RESPONDING TO AND PREVENTING CRISES

CCBHCs, Urgent Care and an Example of One Health System in Maryland and its Approach to Crisis Services within an Accessible Psychiatric Care Continuum

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Responding to and Preventing Crises: CCBHCs, Urgent Care and an Example of One Health System in Maryland and its Approach to Crisis Services within an Accessible Psychiatric Care Continuum

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Abstract:

Models of care are emerging throughout the United States that emphasize access to crisis services, jail diversion, and clinical accessibility to make it easier for end users with mental illness, substance use disorders, and other behavioral health concerns to get into the front door of care from any avenue. One model that has been particularly strong as a compliment to the CrisisNow model for community-based crisis prevention and postvention has been the Certified Community Behavioral Health Clinic model (CCBHC), which has been sponsored through federal efforts and related funding by both the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Centers for Medicaid and Medicare (CMS). This paper highlights these approaches and takes one health system, the Sheppard Pratt Health System in Maryland, which operates a CCBHC funded by an expansion grant (CCBHC-E) at two sites and describes how it links crisis response efforts to an array of services that comprehensively meet the population needs. Throughout this paper, information can be gleaned to help state leaders who are aiming to establish their own crisis service systems in the context of other accessible services when needed through a variety of models.

Highlights:

- CCBHCs are an emerging model with a unique payment structure that can provide flexible services to meet the clinical needs of a community from crisis and beyond.
- Shepard Pratt provides an example of one clinical entity that has a comprehensive range of services at all levels of care, including crisis services that are linked to a broader continuum and accessible in Maryland.
- Urgent care centers and clinical services embedded in retail stores are emerging with a new focus on behavioral health services. They will likely become a bigger enterprise over time to meet the needs of populations especially in light of COVID-19's emotional toll on society.

Key Recommendations:

1) The CCBHC model with prospective payments should be available as a standard option in Medicaid to all states to support the implementation of 988 and meet the ongoing need for services that both respond to and prevent crisis.
2) States should examine their crisis service continuum including examining emerging availability of behavioral health access points in non-traditional settings, such as retail pharmacies and other commercial venues, to understand where there may be additional synergies for access to crisis care and other supports.
3) State policy makers and mental health advocates should look to strong models of service delivery that can provide examples for local communities upon which to build a more complete continuum from crisis services to ongoing recovery supports.

Focusing solely on developing high quality crisis call lines, mobile crisis teams, and crisis stabilization units will not adequately meet the need for crisis services. In order to be effective, the traditional core crisis services must be embedded in and supported by a comprehensive system of behavioral healthcare that provides ongoing prompt access that works to prevent many crises from occurring initially and provides effective care preventing relapse after an effective crisis response.

Beyond Beds: The Vital Role of a Full Continuum of Psychiatric Care called for prioritizing and funding "the development of a comprehensive continuum of mental health care that incorporates a full spectrum of integrated, complementary services….";[1] and suggests that the comprehensive continuum would include "outpatient practices that…reduce bed demand by reducing the likelihood that a crisis will develop or by diverting individuals in crisis to appropriate settings outside of hospitals."[2] There are potentially many pathways to achieve this aim, and the transition to 988 for crisis services has pointed to the importance of its interconnectedness to other types of services. This paper discusses three main promising practices: the Certified Community Behavioral Health Clinic (CCBHC) Model; an example of one system's comprehensive approach to crisis prevention and response, Sheppard Pratt in Maryland that operates a CCBHC funded by an expansion grant (CCBHC-E) at two sites and many other services in an integrated continuum of care linked to crisis services; and examples of urgent care services attached to retail stores that are developing so that individuals with behavioral health challenges can get the care they need, when they need it as another element in the crisis care continuum.

The CCBHC Model

The CCBHC Model is a comprehensive model for mental health services that requires prompt access to a comprehensive continuum of services treating mental illness and substance use disorders that are integrated with general medical care. In this way, it presents unique opportunities for linkage to 988 call centers who can make referrals for those in need of the CCBHC services in a particular region. The CCBHC model is supported by payments calculated to cover the actual costs of proving care from organizations that are held accountable by extensive certification and data reporting requirements. It has generated much discussion and excitement. One aspect of its recent growth is within its ability to offer services more broadly than a traditional fee-for-service model. The CCBHC model provides a funding mechanism that supports the implementation of both the core traditional crisis services of crisis phone lines, mobile crisis response, and crisis stabilization services, and the range of other services that avoid initial crises and prevent relapse to additional crises.

Section 223 of the Protecting Access to Medicare Act of 2014 authorized state demonstration programs to improve community mental health services through the establishment of

organizations to be known as CCBHCs.[3] The Act requires to meet CCBHC criteria promulgated by the Substance Abuse and Mental Health Administration (SAMHSA) and provides Medicaid reimbursement for mental health services to CCBHCs through provider-specific, cost-based reimbursement, referred to as a prospective payment system (PPS), based on guidance promulgated by the Centers for Medicare and Medicaid (CMS).[4] Together, the SAMHSA CCBHC Certification Criteria[5] and the CMS PPS Guidance,[6] define the CCBHC model. **Figure 1** aims to provide further clarity of terminology applying to CCBHC availabilities. It should be noted that SAMHSA has established a time-limited grant program to assist organizations in developing the services and interventions outlined in the SAMHSA Certification Criteria. But these "CCBHC Expansion Grants" do not incorporate the provider-specific, cost-based reimbursement component of the CCBHC Model. Therefore, the following discussion refers to the state demonstration program authorized under Section 223 of the Protecting Access to Medicare Act of 2014.

Figure 1: Terminology Related to CCBHCs

CCBHC Model: a combination of the CCBHC certification standards developed by SAMHSA plus a payment methodology based on the total cost of all care that falls under the certification criteria. Each individual CCBHC's rate is specifically calculated for the costs at that individual CCBHC. The CCBHC model has been implemented both by the federal demonstration project in 10 states and also by individual states utilizing other pre-existing Medicaid program authorities including but not limited to the Medicaid rehab option.
CCBHC Demonstration Program: the SAMHSA certification criteria in combination with the CMS PPS cost report-based payment methodology implemented in the original eight states and then expanded to also include Michigan and Kentucky. Each individual state must certify that each CCBHC meets the certification criteria. The number of CCBHCs they can operate under the demonstration model in each state is limited to the number of CCBHC's initially proposed by the state and included at the start of the demonstration.

CCBHC Expansion Grant program: a combination of the CCBHC certification standards developed by SAMHSA plus a SAMHSA funding grant to pay for CCBHC requirements that are not covered under the pre-existing payment methodologies that were available in that state. Original grants were up to $2 million for two years. The newest round of grants will be 1$ million a year for up to four years. The amount of the grant does not necessarily cover the total agency cost of care for meeting CCBHC standards. Expansion grant CCBHC's must attest to SAMHSA that they meet the certification requirements but are not required to obtain state endorsement of their CCBHC status.

Variations and Combinations: Several CCBHC demonstration states have subsequently implemented state plan amendments allowing them to add additional CCBHC model organizations receiving a cost-based PPS payment outside of the federal demonstration project.

Several CCBHCs operating as part of the federal demonstration have also received SAMHSA expansion grants in addition to their demonstration site PPS payments.

There has been a great deal of activity regarding the CCBHC demonstration grants and state Medicaid programs' efforts to move into offering CCBHC programs. In December 2016, eight states were chosen by the Department of Health and Human Services (HHS) to participate in

the CCBHC demonstration out of 24 states that had received SAMHSA planning grants: Minnesota, Missouri, Nevada, New Jersey, New York, Oklahoma, Oregon and Pennsylvania.[7] These demonstration states designated a total of 66 CCBHCs, which began providing services the same year. While the CCBHC demonstration was initially established for a two-year period, it has been extended by law numerous times, most recently through September 30, 2023.[8] Two states, Kentucky and Michigan, were added to the demonstration in 2020. Minnesota, Missouri, Nevada, and Oklahoma have each also amended their Medicaid State Plans to allow them to expand the CCBHC Model to organizations not included in the Demonstration.

Texas implemented the CCBHC model statewide via a Medicaid waiver and Kansas has a statewide CCBHC implementation underway using a Medicaid State Plan Amendment approved by CMS. On June 24, 2022, Congress passed the Bipartisan Safe Communities Act, which expanded the CCBHC program to allow any state or territory the opportunity to apply to participate in the demonstration and allocating additional planning grant monies for states to develop proposals to participate.[9] Starting in July 2024, and every two years thereafter, 10 additional states will be selected to join the demonstration. The eight original demonstration sites will be extended until September 2025, and the two newer demo states (Kentucky and Michigan) are extended to six years after their program launch.

The Protecting Access to Medicare Act of 2014 also authorized SAMHSA to provide grants directly to community behavioral health provider organizations in order to assist them in adopting CCBHC services and practices in accordance with the SAMHSA Criteria.[10] However, organizations receiving these direct grants do not have access to the funding mechanism that is available to organizations participating in the CCBHC Demonstration, and so do not have the tools necessary to implement several of the practices that have been important to crisis prevention and diversion in the Demonstration states.

The legislation authorizing the Demonstration stipulated that in selecting the states to participate, SAMHSA should give preference to states based on their CCBHCs' ability to **improve the availability of, access to, participation in, and quality of, the most complete scope of services, without increasing net federal spending**.[11]

The SAMHSA Criteria defined the scope of CCBHC services to include:[12]

- An array of crisis response services, including 24-hour mobile crisis teams,
- Screening, assessment, and diagnosis,
- Person-centered and family-centered treatment planning,
- Outpatient mental health and substance use services,
- Outpatient primary care screening and monitoring,
- Targeted case management,

- Psychiatric rehabilitation services,
- Peer supports, peer counseling, and family caregiver supports, and
- Intensive, community-based mental health care for members of the armed forces and veterans.

The SAMHSA Criteria also established requirements related to staffing, the availability and accessibility of services, care coordination, quality and other reporting, and organizational authority, governance and accreditation.[13]

The CMS PPS Guidance outlined an organization-specific, cost-based approach to establishing reimbursement rates designed to enable CCBHCs to achieve the goals of the Demonstration and comply with the SAMHSA Criteria. In order to establish organization-specific rates, each organization completes a cost report that documents its current actual costs as well as proposed new costs required to comply with the SAMHSA Criteria.

States have two options under the CCBHC Demonstration: a daily reimbursement rate, referred to as PPS-1 or a monthly reimbursement rate, referred to as PPS-2.[14] PPS-1 and PPS-2 have distinguishing characteristics, as well as unique advantages and disadvantages; but in both cases, reimbursement is triggered by visits.

A visit is a day (PPS-1) or month (PPS-2) in which there is at least one face-to-face encounter, or one eligible telehealth encounter, between a qualified practitioner and an eligible consumer involving the provision of a qualifying CCBHC service. Only services provided face-to-face, or via telehealth, can count as visits and are, therefore, reimbursable. But costs associated with providing important services and adopting important practices that do not involve a face-to-face interaction with a consumer are, nevertheless, included in the organization's PPS reimbursement rate; a factor critical to adopting several practices key to crisis prevention and diversion (Figure 2).

Figure 2: Flexible Activities and Coverage through the Prospective Payment System

Many CCBHC-required responsibilities and important practices do not involve face-to-face interactions with a consumer and so do not count as reimbursable visits. For example, many of the required care coordination activities, such as tracking admissions and discharges, efforts to follow-up after discharge, care coordination with an individual's primary care physician, as well as other service and support providers, often do not involve face-to-face interactions with a consumer. Similarly, outreach activities to engage individuals in need of community behavioral health services who, nevertheless, do not seek services or seek them from inappropriate sources/settings, often include considerable effort before an individual is engaged in ongoing face-to-face services. Such outreach efforts may target high users of emergency rooms and hospital care, or individuals who frequently come in contact with local law enforcement and the courts. The costs associated with each of these important components can be built into the PPS rate.

Each CCBHC's reimbursement rate is determined by dividing the total allowable costs for providing CCBHC services, and for complying with the SAMHSA criteria, by the total number of visits the CCBHC expects to provide in a year, yielding a reimbursement rate per visit.[15]

Improving Participation: Access and Engagement

The fundamental goal is for people to be able to access and use care when they need it. Making care easier to access makes it easier to use, and outreach and engagement promotes use.

The SAMHSA Criteria promote improving access by requiring CCBHCs to:

- Provide outpatient clinical services during times that ensure accessibility to meet the needs of the consumer population to be served, including some nights and weekend hours,[16]
- Provide services at locations that ensure accessibility to meet the needs of the consumer population to be served,[17] and
- Provide transportation or transportation vouchers for consumers to the extent possible within the state Medicaid program.[18]

These requirements help remove potential barriers to access: limited hours of operation, hard to get to locations, and lack of transportation to services. But the SAMHSA Criteria require CCBHCs to be much more proactive in improving participation, and the CMS PPS Guidelines establish a reimbursement approach that supports practices that enable CCBHCs to meet this challenge.

Components of the CCBHC Model

24-Hour Mobile Crisis Response Teams

As noted in an earlier paper, *Crisis Services: Meeting Needs, Saving Lives*, the SAMHSA CCBHC Certification Criteria require that CCBHCs provide 24/7/365 crisis services in the form of mobile crisis teams in order to engage individuals in crisis.[19] The PPS reimbursement model allows 24-hour mobile crisis to be treated as a capacity that a CCBHC must maintain rather than as an individual service. The costs associated with maintaining the team, including a 24-hour access line, can be built into the organization's PPS rate such that a portion of the cost of maintaining the team is recouped every time the CCBHC receives reimbursement for a billable outpatient visit. If mobile crisis is reimbursed as an individual service, then reimbursement is dependent on the eligibility of the individual in crisis for a given funding sources. Treating mobile crisis as a capacity that the organization must maintain has the advantage that an individual's eligibility for services from a particular funding source is never an issue during a crisis, or an obstacle to receiving services.

Timely Access to Outpatient Services

A warm handoff and timely access to ongoing services is critical following the stabilization of a crisis.[20] The SAMHSA Criteria require that when an individual is seeking or being referred for

services with “an emergency/crisis need, appropriate action is taken immediately, including any necessary subsequent outpatient follow-up”; and when an individual is seeking or being referred for services, with “an urgent need, clinical services are provided and the initial evaluation completed within one business day.”[21] Urgent psychiatric services can provide timely access to ambulatory psychiatric assessment and short-term treatment for patients experiencing a mental health crisis or risk of rapid deterioration requiring hospitalization. Studies of urgent care reported improvements in symptom severity, distress, psychosocial functioning, mental health–related quality of life, subjective well-being, and satisfaction with care, as well as decreased wait times for post-emergency department (ED) ambulatory care, and averted ED visits and admissions.[22]

The SAMHSA Criteria also includes that individuals with routine needs be provided services within 10 business days.[23] In order to comply with these timely access requirements, CCBHCs in the Demonstration found it necessary to hire additional staff.

There is, of course, a national shortage of behavioral health care workers: the current behavioral health care workforce is only able to meet approximately 25% of the need for services, with gaps higher in rural areas.[24] As a result, community behavioral health providers often find themselves competing unsuccessfully with other systems of care in attracting and retaining staff due to low and/or fixed reimbursement rates that deflate their salary structures. However, states have the ability to approve any salary increases that are included as anticipated costs in the cost report. If CCBHCs can document that their salary structures are not competitive, PPS cost-based, provider-specific reimbursement allows CCBHCs to revise their salary structures to attract and retain the additional staff needed to meet the timely access requirements, as well as to provide the required comprehensive array of CCBHC services. For example, as a result of the CCBHC demonstration, CCBHCs in Nevada have been able to recruit and retain all types of behavioral health professionals by offering more competitive wages (The National Council report on *Transforming State Behavioral Health Systems* highlights this issue).[25] Areas that rarely had access to psychiatrists prior to the demonstration now have an onsite psychiatrist and/or psychiatric advanced practice registered nurse, as well as providers to treat certain types of substance use disorders, including providers qualified to use medications for opioid use disorders (MOUD).[26]

Open Access

When an individual calls 988 in need of services, the goal is to not have them have to wait to access them. Moreover, a wait list for routine care when patients wait weeks to months for an initial visit is in many ways a series of crises waiting to happen.[27] Patients and caregivers often describe a struggle to find more immediate care during or after a crisis, particularly when seeking help for the first time[28,29] For individuals with SUDs, immediate access to SUD treatment is of critical importance, as typically a short window of opportunity exists when a person in need is ready and willing to engage in care.[30] For people who are experiencing a mental health crisis or who have just been discharged from psychiatric hospitalization, quick

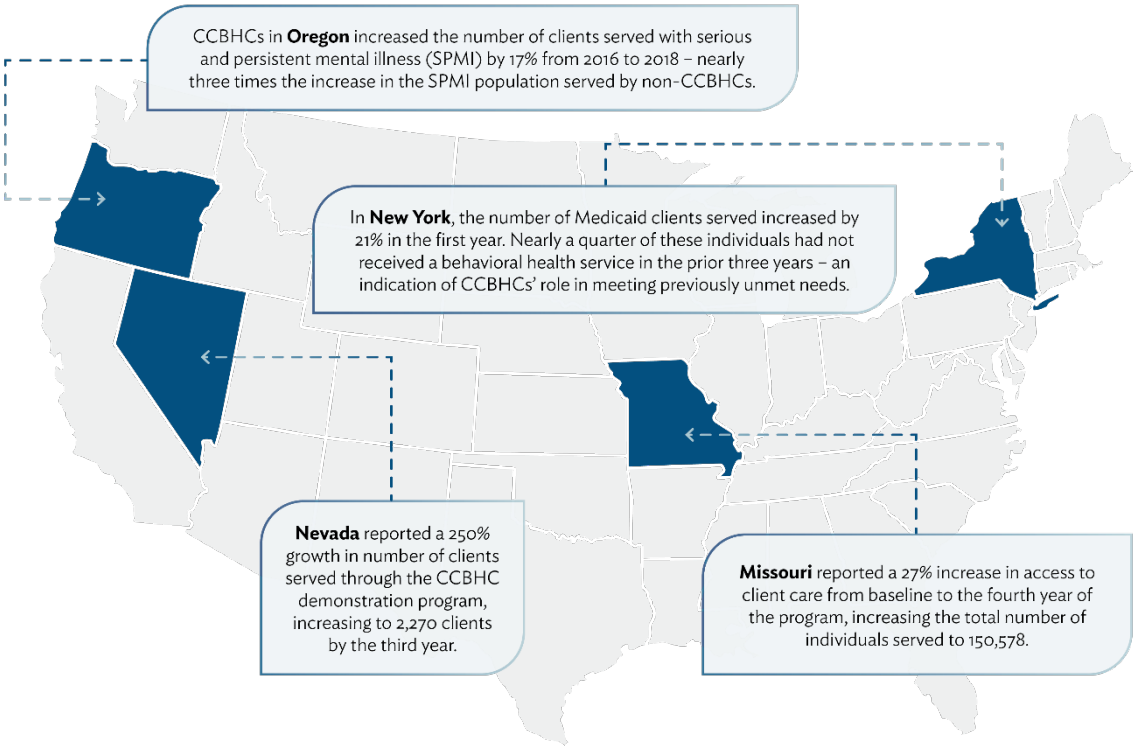
access to an assessment for outpatient care, including psychopharmacology, may make the difference in preventing escalating crises.[31] Despite the need, individuals and provider organizations report waits of multiple weeks for an initial intake appointment and even longer for a psychopharmacological evaluation. Studies conclude that the longer the duration between a crisis and access to services, the less likely it is that a patient will keep an appointment.[32] Although there are multiple reasons for no-shows, patients often report that they sought acute services at an emergency room (either because the delay in care exacerbated the crisis and made a higher level of care necessary or because it was the option of last resort), found services elsewhere, or no longer felt they were in crisis.[33] In the case of patients with SUDs, they may resume or continue their substance use to avoid withdrawal symptoms. Perceived societal stigma may also be a barrier for some families and patients who may delay seeking care until the situation is dire, further lengthening the time between crisis and initiation of services. The absence of a timely and simple pathway to care keeps individuals from receiving the behavioral health services they need.

One strategy to enhance more immediate access to care is in technological solutions to help create pathways that can be easier to navigate. Open access is a scheduling system in which individuals receive an outpatient appointment on the same day they contact the organization. The SAMHSA CCBHC Certification Criteria do not require CCBHCs to adopt open access. Nevertheless, approximately half of CCBHCs in the Demonstration states adopted open access under the Demonstration. State officials have described CCBHCs' adoption of open access models as "earth-shattering" in the mental health field.[34]

The cost-based, provider-specific PPS reimbursement mechanism enabled CCBHCs to hire additional staff CCBHCs to accommodate open access as well as demand for clinic and medication management appointments. As a result, New York's CCBHCs eliminated wait lists; and the number of Medicaid-eligible individuals served increased by 21% in the first year of operation (Figure 3).[35] New York also reported a 24% increase in providing children and adolescent services, noting that this was possible, in part, because the PPS allowed CCBHCs to hire more child psychiatrists.[36] Many CCBHCs in New York and other states have implemented open access scheduling in combination with expanding psychiatric workforce is open access scheduling in combination with expanding psychiatric workforce as a two-pronged strategy to increasing access.

New Jersey reported that all CCBHCs offer at least some open access hours, and that open access helped facilitate a 14% increase in the number of individuals served between the first and third demonstration years.[37] Missouri reported a 27% increase in access to client care from baseline to the fourth year of the program, primarily because of adopting open access.[38] Oregon and Nevada also experienced significant growth in the number of individuals receiving services through the organizations certified as CCBHCs under the CCBHC Demonstration Project.

Figure 3: CCBHC Demonstration Project Outcomes



Leaders within states note that even when offered same day appointments, some individuals, and families in particular, were unable to come in immediately. Nevertheless, Missouri reported that in the third year of the demonstration, 81% of all new clients and 83% of all new Medicaid clients had an initial evaluation within 10 business days, and New York improved on its already strong performance on this measure, decreasing time to initial evaluation from 7.3 days on average in the first demonstration year, to 4.9 in the third year of the demonstration. These are both noteworthy findings given research that indicates the average wait time for mental health and substance use services across the United States is 48 days.[39]

CCBHCs have taken advantage of the flexibility offered by the SAMHSA CCBHC Criteria by developing innovative approaches to improving access. See, for example, **Figure 4**, describing Oklahoma's Grand Lake Mental Health Center's innovative use of technology to improve both access during a crisis and to provide ongoing services to prevent crises.

Outreach and Engagement

Many people with behavioral health needs do not seek treatment from behavioral health providers. Instead, they seek care from primary care physicians who may not be equipped to provide the appropriate treatment, or repeatedly burden hospital emergency rooms. Others may not recognize their need for care and find themselves repeatedly interacting with law enforcement as a result of their untreated illness.

Engagement in treatment for a person having a behavioral health crisis is critical to fully address the concerns of the individual as well as to prevent future crises. For example, establishing outreach visits from a local community mental health provider to psychiatric patients in an emergency department showed a significant increase in initial appointment attendance at the local mental health clinic in the aftermath of a psychiatric crisis.[40]

The SAMHSA Criteria require CCBHCs to provide outreach engagement services.[41] Typically, payers only reimburse providers for direct services provided to individuals or families. Consequently, behavioral health providers often have no means to fund activities that involve reaching out to individuals who do not seek services, but who rely on other social sectors that are often ill-equipped to respond as a result of their untreated behavioral health issues. Although CCBHCs only receive reimbursement when they provide a direct service to an individual or family (i.e., through a visit), the PPS model allows CCBHCs to build the cost of outreach and engagement activities into the CCBHC PPS rate, so that the reimbursement received for each visit helps to cover the cost of outreach and engagement initiatives.

Figure 4: Access Using Technology

Grand Lake Mental Health Center, Inc. (GLMHC), a CCBHC serving 12 counties in largely rural Northeast and Northcentral Oklahoma, is a leader when it comes to providing mobile telehealth services for clients in need of mental health, substance use, and crisis services. Many of the individuals and families served by GLMHC are living well below the poverty level, have limited or unreliable transportation, and have often relied on hospital emergency departments and inpatient services when in crisis. In order to improve access to timely outpatient treatment, reduce Emergency Department admissions, and reduce unnecessary inpatient treatment episodes, GLMHC embarked on a bold mission of bringing mobile technology to clients "when and where" they needed it. GLMHC partnered with MyCare Software Solutions to develop an application installed on iPads that gives clients access to a calendar of their appoints, the ability to request a call-back from a member of their treatment team, access to relevant documents and a crisis call button for immediate assistance. It also allows GPS tracking that enables GLMHC to engage law enforcement if necessary. The goal is to increase access to services, not only in crisis situations but in all scenarios, including regular outpatient mental health and substance use services so that individuals never escalate to the point of needing traditional crisis intervention services. Individuals who access one of GLMHC's three Urgent Recovery Centers receive an iPad, as do individuals with high PHQ-9 scores at their first screening. To date, approximately 6,000 of the 11,000 individuals served by GLMHC have been issued an iPad, giving them access 24/7 to relapse prevention, crisis intervention and general mental health services at the touch of a button.

Under the CCBHC Demonstration, states have implemented a number of outreach and engagement initiatives aimed to divert individuals from other systems of care, such as police community response, and thereby result in savings in other systems of care that offset the CCBHC costs.

Prior to its participation in the CCBHC Demonstration, Missouri, for example, was funding outreach and engagement teams that targeted emergency rooms at some of its CMHCs, using state general revenue exclusively. The teams were designed to divert high users of emergency room services to ongoing care at the CMHCs. Missouri expanded this initiative as part of the Demonstration by requiring all CCBHCs to develop emergency room outreach teams. An evaluation of this initiative by the Missouri Institute for Mental Health of the University of Missouri-St. Louis found a 74% reduction in both emergency room usage and hospitalization at six months by those engaged by the outreach teams.[42] The report also found that for individual who were homeless, unemployed, or had interactions with law enforcement prior to engagement with the outreach team, at six months following engagement there was a 67% reduction in homeless, a 61% reduction in unemployment, and a 69% reduction of law enforcement involvement.[43]

Prior to participating in the Demonstration, Missouri had also established behavioral health homes (Community Mental Health Centers that provide care management, care coordination, preventive care, individual support and access to community resources) and had built into its behavioral health homes adequate staff to outreach to individuals with behavioral health diagnoses who were high users of Medicaid services, but who were not engaged with community mental health services.[44] Under the CCBHC Demonstration, Missouri embedded these activities within the CCBHC program, essentially establishing health homes as a foundation on which CCBHCs were required to build. In 2021 Missouri reported that, "From 2012 through 2018, more than $377 million in savings have been attributed to the Missouri Community Mental Health Center (CMHC) Healthcare Homes as a result of diverting individuals from unnecessary trips to the hospital or emergency departments. While cost data is not yet available for the full range of coordination, monitoring and follow-up activities conducted by Missouri's CCBHCs, at a minimum, it would be expected to exceed the cost savings achieved by the health homes program."[45] Other states opting to build on these types of outreach and engagement initiatives through the CCBHC model could reasonably expect to see similar savings.

Follow-up After Hospitalization

Monitoring follow-up after psychiatric hospitalization within seven and 30 days of discharge are routinely used healthcare effectiveness measures. These are defined as the percentage of discharged patients who had an outpatient visit, an intensive outpatient service, or partial hospitalization with a mental health provider within seven or within 30 days of discharge.[46] One study analyzing the impact of follow-up on the day of the discharge proved that having a contact in the community on the day of discharge (24 h follow-up) is effective in reducing readmission rates, and so is receiving outpatient treatment at a CMHC within the first seven

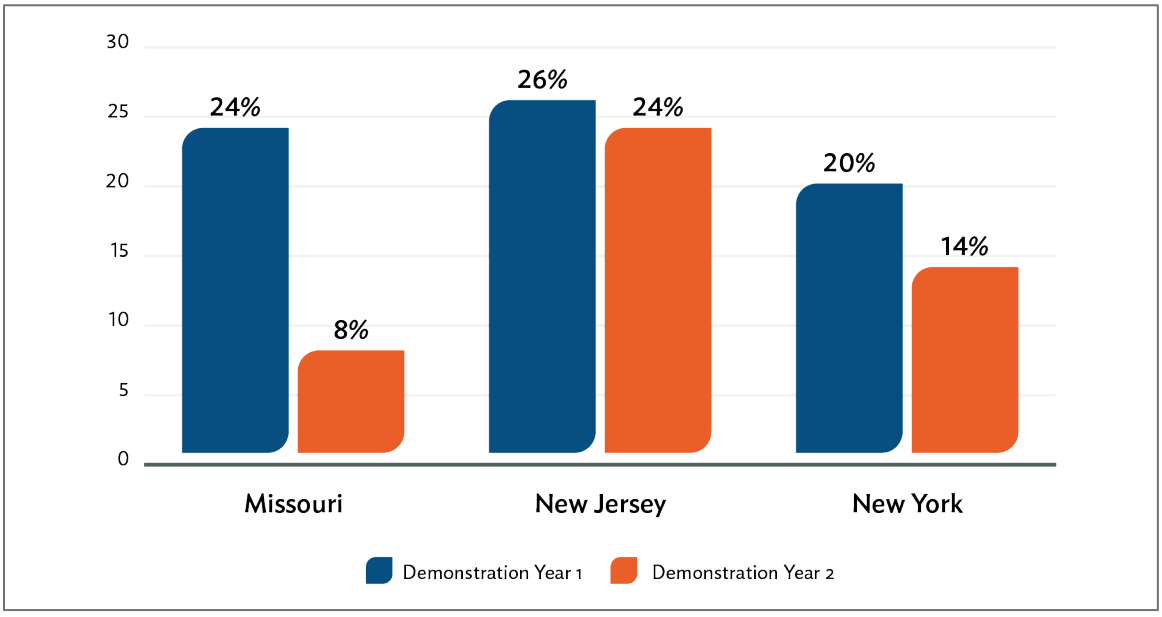
days of discharge. Five studies reported that follow-up within 30 days from discharge significantly lowered readmission rates.[47]

The SAMHSA Criteria call care coordination the "linchpin" of the CCBHC model,[48] and detail a number of care coordination expectations, including the expectation that CCBHCs "will make and document reasonable attempts to contact all CCBHC consumers who are discharged [from hospitals, emergency rooms and other crisis settings] within 24 hours of discharge."[49] Actually contacting all individuals within 24 hours of discharge is an exceedingly lofty goal. CMS requires CCBHCs to document and report follow-up after an emergency room and hospitalization within 7 days and within 30 days.[50]

Both New York and Missouri report that CCBHCs in their states outperformed other providers on follow up metrics. The seven-day follow-up after hospitalization rate was 65% for New York's CCBHCs compared to the state Medicaid average for this metric of 58%. Similarly, CCBHCs in New York had an average follow-up rate of 42% for individuals visiting the emergency department for alcohol or other drug dependence in the second performance year, which was double the overall state Medicaid average of 21%.[51] In the second year of the Demonstration, Missouri CCBHCs had a 43% follow rate within seven (7) days for adults discharged from emergency rooms compared with a 20% rate for all other Missouri Medicaid providers, and a 76% follow up rate within 30 days for adults after discharge from a hospital compared to a 33% rate for all other Missouri Medicaid providers.[52]

Effective follow-up likely contributed to the reduction in all-cause psychiatric hospital readmission rates that CCBHC consumers experienced in Missouri, New Jersey, and New York (Figure 5).

Figure 5: All-cause Psychiatric Hospital Readmission Rates for Missouri, New Jersey and New York CCBHCs



The three organizations participating in the Oklahoma CCBHC Demonstration Project each had an impact on both emergency room usage (Figure 6) and hospitalizations (Figure 7) as a result of follow-up, care coordination, and easy access.

Figure 6: Oklahoma: Data from three individual CCBHCs and the Percentage of Clients Treated at Emergency Departments by year

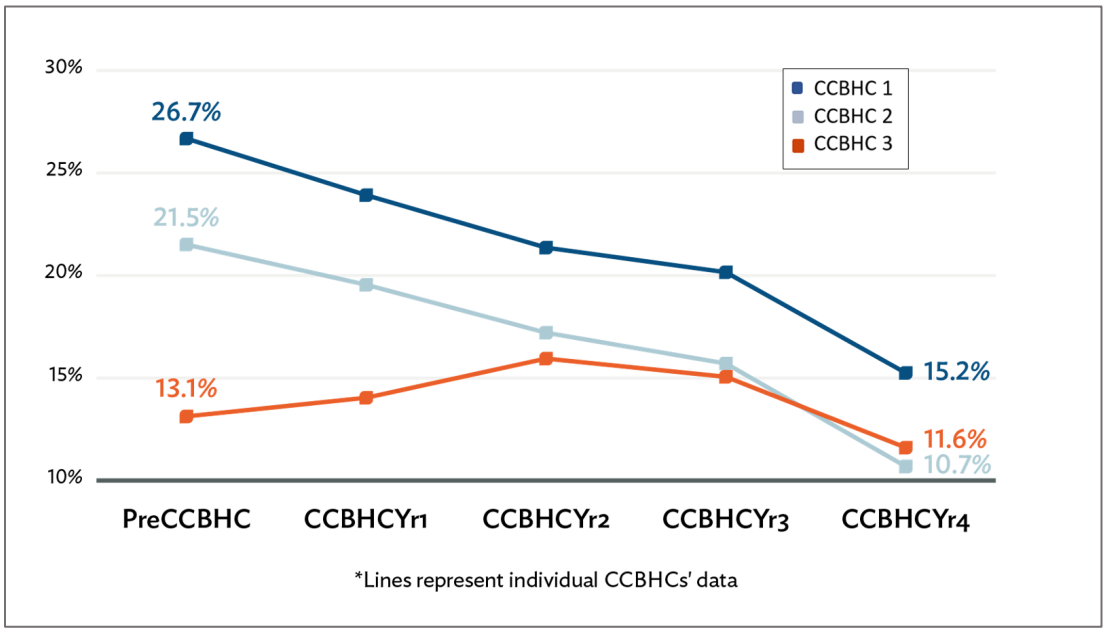
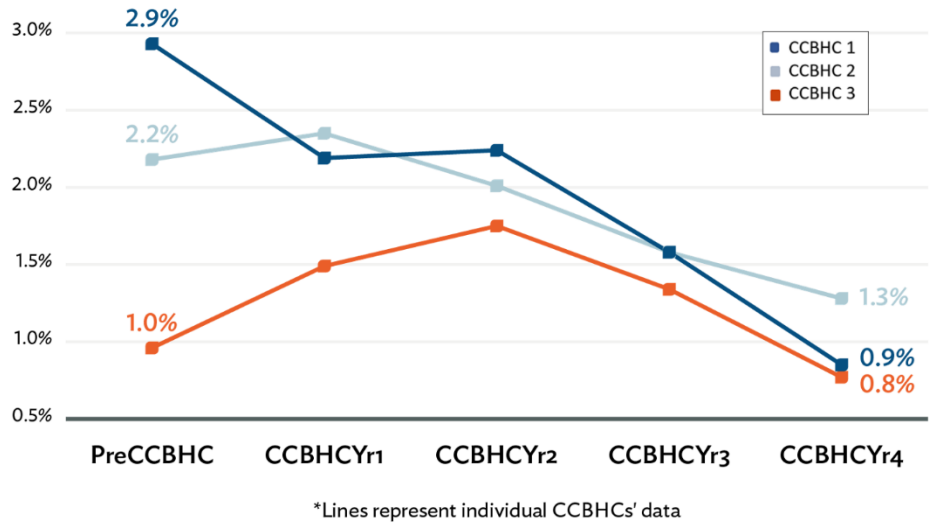


Figure 7: Oklahoma: Data from Three Individual CCBHCs and the Percentage of Clients Admitted to Inpatient Care by year

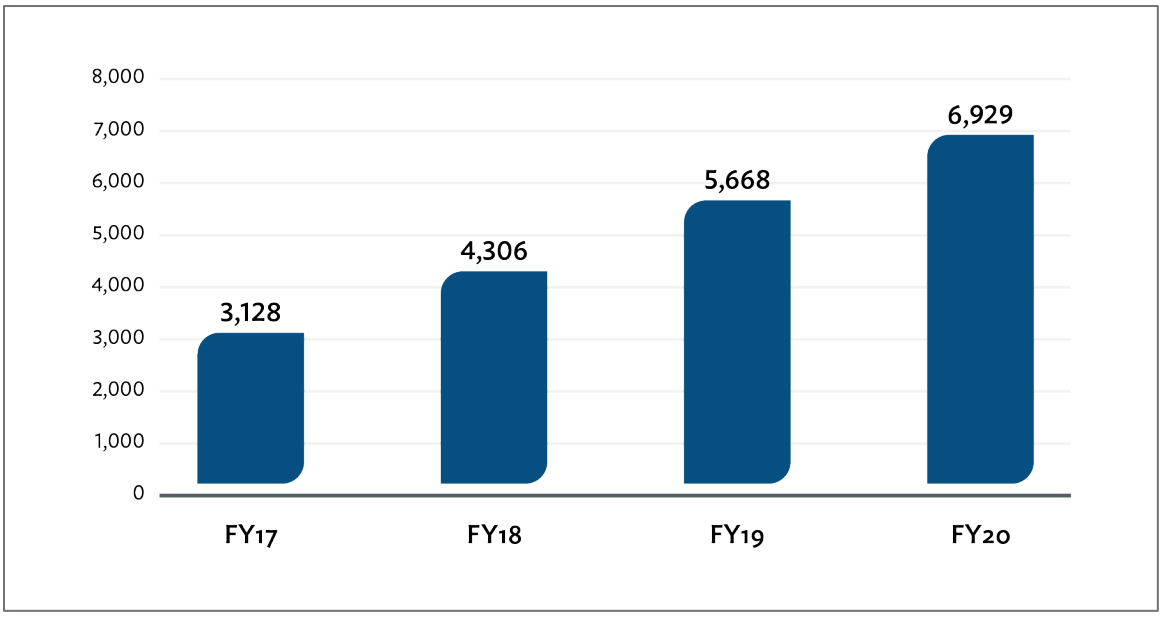


Evidence-based Practices: Medication Assisted Treatment

Under the SAMHSA Criteria, states are expected to require that CCBHCs adopt a minimum set of evidence-based practices.[53] States have thus required the adoption of a broad range of evidence-based practices under the CCBHC Demonstration in order to best meet the needs of the people they serve. Since the SAMHSA Criteria require that CCBHCs employ medically trained behavioral health care providers who can "prescribe and manage medications independently under state law, including buprenorphine and other medications used to treat opioid and alcohol use disorders,"[54] states participating in the Demonstration have adopted Medication Assisted Treatment (MAT) as one of their required evidence-based practices.

MAT is associated with reduced general health care expenditures and utilization, such as inpatient hospital admissions and outpatient emergency department visits.[55] Nationally, many people who could benefit from MAT do not receive it, with less than 20% of individuals with an opioid use disorder receiving MAT in the past year, and less than one-third of substance use facilities offering medications to treat opioid use disorder.[56] By contrast, CCBHC Demonstration states saw significant growth in the number of individuals receiving MAT. Missouri reported a 122% increase in MAT from baseline to the fourth demonstration year (Figure 8).

Figure 8: Individual's Receiving Medication Assisted Treatment from Missouri CCBHCs



Oklahoma had 128 individuals receiving MAT prior to the Demonstration. By year four of the Demonstration, 988 individuals were receiving MAT. In New Jersey, CCBHCs nearly doubled the number of clients receiving MAT for opioid use disorder from the first to the second demonstration year.[57]

Screening and Monitoring Chronic Conditions

Individuals with behavioral health diagnoses have significant levels of co-occurring chronic diseases and health conditions that increase their risk for hospitalization due to non-behavioral health conditions. Systematic monitoring and care management of metabolic syndrome and other chronic conditions by community mental health centers has been shown to be effective in improving quality of health indicators such as control of hypertension hemoglobin A1c and was associated with reductions in hospital and emergency room utilization. [58]

The SAMHSA Criteria recognize the need to see the whole person, adopt an integrated approach to health and wellness, and address the historic tendency of behavioral health systems to overlook non-behavioral health conditions by requiring that CCBHCs screen and monitor key health indicators and health risks.[59] How states participating in the CCBHC Demonstration have responded to this mandate depends on whether they had already adopted an integrated approach, as some states had under the Medicaid health home program, and whether they chose to expand on the SAMHSA requirements by requiring CCBHCs to directly provide primary care services.

For example, Oregon required its CCBHCs to provide 20 hours of on-site primary care per week, and Nevada carved in certain primary care services (e.g., taking client histories and establishing medical diagnoses).[60] CCBHCs in New York took a variety of approaches to strengthening the integration of care with some opting for a co-location model.[61] The flexibility of the SAMHSA CCBHC Certification Criteria and the CMS CCBHC PPS payment methodology in general, allows, and indeed, invites this type of adaptation, which is designed to strengthen integrated care. In order to continue the pre-existing Medicaid Health Home program and integrate it into the CCBHC model, Missouri, which had already adopted the Medicaid health home program, incorporated in their state CCBHC certification requirements their pre-existing Health Home requirement that qualifying organizations be recognized by the Department of Mental Health as CMHC Healthcare Homes and be accredited as health homes by CARF or the Joint Commission.

Regardless of the specific approach, the CCBHC model takes seriously the need to serve the whole person, to recognize and address the fact that the individuals they serve may have high blood pressure, high cholesterol, diabetes, metabolic syndrome, cardiovascular disease, and asthma, and that many of the people they serve smoke cigarettes or have significant weight issues. The CCBHC model can be a powerful tool for reducing the premature mortality related to serious mental illness.[62]

Peer and Family Supports

A large body of evidence has shown that services provided by peer workers are effective and associated with a range of positive outcomes, including reduced substance use, improved social supports, reduced hospitalizations and emergency department visits and decreased criminal justice involvement.[63] The SAMHSA Criteria require that CCBHCs employ specialists and family

support providers,[64] and Minnesota, Missouri, New Jersey, Nevada and Oregon were all able to significantly expand the number of peer workers, and in some cases, family support specialists employed at their CCBHCs.

Prior to participating the CCBHC Demonstration, peer specialists in Minnesota were only allowed to work with individuals with mental health conditions within a psychiatric rehabilitation setting. Under the Demonstration, certified peer specialists employed by CCBHCs serve the full range of people coming for care regardless of mental illness severity. Minnesota also launched family peer services and reported success regarding the use of peers to engage individuals released from jail or prison in ongoing services.[65]

Prior to the CCBHC demonstration, less than half of Missouri's current CCBHCs had peer support specialists and less than a third had family support specialists. As a result of giving priority to the CCBHC requirement to provide peer and family supports, as of May 2021, all CCBHCs in Missouri employed peer specialists and family support providers, with the number of peer specialists increasing more than 330% and the number of family support specialist increasing more than 90%.[66]

Recovery Supports and In-Home Services

Services that have a recovery orientation are welcoming, empowering, and promote self-determination and hope, which are particularly necessary in crisis systems. The SAMHSA Criteria require that CCBHCs provide recovery-oriented services[67] and that to the extent possible within a state's Medicaid program, CCBHCs provide in-home services.[68] The CCBHC national evaluation reported that 78% of the 92% of CCBHCs that provided services outside the clinic provided in-home services.[69]

The states participating in the CCBHC Demonstration Project have shown that implementation of the CCBHC model with fidelity to the SAMHSA Criteria and the provider-specific, cost-based reimbursement rates of Prospective Payment can significantly improve the availability, accessibility and quality of comprehensive community behavioral health care, while generating offsetting emergency room and hospital costs, and helping to prevent, appropriately intervene in, and stabilize crises.

Urgent Care Centers Linked to Other Community Based Enterprises

Although CCBHCs offer tremendous opportunities to maximize immediate access to care regardless of payor, they may not be available in a particular region, and individuals may want alternative options for where care can be received. Access when needed to the right care is a critical element of a robust continuum of psychiatric care.[70] Yet waiting times for clinical access to therapists and especially psychiatrists can take months. Wait times for care can be major detractors for people who feel their mental health issues cannot be put off, and they can lead to problematic outcomes. Although limited resources are often cited as a reason for delays in openings, one study found that waiting times across a variety of clinical services were reduced

by applying analyses of where bottlenecks occur that could be resolved with careful clinical management and involvement in frontline personnel.[71] In addition to addressing infrastructure and operations, and creating new payment models through CCBHCs, another area of growth for population health includes the marketplace of urgent care centers, emerging in the landscape of services for people with mental health needs. With the increase in emotional challenges related to COVID-19, many retailers are moving into the market space of providing mental health services. New sites for urgent care, such as CVS Minute Clinics, Walgreens, Albertsons, and Rite Aid are among those where retailers are beginning to offer mental health assessments, referrals and counseling, covered by insurance or available for cash payments for initial assessments and 30-minute therapy and counseling sessions in person or virtually.[72] What this will mean overtime is unknown, but these services aim to help address the needs of broad populations, beyond those with serious mental illness. There have been examinations of promising practices across retail sites such as for substance use disorder care. One study described that medication disposal kiosks in a retail pharmacy chain, combined with naloxone dispensing and patient education as one means of prevention to address the opioid crisis.[73] Although some caution is required in this scaling out of potential evidence-based interventions, there may need to be adaptations to models that can lean on evidence while continuing to collect data to determine program effectiveness in new settings.[74]

One other model of urgent care access involves bridge clinics or transition clinics, for immediate after care following an intervention such as one at a crisis stabilization unit or emergency department or even recently discharged from an inpatient setting. Many systems have crafted "open clinic slots" for after a person is seen in crisis and needs more immediate access to prescribers or other types of therapists. This then allows for a handoff to a provider who may otherwise have a waitlist for continuing care. The University of California at San Francisco, for example, established a Bridge Clinic to allow for brief crisis intervention interim care, pharmacotherapy consultation and treatment, teaching with child and adolescent psychiatrists on a consultation/liaison service and collaboration between treatment entities to help smooth out a patient's transitions in care.[75]

Each of these approaches are innovative models that are designed to expand the scale of access, and many are increasingly relying upon telehealth to do so. Research on how they connect individuals to longer term care when needed, meet the needs of diverse populations, and improve mental health outcomes as well as their cost effectiveness is needed. Still with increasing demand for care, they are likely to continue to grow.

Sheppard Pratt in Maryland: One Model Linking Crisis Care to Comprehensive Care

In addition to innovative models like CCBHCs and urgent care access, Maryland's Sheppard Pratt system has evolved as an example of how many services--from crisis care to continuing care-- can be woven together to provide a seamless care delivery system across multiple regions within the state.

Figure 9: Sheppard Pratt in Baltimore in the 19th Century

When Sheppard Pratt's psychiatric hospital was created in the 19th century (Figure 9), crises were broadly defined to include unusual behaviors in addition to dangerous ones. The hospital's founding benefactor, Moses Sheppard, was innovative for his time and redefined crisis services by changing the method and place of intervention from containment in jails to treatment in "asylums."[76,*] As Sheppard Pratt embraced evidence-based practices in the 2000s such as Illness Management and Recovery, its community-based crisis interventions shifted from focusing solely on preventing crises to also teaching people how to manage crises. Today, with 988 available to link individuals from crisis to care, the Sheppard Pratt system serves as an example for policy makers looking at models that can include a comprehensive array of hospital and community services, as well as those integrated in general hospitals to facilitate more rapid and effective discharge to outpatient programs.

Figure 10: Sheppard Pratt's Baltimore Hospital Campus Today

Sheppard Pratt serves 70,000 individuals of all ages each year at 380 sites across 16 Maryland counties (Figure 10). Programs include:

- 2 mobile crisis teams
- 5 residential crisis programs
- 2 psychiatric urgent care programs
- 1 CCBHC funded by an expansion grant (CCBHC-E) at two sites
- 13 outpatient mental health clinics
- 2 hospitals
- 4 partial hospitalization programs
- 12 special education schools
- 11 psychosocial rehabilitation, supported housing, and supported employment programs
- 5 assertive community treatment teams
- 17 Medicaid health home programs
- 1 outpatient opioid treatment program
- Many other programs that provide treatment and rehabilitation and address social determinants of health.

[*] The name of the "Sheppard Asylum" was later changed to "Sheppard and Enoch Pratt Hospital" when 19th century philanthropist Enoch Pratt made a significant contribution.

This paper focuses on three specific crisis-related Sheppard Pratt programs: mobile crisis, psychiatric urgent care, and residential crisis. Each employs innovative components, and the integration among them within the Sheppard Pratt system of care provides additional distinction that can be useful for other states looking to expand the array of services available in their locales. Also noteworthy are Sheppard Pratt's partnerships with state and local governments that help create system change to develop and enhance crisis services.

Mobile Crisis

Sheppard Pratt's mobile crisis services (MCS) start at initial points of contact with individuals in crisis, bringing the institution back to its roots by diverting people from jails and hospitals when a hospital is not needed. Recognizing differences in local and individual needs, Sheppard Pratt provides MCS 24-hours per day, seven days per week in Frederick County, Maryland with teams of two mobile crisis counselors who respond with and without police accompaniment. In a smaller county, Sheppard Pratt provides mobile crisis services 84-hours per week with one counselor who is accompanied by law enforcement for all initial calls.

In addition to providing MCS 24/7, the Frederick program also operate an innovative pilot for 80 hours/week called the "Crisis Car," which teams a Sheppard Pratt mobile crisis counselor with a non-uniformed City police officer and a county paramedic or EMT. This multi-disciplinary first-responder team travels together in an unmarked van responding to crises, as well as providing follow-up, post-crisis support. Of course, pairing mobile crisis counselors with law enforcement has been happening throughout the country for decades. More recently, some programs have paired mobile crisis counselors with paramedics/EMTs, seeking to reduce the potential of escalation that can arise from fears of law enforcement.[77,78] The disadvantage of this model is that by excluding law enforcement, the teams are unable to respond to a significant number of situations that are dangerous or require involuntary hospital evaluations. The Frederick pilot retains the advantages of including law enforcement while mitigating the disadvantages by having the vehicle unmarked and staffed with non-uniformed police officers who receive additional training.

As another innovation, one law enforcement agency shares 911 call data with Sheppard Pratt to identify frequent callers so that mobile crisis counselors can develop proactive plans with these individuals. Initially, the police department had legal concerns about sharing that information, but then agreed that the data is not protected health information and could be shared with a mobile crisis provider.

Sheppard Pratt invested significant time over many years nurturing trust with law enforcement agencies in both jurisdictions. Trust is crucial for inter-agency crisis response because there is less time to plan services and process conflict. The value of personal relationships is as important to the success of agency collaboration as it is to the effectiveness of individual clinical care. Trust has been especially critical in the infrequent times that the services resulted in negative outcomes. The agencies have been able to debrief critical incidents without defensiveness or blame. Similar to Sheppard Pratt's clinical approach of teaching individuals

how to manage crises as opposed to focusing solely on preventing crises, Sheppard Pratt measures effectiveness of agency collaboration, in part, by how well the partners work together to manage and learn from negative outcomes.

Rapid Access to Outpatient Clinic Services

Sheppard Pratt operates 13 outpatient mental health clinics throughout Maryland, five of which are dually licensed to provide outpatient substance use disorder treatment. Several innovations poise these clinics to respond more effectively to crises.

- *Same Day Access to Therapist:* As with many other clinics in the country, Sheppard Pratt's clinics are moving to offering same-day access with a therapist, including virtual appointments. One successful innovation is the use of a QR code to allow the client to gain easy and quick access to a virtual room staffed by a receptionist.
- *Two-day Access to Psychiatric Provider and Short-term Stabilization*: Another innovation is a contract with Howard County General Hospital in which Sheppard Pratt assures that referrals from the hospital can meet with a psychiatrist or nurse practitioner within two business days of referral and receive two follow-up medication visits with the psychiatric provider and seven sessions with a therapist. The hospital pays an amount toward the direct cost of the psychiatric provider for the held timeslots, and Sheppard Pratt bills insurance, if any, to cover a portion of the other direct and indirect costs of the program, including therapist time. Hospital staff are able to access a real-time, web-based scheduling system 24 hours/day so that patients leave the hospital with the outpatient appointment arranged. An unpublished pre/post intervention analysis by Maryland's Health Information Exchange indicated that participants experienced a 38% reduction in hospital care costs, comparing 12 months before and after program initiation. An internal analysis by the hospital indicated a 43% reduction in costs. The hospital has chosen to renew the contract every term since the pilot began.
- *Bi-directional Health Information Exchange (HIE):* Sheppard Pratt is piloting an innovation with Maryland's HIE in Frederick County for individuals served by its clinic and psychiatric rehabilitation program. For a number of years, the HIE has been sending email alerts to outpatient providers when their clients are admitted to any Maryland hospital. With the Sheppard Pratt pilot, the HIE also alerts the hospital that the patient is served by Sheppard Pratt. This bi-directional information is especially helpful when serving individuals who do not acknowledge they have a mental illness or identify their provider. In addition, the innovation recognizes that many programs such as outpatient clinics and ACT teams do not always know in real time when a client accesses an ED. The diversion and rapid discharge protocols that Sheppard Pratt has created in collaboration with general hospitals can be triggered only if both providers know that the hospital patient is also served by Sheppard Pratt.

Sheppard Pratt's Psychiatric Urgent Care

Sheppard Pratt operates psychiatric urgent care (PUC) clinics at its two hospitals campuses. This service helps provide urgent assessments to those in crisis, offering timely evaluations and triage to voluntary patients helping establish appropriate levels of care. While these programs are not unique, they do employ several innovations. First, given the co-location on Sheppard Pratt hospital campuses also offering intensive inpatient level care, most individuals who are determined to need acute psychiatric stabilization are admitted seamlessly bypassing the resource intensive and cumbersome emergency department route. Additionally, those who need high-level care but not necessarily hospitalization, are connected to partial hospitalization resources that are also offered at both campuses. For those needing outpatient level of care, urgent care staff are able to schedule follow-up outpatient appointments, as opposed to handing out a referral list for the patients to call and negotiate during a difficult crisis state. Sheppard Pratt is able to provide these important linkages through its array of facility-based and community outpatient programs that are connected by a system-wide centralized call center and scheduling system. Finally, virtual telepsychiatry visits are available, which is especially beneficial for individuals and families who live significant distances from the hospitals. It is also helpful for people who are ambivalent about receiving care and are reluctant to arrive at a hospital or an emergency room setting.

Residential Crisis Services (RCS)

Sheppard Pratt operates 79 residential crisis services (RCS) beds in four Maryland jurisdictions. These programs range from four to 16 beds in single-family homes, have 24/7 on-site staffing with a staff-to-client ratio of 1:4, and have an average stay of 14 days. Such programs meet the SAMHSA definition of effective "Short-term Crisis Residential Stabilization Services."[79] Sheppard Pratt has enhanced some of its RCS programs with several innovations.

- *24/7 Availability of Psychiatrist/Nurse Practitioner*: Sheppard Pratt chose to add 24/7 Psychiatrist/Nurse Practitioner availability to all of its programs even though the State does not currently reimburse for this.
- *Pilot for Voluntary Drop-off, Detox, and Medication for Addiction Treatment (MAT):* Sheppard Pratt is implementing a pilot with local grant funds that adds voluntary drop-off, peer specialists, ambulatory detox, and initiation of MAT. Sheppard Pratt is exploring with the Maryland Department of Health the possibility of braiding Medicaid funding to cover these enhancements for this pilot and other replicated programs.
- *Targeted Hospital Diversion*: Sheppard Pratt developed a pilot in collaboration with all six general hospitals in Montgomery County, Maryland. This 16-bed RCS program streamlines referrals from those hospitals to expedite patient discharge from their EDs and inpatient units. The program embeds Sheppard Pratt staff in the hospitals to provide consultation to hospital discharge coordinators, join discharge planning meetings, promptly assess referred patients for appropriateness of RCS, and transport patients to the RCS program. The pilot is a strong public-private partnership: the

hospitals provided funds to Sheppard Pratt toward start-up costs; the State approved the pilot to receive fee-for-service reimbursement to sustain the program; and Sheppard Pratt purchased and renovated the facility and assumes the on-going financial risk inherent in a fee-for-service financing model. The State supported the pilot because of the innovation and the significant financial investment from the hospitals and Sheppard Pratt.

A fair criticism of the RCS model is that unlike some other types of crisis stabilization centers, this program does not prevent individuals from accessing EDs as individuals may pass through an ED before entering an RCS. On the other hand, with models that deflect people from EDs, it can be difficult if not impossible to determine exactly how much use is avoided. Another advantage of this model relates to siting programs, which is an important practical factor in developing crisis services. These programs, as with most other types of solely residential mental health programs, are legally protected by the federal Fair Housing Act. This is especially important in the face of an increase in "Not in My Backyard" disability discrimination. Especially relevant to RCS programs is the position of the U.S. Department of Justice, supported by court decisions, that homeless shelters and short-term residential treatment programs are considered to be "dwellings" and therefore are protected under FHA, even though the lengths of stay may need to be brief – indeed, as short as 14 days as is the case with RCS.[†]

The pilot is being replicated in Baltimore in partnership with another general hospital that is making a similarly significant financial contribution toward start-up costs. In addition, Sheppard Pratt is administering a similar RCS program that streamlines referrals from state hospitals and embeds RCS staff in those hospitals.

Sheppard Pratt in Context

Today, with 988 available as a way to access crisis supports, and the CrisisNow model being discussed nationally, Sheppard Pratt, like other systems will continue to innovate to help meet the demands and pivot toward strategies that help people resolve crises and receive the care that they need. The review above is aimed to help system leaders see one healthcare entity's evolution over time to support individuals in crisis that go beyond walls in hospitals and barriers in communities.

[†] See Statement of Interest of the United States of America, filed by U.S. Department of Justice in *Defiore v. City Rescue Mission of New Castle*, No. 2:2012-cv-01590 (W.D. Pa. 2013).

Conclusion

There are tremendous waves of change to help address the need of psychiatric patients "beyond beds" and through a continuum of care that offers varying levels of clinical and ancillary supports across settings with crisis services often functioning as the front door to care, now accessible through an easy to remember three-digit number of 988. Some of the more immediate developments include focusing on mobile crisis interventions and jail diversion, but also on infrastructure and linkages to help connect people in crisis to care without delay. These goals are critical as all too often individuals fall in the gaps, and barriers to seamless services create major impediments to treatment retention overall. Maryland's Sheppard Pratt system is just one example of a system that bridges across various crisis services to meet the demands for current times. In addition, CCBHCs are viewed as incredibly promising, giving a financial structure that will allow for flexibility based on the needs of populations served, with funding mechanisms that allow the CCBHCs to be available to serve anyone who appears for care. Urgent care centers in communities including in retail stores, bridge clinics, and other delivery models aim to provide rapid access that is taken to scale across populations. This paper reviewed some of the exciting developments of our time for these types of system interventions. It is hoped that with these developments, some of the knottiest problems of persons living with mental illnesses and substance use disorders can be more immediately resolved.

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