hours
IL	Certified Recovery Support Specialist	100	2,000	100	24	40
IL	Certified Peer Recovery Specialist	100	2,000	100	24	30
IN	Certified Peer Addiction Recovery	30	N/A	N/A	24	40
IN	Certified Peer Addiction Recovery	46	500	25	24	40
KS	Kansas Peer Mentor In Training	6	N/A	N/A	N/A	N/A
KS	Kansas Certified Peer Mentor	15	N/A	N/A	N/A	N/A
KY	Registered Alcohol and Drug Peer	60	500	25	36	10
LA	Peer Support Specialist	76	N/A	N/A	12	10
MD	Registered Peer Supervisor	6	N/A	N/A	24	N/A
MD	Certified Peer Recovery Specialist	46	500	25	24	20
ME	Certified Intentional Peer Support	N/A	72	N/A	12	2

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