HMA

HEALTH MANAGEMENT ASSOCIATES

# *Prince George's County Behavioral Health System Needs Assessment, Gap Analysis, and Action Plan*

PREPARED FOR
PRINCE GEORGE'S COUNTY HEALTH DEPARTMENT

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# Executive Summary

On behalf of the Prince George's County Health Department ("Health Department"), Health Management Associates, Inc. (HMA) conducted a County-wide behavioral health needs assessment and gap analysis to identify and quantify the behavioral health needs in the County, as well as service and provider gaps within the existing behavioral health system. This report presents recommendations to help the County develop a robust, effective, and efficient behavioral health system. The recommendations are actionable, with detailed steps to improve the quality of services, increase access to behavioral health services, and ultimately improve the health outcomes of Prince George's County residents.

## Major Findings

Major findings include the following:

1. The County's behavioral health system is weak on prevention and early detection of mental illness and substance use disorders (SUD). As a result, many adolescents and young adults live with undiagnosed behavioral health problems, and are not treated promptly when they are diagnosed. This can lead to a downward spiral for these individuals, with tragic results that include failure in school, unemployment, housing problems including homelessness, and repeated encounters with the justice system.
2. The County does a better job with emergency response, but frequently this leads to dropping off youth and adults to emergency departments, crisis centers, and other venues. Care in these settings is frequently very short, and too often ineffective, with insufficient follow up.
3. The County's main emphasis in the use of data is on "counts" of people enrolled in programs, with too little emphasis on actual service delivery, quality of services, and outcomes.
4. Even with the emphasis on "counts," the number of people actually participating in many of the County programs is quite low.
5. There are insufficient initiatives to link primary care and behavioral health care. For example, more work also needs to be done to establish "warm hand-offs" between emergency department visits and hospital discharges to behavioral health providers in the community.
6. Overall, the County needs a greater emphasis on bridging the gap between physical health care and behavioral health care. Co-location of services, more standardization of patient records across the somatic/behavioral health divide, and greater use of telemedicine can lead to a better continuum of care.
7. A greater emphasis on medication management would help improve health outcomes.
8. The County needs to transcend the silos that separate mental illness and substance use disorders, which are frequently co-occurring.
9. The County needs much stronger linkages across agencies including the Department of Health, Department of Social Services, Department of Family Services, and housing and transportation agencies.
10. The County needs much more emphasis on measuring the quality of care delivered by behavioral health providers, and incentives to improve quality. There is a corresponding crucial

need to adopt evidence-based practices in behavioral health care. Overall, the goal is greater accountability and performance.

11. There are important opportunities to assist providers in properly billing third-party payers so that legitimate and proper reimbursement is not "left on the table."
12. A lack of transportation options to travel to appointments with community-based behavioral health providers is a very significant barrier to care. The main focus of the problem is people in the southern part of the County being unable to access services that are primarily located in the northern and eastern parts of the County.
13. There is an overall shortage of affordable housing; this exacerbates the dangerous plight of the homeless, who frequently have serious mental illness and/or substance use disorders in the County.
14. The County has done an excellent job enrolling eligible individuals in Medicaid and the new Affordable Care Act (ACA) health insurance Marketplace. However, more can be done to enroll those who remain on the sidelines, many of whom are harder to convince about the value of insurance coverage, and are in need of financial assistance to meet cost-sharing requirements in Marketplaces.
15. The County has the lowest "Medicaid penetration rate" for behavioral health services. Only 7.2 percent of Medicaid enrollees used at least one behavioral health service in a year's time, which is the lowest penetration rate of any Maryland county.
16. There are racial/ethnic disparities in the use of behavioral health services. Black residents of the County are using services roughly in proportion to their representation in the population; however, Whites are using services proportionally more than their share of the population, while Hispanics are using services proportionately less than their share of the population.
17. On the surface, it appears that the County may have an adequate number of behavioral health providers. But digging beneath the surface, we find that given the national shortage of psychiatrists, there will be a need to supplement their work through behavioral health nurse practitioners, caring for behavioral health conditions in primary care, and the use of community health workers (CHWs). Further complicating the problem is that many providers do not accept patients who have Medicaid or are uninsured, while others accept no insurance. Some have closed their practices to all new patients. Further, there is a mal-distribution of providers relative to need, with a very disproportionate share of providers in the northern and eastern parts of the County and the District of Columbia, while many patients in need do not reside in these areas. This interacts with the transportation problems noted above.
18. The County has an array of behavioral health programs, yet relative to need and the size of the population, enrollment in most of these programs is very low.

## Recommendations

A behavioral health system exists within a clearly defined mission and vision. This involves creating healthy communities sustained through strong prevention and promotion activities; early identification of behavioral health conditions and a service continuum that embraces family-directed and community-based services; a philosophy of recovery and resiliency; evidence-based practices; person-centered care;

and responsiveness to individuals' and families' social, economic, and cultural and linguistic preferences and influences.

The County has options for improving its behavioral health system. At a high level, these include:

- Improving its Medicaid penetration rate;
- Making infrastructure enhancements (e.g., modernizing facilities);
- Creating regional partnerships with neighboring county providers to share limited resources;
- Recruiting and retaining additional behavioral health providers;
- Developing a behavioral health career pipeline at county schools and with higher education institutions;
- Tapping into the expertise and advice of the Behavioral Health Work Group (BHWG) to build support for behavioral health system improvements. Expanding engagement of community stakeholders on the Work Group will further build momentum; and
- Building and strengthening collaboration between somatic and behavioral health providers, in recognition of the relationship between physical and behavioral health, the high incidence of chronic medical conditions in people with serious mental illness, and the importance of primary care as the "medical home" for children, youth and families, and adults. Placing a strong focus on primary care recruitment and integration with the behavioral health delivery system will be especially critical to improving the County's population health while maximizing treatment capacity.

## Short-Term Recommendations

The following are recommendations for behavioral health system improvement that Prince George's County can begin to implement immediately and could complete by the end of 2016.

1. **Become a data-driven system supported by defined metrics to measure progress in meeting clearly defined goals.**

The success of Prince George's County behavioral health system transformation must be measured by looking at processes and outcomes, and cost-per-unit and cost-per-service, not just counts of services delivered. Regular reporting of measures is foundational to transparency and accountability in government. The County uses data, but the emphasis is mainly on "counts" of people receiving services. This has to be extended from counts to accountability for improved access to care, quality services, and better outcomes.

For 2016, the County should consider selecting three important behavioral health quality metrics and establishing a task force from the BHWG to oversee the implementation of these metrics across behavioral health providers in the County. A good place to start would be to work with the State and ValueOptions to see what behavioral health quality measures they are using statewide. For example, in Maryland, ValueOptions is conducting alcohol prevention and screening during pregnancy; promoting early detection and screening of alcohol use by youth; Screening, Brief Intervention, and Referral to

Treatment (SBIRT); and suicide risk assessment and alternative care training.[1] The County could build on what is already available from ValueOptions and add other metrics as needed. Another promising approach is for the County to leverage its membership in the Association of Core Services Agencies (CSA), which brings Prince George's County CSA officials together regularly with their counterparts in the other counties in Maryland. Exploring with the CSAs to determine what behavioral health quality metrics and incentives the other Maryland counties are using would be helpful. This would allow Prince George's County to adopt the best methods already in use in other counties.

Although the State collects data on the highest utilizers, the information does not identify individuals with poor outcomes and high costs generated in other County agencies such as jails or public safety. The County should use State Medicaid data and cross-match against data from the Health Department and other County agencies to identify individuals with the highest *overall* utilization patterns. The County should also develop performance measures such as the number of regular contacts with outpatient care (number of contacts per week or month) and condition improvement (improvement can be demonstrated by a reduction in the use of crisis or acute care services, eventually reducing system cost).

After a small-scale start using data across systems, the County can develop County-specific indicators and move away from measuring only what is required. New indicators could include:

- Number of individuals and families who receive services within seven days following a crisis service by using Public Use Microdata (PUMAs) or zip codes. Breaking data into smaller catchment areas would support identifying trends and disparities more easily.
- Percentage reduction in the number of individuals with a behavioral health diagnosis and claims for service in the past six months or year who violate the conditions of their probation.
- Reduction in the percentage of individuals who, although they receive authorization for behavioral health services, never see a provider, or see a provider only one time.

The County should establish a strong but realistic goal for each of these metrics. An example would be: "in Year One, at least 50 percent of individuals who receive a crisis service have a follow-up appointment within seven days". The next year, the bar could be raised to 60 percent, and then 70 percent the following year. These examples are illustrative, and other benchmarks should be established based on expert opinions. The point is to set specific goals and indicators, and then track progress toward meeting them.

The County should also identify and use a set of metrics that indicate a deterioration in health status for individuals with behavioral health conditions. These metrics could include: ED visits, hospitalizations, crisis service use, suicide attempts, overdoses, and poor self-assessments of health status. These indicators help the County develop a risk-stratification plan that focuses resources on those with the most serious needs.

The measures noted above are process measures, or they could be thought of as intermediate outcomes. This is an appropriate way to start the process of establishing goals and building

[1] http://www.valueoptions.com/company/Experience/ValueOptions-Existing-Integrated-Care-Programs.pdf

accountability for quality into the delivery system. Ultimately, the challenge will be to develop outcome measures such as improvements in health status, reductions in days absent from school or work, reductions in ED use and inpatient admissions, and lower total health spending per patient. But for this first phase of the reforms, process goals are completely appropriate and more readily achievable.

A system of financial rewards should be established for providers who meet quality targets. This could start out in a modest way in the first year, and be augmented in later years. Providers who perform well should get a bump-up in their reimbursement. After that, a bonus pool could be established, to be distributed at year's end for high-performing providers. These are practices widely used in the private sector and among States, including in Maryland.

The bottom line is to use metrics already collected to set specific goals and targets, measure progress across providers toward meeting the targets, and reward those providers who do so.

**2. Leverage the Behavioral Health Work Group as a champion**

The County should designate the Prince George's County Behavioral Health Work Group (BHWG) as the entity that will oversee, stimulate, and evaluate the behavioral health system transformation plan. The BHWG will become the entity responsible for coordinating the planning and implementation process across behavioral health service providers and partnering agencies, including the justice system, social services, family services, hospitals, federally qualified health centers (FQHCs), community organizations, and other stakeholders and providers.

The BHWG needs a growing and broadly representative group of committed partners and stakeholders who join together, develop a common vision and mission, and pursue a detailed, feasible, and actionable strategic plan to improve behavioral health outcomes in a cost-effective way. It is important for the Work Group to distinguish vision from specific short-term action steps. For example, if the vision was to end homelessness over a period of years, an action step could be to create 10 new supportive housing units during 2016.

**3. Establish "No Wrong Door" points of entry into the behavioral health system**

Through its Systems of Care plan, the County is moving ahead toward multiple points of entry to the behavioral health system. The goal is that by opening any door (e.g., the physician's office, the ER, foster care, housing assistance, or social services), an individual gains access to the other doors, rather than having to start over every time. The County should develop a standardized assessment, referral for specific services, and supporting coordination.

To support establishment of a "no wrong door" system, the County should prioritize the development of interagency memoranda of understanding (MOU) for interagency service linkages. One interagency agreement is in progress (DataLink for the Core Service Agency, ValueOptions, and the local detention center to share information). Additional MOUs established in 2016 could formalize the blending and braiding of funding and integration of services and supports, while decreasing duplication of services and consumer burden (i.e., avoiding requiring consumers to complete intake forms at multiple

agencies). The County should also develop a common intake form for County behavioral health services so individuals can indicate which services they need assistance to access.

The County should prioritize the BHWG discussion and exploration of the Maryland First Responders Interoperable Radio System Team (Maryland First), an interoperable 700 MHz radio communication system for state and local public safety agencies. This system could be expanded to provide real-time linkages across County agencies that all touch behavioral health emergencies. This would help mobilize and connect several County agencies trying to help an individual at the time of a behavioral health emergency so that they could work as a team to provide immediate support.

Building the prompt response to behavioral health emergencies into the County's new Request for Application (RFA) would help integrate this emergency treatment into the overall system of first responders, including the Policy Department, the Sheriff's Department, and the Fire Department. The ultimate goal is achieving a level of interoperability among first responders and linking them to hospitals, crisis centers, and other behavioral health providers so that a person who enters the emergency response system, from any point, is steered toward crisis treatment in the least restrictive environment consistent with public safety, and receives appropriate follow-up care. This approach holds the promise of influencing the reduction of the incidence of jail confinements for people who are not a threat to public safety.

**4. Build provider capacity**

Critical to a high-quality, responsive, and flexible behavioral health system is a continuum of services provided by accessible, well-qualified, culturally sensitive and linguistically competent providers who are available to provide the right service in the right place at the right time. As a first priority, the County needs to improve its overall supply of community-based and outpatient/ ambulatory providers; strengthen the partnership between mental health and addiction services; and expand the cultural and linguistic competency of organizations.

Through the System of Care Implementation grant, the County has identified the strategic plan and vision for wrapping community-based services around children, youth, and their families with severe emotional disturbance. The vision is an effective organizing philosophy and structure, and it supports giving voice to the child, youth and family, and partnering with families to facilitate family-driven treatment planning. By wrapping services and supports around the child, youth, and family, the resources leverage the resiliency of all of them to remain together in their communities.

The County will need to establish a process for determining implementation of Evidence-Based Practices (EBPs) within its behavioral health system. Integral to inclusion of EBPs within the behavioral health system is the provider community's ability to invest in the EBPs, support associated costs of training staff in EBPs, including mentoring and coaching, and the evaluation of fidelity to the model and retraining. The County will need to determine how it can support EBPs, including enhanced reimbursement through Medicaid. Investment in EBPs is more than a one-time cost; it requires an ongoing stream of funding.

Hospital services, including intensive outpatient and partial hospitalization programs, are part of an effective behavioral health system. Since the County is one of the sponsors of the Regional Academic Medical Center development, in partnership with University of Maryland and Dimensions Health System, it is critical that the County assert its position that planning for psychiatric and substance use disorder hospital-based services be made a priority in the new academic medical center. The construction of this new delivery system is a huge commitment of County and State resources. There is a critically important opportunity here to ensure that the new delivery system includes satellite, community-based behavioral health services. This would help improve health outcomes for individuals with behavioral health problems. At the same time, it would be consistent with, and foster the goals of the All-Payer Model in Maryland to avert ambulatory-sensitive admissions and readmissions by moving upstream in the delivery system from care in the highest-cost settings to preventive and community-based care in lower-cost settings, including services that fall outside of the medical model.

**5. Ensure proper Medicaid billing**

Prince George's County frequently spends grant funds for services that could be reimbursed under Medicaid. Further, behavioral health care providers can enhance their reimbursement under Medicaid by improving their ability to bill for the full range of services that they provide during an office, clinic, or facility visit.

The County should conduct a careful review with high-volume behavioral health providers who see many Medicaid patients to ensure they are billing Medicaid properly and not leaving legitimate reimbursement on the table. For example, fees for Evaluation and Management (E&M) in non-facility settings range from $26.01 to $165.21, depending on the complexity of the case. Too frequently, the billing is at the lowest level, even though the patient is actually experiencing a more complex situation than the referring physician indicated. Further, the actual visit in the clinic or physician's office frequently includes not just the E&M, but also medications, lab work, or a medical test that is done on-site.

The County should also encourage and educate providers to examine their case mix and determine whether their billing reflects the actual case mix of their patient population. How many are going to the ED repeatedly? Does their coding match the severity of illness of their patients?

Of course, it is absolutely necessary to avoid "up-coding," which is illegal and unconscionable. But there is reason to believe that there is "accidental down-coding" in behavioral health care, as well as the missed opportunity to bill for the range of services provided in one visit. Therefore, we urge the Health Department and the BHWG to develop an outreach plan to providers to help them bill to the fullest allowable extent and consistent with services provided.

The County has a year to develop the Medicaid billing and payment system, including a determination of indirect costs of care for Medicaid reimbursement of substance use disorder services. It is critical that the County make this planning and transition a priority, as it establishes the needed infrastructure to participate fully in the state's reform efforts and the future health care landscape under the Affordable Care Act.

### 6. Increase enrollment in Medicaid and Maryland Health Connection

Individuals who are uninsured and seeking behavioral health services can be directed to specific locations where they can determine if they are eligible for Medicaid and other means-tested programs (e.g., SNAP, formerly known as Food Stamps). Although some providers do this now, our experience indicates that it is not enough to say, "You may be eligible for Medicaid and here is a number to call, or here is an address." Providers need to inform patients about the precise location of the government office that is nearest to the patient's home or place of work; the telephone number; the hours of operation of that office; and the exact documentation that they will need to enroll in Medicaid or other programs.

The County could target parents for enrollment in Medicaid and use back-to-school immunization clinics to reach out to unenrolled but eligible parents. The County could also prioritize enrollees with frequent cycling on and off Medicaid (churning). County residents who enroll, dis-enroll (or are dis-enrolled by staff even though they remain eligible for lack of data supplied by enrollees), and re-enroll cause the government to incur avoidable administrative costs and frequently lose coverage.

A study by the Hilltop Institute identified the magnitude of the churning problem. This study found that 69 percent of Medicaid enrollees in Maryland were continuously enrolled throughout the year. Some 18.0 percent gained eligibility during the year while 11.6 percent lost eligibility. Only 1.4 percent both gained and lost eligibility during the year.

Of particular interest to this project, the Hilltop Institute report found that 13.5 percent of those losing Medicaid eligibility had a mental health condition and 4.3 percent had a substance use disorder. According to the Hilltop analysis, adding continuity of care protections would add only $0.07 per member per month for commercial carriers and $0.05 per month for Medicaid MCOs.[2]

County residents who lose publicly sponsored coverage, even though they are still eligible for it, frequently forgo needed preventive care and other critically important health services. The County could use state data to determine which consumers sought care but were not in the eligibility verification system (EVS) on a given date of service. This could reveal demographic patterns of churn that may be overcome via conducting outreach and education.

In addition, the County should review the Medicaid application processes, media messaging, outreach/out-stationing processes, and eligibility determinations and re-determinations to make the best effort possible to enroll and retain those who are eligible for the major health programs. Much work has already been done in the County to increase enrollment. Those still on the sidelines, however, are likely the hardest to convince, as people eager to have health coverage have already enrolled. People need timely information, particularly at tax filing season, about the advantages of Marketplace coverage, juxtaposed with the penalties they are liable for if they do not enroll. This will help the "hold-outs" see that the "marginal cost" of enrolling is actually relatively small, particularly as ACA penalties for remaining uninsured are increasing. Another step is to inform County residents that they can enroll

[2] http://www.hilltopinstitute.org/publications/ContinuityofCareBetweenMedicaidAndExchanges-June2014.pdf

throughout the year, not just in the open enrollment period, if they have life-changing circumstances such as job loss, marriage and divorce, or the birth of a child.

### 7. Improve transportation to improve access to behavioral health services

The Health Department should partner with the County's Department of Transportation and also with the State Medicaid program (Maryland's Department of Health and Mental Hygiene) to establish a comprehensive and joint plan to improve travel within the County to support the behavioral health system redesign. While the transportation challenge cannot be fully solved in 2016, a good place to start would be to conduct an immediate outreach campaign to educate all of the players in the behavioral health system about the coverage provided by Medicaid for non-emergency transportation.

The County can work with the Medicaid Transportation Director at DHMH to begin the process of improving non-emergency transportation, which is a Medicaid-covered service. The County can also work with Procare Ambulance of Maryland, Inc., which provides mobile integrated transportation throughout Maryland. Other potential partners include hospitals in the County who could utilize some funds under their community benefit requirement. Under the All-Payer Model, Maryland hospitals now have an incentive to reduce avoidable admissions and readmissions, and improving transportation to community-based primary care and behavioral health care is in their best financial interest.

In 2016, the County should aim to develop one to two routes for a shuttle service that connects people in the southern part of the County with providers who are mainly located in the northern and eastern parts of the County.

### 8. Expand the ACT team

The County should provide more resources and support for People Encouraging People (PEP), which offers Assertive Community Treatment (ACT), featuring evidence-based practices, for adults, children, and youth. Mobile treatment services under ACT are community-based, intensive, outpatient services providing assertive outreach, treatment and support to individuals with mental illness who may be homeless, or for whom more traditional forms of outpatient treatment have been ineffective. Mobile service is provided by a multidisciplinary team in the individual's setting, such the home, street, or shelter. Services include psychiatric evaluation and treatment, clinical assessment, medication management and monitoring, interactive therapies, support with daily living skills, assistance with locating housing, and case management.[3] Ultimately, an additional ACT team may be needed to meet demand. But in 2016, the County's investment in increasing the capacity of the existing program would most likely yield a positive return on investment because it would enable the team to serve more people, thereby reducing ED visits and inpatient hospital admissions. For example, funding could help support some new staff positions to augment capacity.

[3] http://maryland.valueoptions.com/provider/handbook/MTS_Assertive_Community_Treatment.pdf

9. **Provide follow-up support to the project bringing behavioral health providers into schools in TNI neighborhoods**

The current initiative that brings behavioral health providers into about 30 schools in the Transforming Neighborhoods Initiative (TNI) neighborhoods is very promising. A short-term step that can begin quickly is to provide "warm hand-offs" to providers in the community who can provide ongoing care. Although assessments in the school settings are useful, they are not sufficient. Students evaluated as requiring regular care will need an ongoing relationship with a provider outside the school system, not only during the school year, but also in the summer when school is out of session. The County should aim to launch such an effort in 2016.

## Long-Term Recommendations

1. **Direct more resources to prevention and community-based treatment**

The County should evaluate current activities and initiatives, and direct resources into prevention, promotion, and community-based interventions supporting greater emotional wellbeing and resiliency. The County should leverage public health county-wide initiatives and establish strong sister agency collaboration to develop a single and unified plan that joins all the elements and plans together, and enhances the overall health and wellbeing of the residents of the county. The role of primary care in screening, identification, treatment, and referral as needed to behavioral health is critical in a continuum of prevention and community-based treatment.

2. **Strengthen the partnership between mental health and substance use disorder services and expand the cultural and linguistic competency of organizations**

The County should change purchasing to move toward integrated care between mental health and addiction services. It should become a more discriminating purchaser of services by evaluating and utilizing vendors who can deliver high-quality integrated services based on community need and performance.

The County should review the level of cultural and linguistic competency within the health department to address the gaps in personnel and their ability to offer the linguistic and culturally competent behavioral health services in the County. The County has made a good start by hiring a part-time employee to work on cultural and linguistic competency as a part of the system of care initiative.

The County can partner with the Human Resources Department to review the positions and job descriptions within the Health Department and the adequacy of types of behavioral health positions available. Undergoing a major system transformation will require strong leadership and a sophisticated and receptive team of individuals within the Core Services Agency and addiction services.

3. **Achieve greater coordination across service areas and agencies**

The County's System of Care activities include an effort to build stronger linkages with the Department of Social Services, the Department of Family Services, the Sheriff's Department and Police Department, the Mental Health Court and regular juvenile and adult justice systems, the correctional system, and the Department of Housing. Based on our interviews, further work is needed in this critically important endeavor. Many people are touching multiple programs and need an array of health, behavioral health and social services; development of closer linkages, sharing resources, and joint planning among sister agencies is foundational to system transformation.

The County should anchor sister agency collaboration in a process of assessment, identifying common areas of interest within the behavioral health system, and potential synergies achieved through braiding funding from different sources. This process does not change a sister agency's authority and responsibility. Rather, it is a joint exploration of shared services to meet the complex needs of each agency's population, and together identify the services provided, contracted, or directly delivered by the County, financing for the services, population need, and the potential for joint purchase and/or provision by the County employees. We recommend the establishment of an interagency work group that meets monthly to build these linkages.

4. **Optimize health system performance**

The County should leverage the Prince George's County Primary Healthcare Strategic Plan (2014) to increase primary care for its residents and support service provision to move toward greater integration, not just within the behavioral health system, but across the full continuum of care in a way that links behavioral and physical health care. Primary care can be a major provider of behavioral health services for children, youth, and adults with mild to moderate behavioral health conditions.

In conjunction with the primary care strategic plan, the County should explore how it will engage primary care practices, physicians in hospital and ambulatory sites, and other physicians to help them provide a robust array of services for individuals with opioid addiction, including Medication Assisted Treatment (MAT) in conjunction with Opioid Treatment Programs/Substance Use Disorder (OTP/SUD) programs. Such inclusion is significant to the County's efforts to expand its SUD services, leverage available funding, and meet the needs of its population.

Patient registries can be a useful method of improving outcomes for individuals with serious mental illness and/or those with substance use disorder. Patient registries consist of a collection of standardized information about a group of patients who share a health condition or experience. These registries can help County officials learn about population behavior patterns and how they affect disease development and to learn about best practices in care delivery.

5. **Increase housing placements and subsidies for individuals with behavioral health needs**

The County should increase the availability of short-term and long-term affordable housing options and improve access through increased funding for housing subsidies for individuals with behavioral health needs. Such housing should be flexible to include residents in recovery, who are not yet fully clean and

sober (expanding the successful Housing First program), and should provide onsite support services or linkages to community-based services.

As part of the sister agency collaboration, strengthening the relationship with the Department of Housing holds promise in identifying additional funding and expansion opportunities, not only for Section 8 programs, but also for innovative models to support individuals and families in obtaining and maintaining stable housing.

6. **Assess and adjust funding strategies in the context of Maryland finance reform and the County's transition to Medicaid payment**

The County should conduct a comprehensive review of all of its funding streams for behavioral health services and assess the service areas in which it leverages current Medicaid reimbursement as well as potential (SUD) reimbursement; receives grant support and for what services; and receives County funded support (type of services, how many, contracted or County staff delivered). The County should also identify opportunities for more extensive collaboration with sister agencies, to more effectively leverage County, Medicaid and other State and Federal funds.

Finally, the County should consider the implementation of pay-for-performance programs to help align provider incentives to deliver care to individuals at their own, customized level of need, rather than fitting individuals into slots of programs, with little motivation to customize services to be more responsive to the person's unique needs.

# Introduction and Objectives

The Prince George's County Health Department engaged Health Management Associates to conduct a behavioral health needs assessment and gap analysis highlighting disparities between community needs and available resources, and to develop an action plan to bridge these gaps.

This report presents:

- A data-driven **Behavioral Health Needs Assessment and Gap Analysis (Section 1)**, which draws upon quantitative data as well as findings from interviews and focus groups to identify the behavioral health needs of Prince George's County residents and examine the service/provider gaps in the current system.
- An **Assessment of the Current Behavioral Health Service Infrastructure, Policies, and Monitoring (Section 2)** that shape the County's behavioral health system today.
- A description of how to **Improve Access to Behavioral Health Services and Best Practices (Section 3)**, which summarizes the key elements in providing timely access to behavioral health services and best practices in treating people with mental illness and substance use disorders.
- Finally, we offer **Recommendations and an Action Plan (Section 4)** aimed at improving, integrating, and increasing access to behavioral health services in the County.

# Section 1: Behavioral Health Needs Assessment and Gap Analysis

## 1.1 Background

This section describes the role of the County in overseeing the delivery of behavioral health services, including the current state of the County behavioral health system, its organizational structure, and a brief overview of funding issues. It also includes a logic model that provides a framework for our approach to the needs assessment. Our approach was also informed by national efforts to modernize behavioral health systems, including the Substance Abuse and Mental Health Service's Administration (SAMHSA)'s *Description of a Good and Modern Addiction and Mental Health Service System:* [4]

> "[A] modern mental health and addiction service system provides a continuum of effective treatment and support services that span healthcare, employment, housing and educational sectors. Integration of primary care and behavioral health are essential. As a core component of public health service provision, a modern addictions and mental health service system is accountable, organized, controls costs and improves quality, is accessible, equitable, and effective. It is a public health asset that improves the lives of Americans and lengthens their lifespan….The vision for a good and modern mental health and addiction system is grounded in a public health model that addresses the determinants of health, system and service coordination, health promotion, prevention, screening and early intervention, treatment, resilience and recovery support to promote social integration and optimal health and productivity…."

[4] https://www.dshs.wa.gov/sites/default/files/BHSIA/dbh/documents/good_and_modern_12_20_2010_508.pdf

### 1.1.1 Core Service Agencies

The Core Service Agency (CSA) is the local mental health authority responsible for planning, managing, and monitoring the public behavioral health system at the local level. Each of the 24 counties in Maryland is represented by a CSA. Although the CSAs have the same general legal mandate,[5] each operates differently based on community needs and resource availability. Maryland CSAs provide oversight and monitoring of all Behavioral Health Administration grant-funded programs for individuals with mental illness. In FY 2014, the CSAs received $5.147 million in grant funds and provided oversight to 30 programs. According to its FY 2014 budget for state general funds, the Prince George's County CSA received $790,064 for program administration (10 staff) and $1.477 million in total funds from the state Department of Health and Mental Hygiene (DHMH). In FY 2016, it received almost $1.749 million in total DHMH funds. [6]

The Maryland Association of Core Service Agencies describes the CSA duties as including, but not limited to:

> "authorization of services; coordination of care; management of high cost users and diversion to lower levels of care; quality assurance; residential [rehabilitation] program [housing unit] inspections; review appeals; investigation and resolution of complaints; audit of programs for regulatory compliance; identification of potential fraud, waste and abuse; and response to public calls for assistance, information and referral. Planning and budgeting responsibilities include development and annual update of a local mental health plan based on needs assessments; development of annual budgets; execution of local vendor contracts; monitoring PMHS [Public Mental Health System] spending; contract monitoring and auditing; development and release of Requests for Proposals (RFPs); and development of comprehensive continuum of community based services. CSA network development addresses coordination of care and linkage including integration of services and benefits by collaboration with other public and private agencies/organizations, including the justice, education and social services systems; public education and provider training; evaluation of services; and review of new provider applications." [7]

### 1.1.2 Organizational Structure

In 2005, the Prince George's County Individuals with Disabilities Office merged with the Mental Health Authority Division to form the Mental Health and Disabilities Administration within the Department of Family Services. In response to the state-level merger of the Mental Hygiene and Alcohol and Drug Abuse Administrations into the Behavioral Health Administration, many CSAs have moved to integrate mental health and substance use services into a single behavioral health entity. Prince George's County moved to integrate its behavioral health services by relocating the CSA from the Department of Family Services to the Health Department, under the Behavioral Health Services Division. In 2012, as part of its Health Enterprise Zone grant application, the County wrote that "the division will facilitate linkages

[5] The legal mandate for the CSA is set forth in Md. Code Ann §§ 10-1201 et seq.
[6] Fiscal Year 2014 Annual Report & Fiscal Year 2016 Annual Plan. (2015). Prince George's County Health Department, Behavioral Health Services, Core Service Agency.
[7] Integrated Care for Individuals with Behavioral Health Disorders. (2011). I Maryland Association of Core Services. http://www.marylandbehavioralhealth.org/_literature_103022/MASCA_White_Paper_on_Behavioral_Health

between other providers that expand into the zone and behavioral health providers who have already expressed an interest in working in the Zone."[8]

### *Fiscal Organization*

Prince George's County Health Department provides some limited direct-care services, with funding primarily through grant awards. When the State's 1115 HealthChoice waiver was implemented in 1997, most mental health services were carved out from managed somatic[9] health care. Over time, the majority of mental health services became Medicaid-reimbursable. Consequently, state-only grant funds to support the delivery of public mental health services have greatly diminished, with the exception of those available for crisis services. In response to the reduction in grant funds, some local jurisdictions developed their own outpatient mental health center (OMHC) and began to bill for services (i.e., Allegany, Anne Arundel, Caroline, Frederick, Garrett, Kent, Montgomery, Wicomico). Others have developed capacity to bill for services provided by licensed mental health professionals employed by the local health department, who are compensated using the appropriate fee schedule.

In 2016, as the State transitions funding for the delivery of substance use services from grant dollars to Medicaid-reimbursed services managed by the Administrative Services Organization, local health departments that provide substance use services will be required to enroll in the Medicaid program provider type 50, certified program and/or provider type 32, opioid treatment program. Counties, including Prince George's, must ready themselves for a significant cultural shift as the State further reduces and eventually largely eliminates grant funding for the delivery of substance use services. Over $8 million in State general funds was withdrawn from the FY15 Behavioral Health Administration in recognition that many behavioral health services will be reimbursed by Medicaid.[10]

While it is permissible for States to charge premiums and establish out-of-pocket spending requirements for some Medicaid beneficiaries, Maryland prohibits cost-sharing except for families enrolled in the Maryland Children's Health Program (MCHP) Premium. MCHP Premium charges $50 per month per family for those with income between 200 and 250 percent of federal poverty ($40,180-$50,225 for a family of three in 2015) and $63 per month per family for those with income between 250 and 300 percent of federal poverty ($50,225-$60,270 for a family of three in 2015).

Also of concern are lagging rate increases or rate cuts to public system providers. Community providers have received few inflationary adjustments over the past two decades, despite rising operational costs. In January 2015, the Board of Public Works reduced psychiatrist evaluation and management reimbursement rates from 100 percent to 87 percent of Medicare, effective April 2015. It also reduced the mental health provider rate increase from 4 percent to 2 percent, effective immediately.[11] Although

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[8] Prince George's County Health Enterprise Zone: Primary Care – Public Health Integrated Service Model. (2012). *Prince George's County Health Department.* http://dhmh.maryland.gov/healthenterprisezones/Documents/Prince%20Georges%20County%20HEZ%20Application%20-%20Redacted%20Version.pdf

[9] Somatic: of or relating to the body, especially as distinct from the mind.

[10] Operating Budget Data. (2014). *Behavioral Health Administration, Department of Health and Mental Hygiene*. http://mgaleg.maryland.gov/pubs/budgetfiscal/2015fy-budget-docs-operating-M00L-DHMH-Behavioral-Health-Administration.pdf

[11] Supplement B: Action Agenda. (2015). *Department of Budget and Management*.

the General Assembly passed legislation in 2010[12] that was intended to require annual inflationary rate adjustments for community providers, no regular adjustments have been forthcoming.

### 1.1.3 Overall Approach of the Study

The methodology was designed to perform a comprehensive assessment of the behavioral health system in Prince George's County that would provide a better understanding of existing behavioral health services and resources, while identifying gaps and needs in the County. Therefore, the methodology included the collection and analysis of a wide range of both quantitative and qualitative data. In addition, relevant reports and other documents were obtained from County, State, and other sources. The findings from analyzing all the data and documentation formed the basis of the assessment of the current behavioral health system, as well as the evaluation of a host of critical activities required to support the system, such as monitoring, tracking, and reporting behavioral health services utilization in the County and others. In addition, a logic model was developed to provide key questions and a framework to guide the assessment and gap analysis, which can be found on the next page.

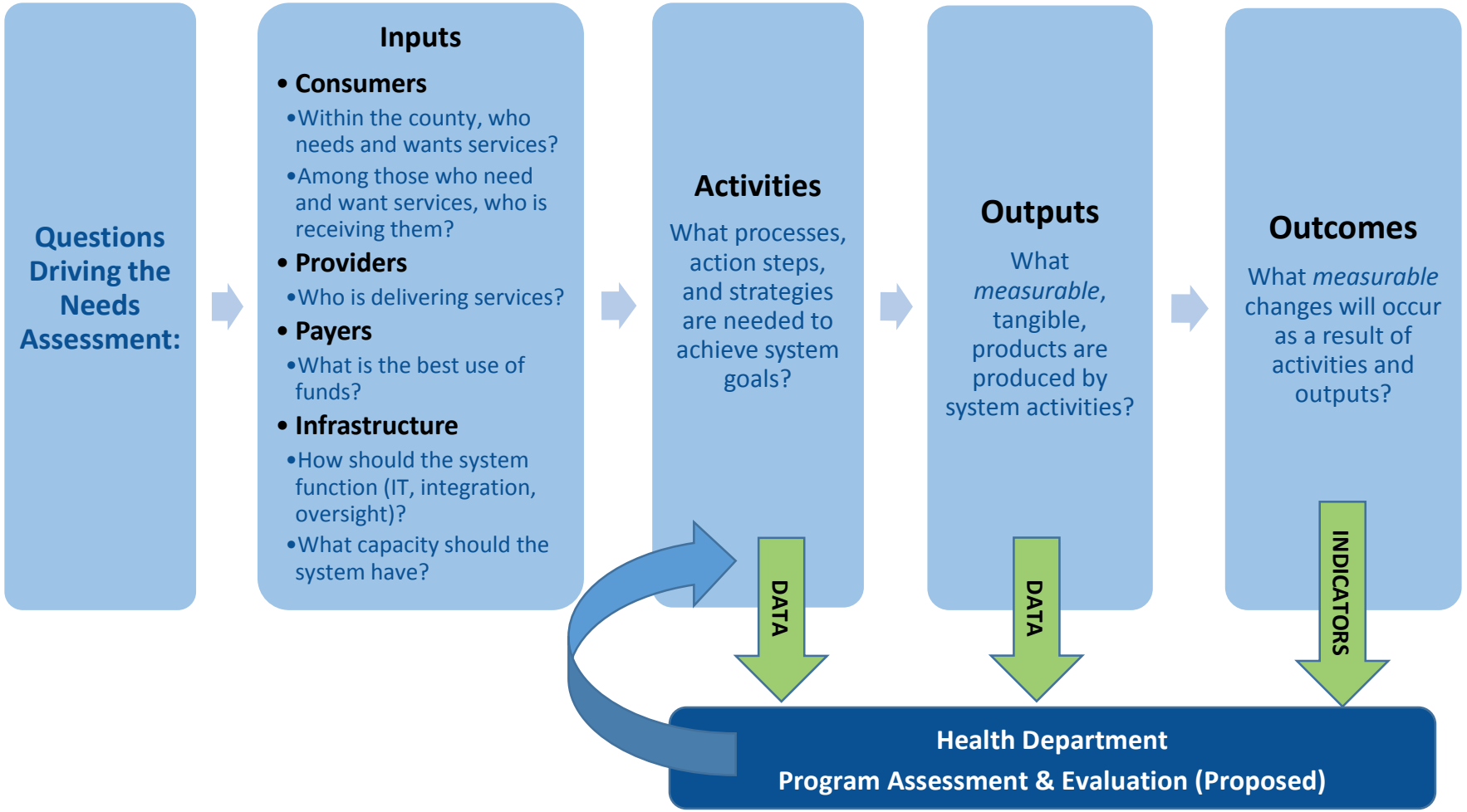
The quantitative data collected and analyzed were obtained from established, credible sources such as the Behavioral Health Risk Factor Surveillance Survey (BRFSS), Healthcare Cost and Utilization (HCUP), regular Census data, SAMHSA, and the Census Bureau's American Community Survey. HMA estimated prevalence of diseases, analyzed utilization trends, and determined gaps in behavioral health service delivery in Prince George's County. The qualitative data approach was designed to capture the lived experience of key informants who are most directly involved and impacted by the County's behavioral health system. This data were collected through more than 40 interviews with a broad range of key informants, such as those from the County health department, multiple sister County agencies, and State-level behavioral health staff, community organizations and associations, faith-based organizations, behavioral health providers and hospitals in the County, and vendors contracted with the County to provide services. In addition, two focus groups were convened: one with behavioral health services recipients and another with families of behavioral health service recipients. More information and detail about the data collection and analysis process is in Section 1.2.

http://www.dbm.maryland.gov/budget/Documents/operbudget/2015/010715-BPW-item.pdf

[12] S.B. 633, Chapter 497. (2010). http://mgaleg.maryland.gov/2010rs/chapters_noln/Ch_497_sb0633E.pdf

### 1.1.4 Logic Model

The following logic model illustrates the questions driving this needs assessment and gap analysis. It also proposes a continuous feedback loop in which the health department collects data from its activities, outputs, and outcomes on an ongoing basis and uses the data to inform its strategies and activities.



## 1.2 Methodology

A combination of secondary quantitative data, structured interview, and focus group data inform the Prince George's County behavioral health assessment. The quantitative and qualitative methods used were thorough, allowing for a comprehensive picture of Prince George's County to be obtained, by reviewing:

- Population estimates of behavioral health and analysis of need from BRFSS, HCUP, DHMH, and the State Health Improvement Process;
- Federal data from the Health Resources and Services Administration (HRSA) and SAMHSA;
- Service utilization and claims from the Behavioral Health Administration, ValueOptions/Medicaid, the Chesapeake Regional Information System for our Patients (CRISP) and the Core Service Agency (CSA);
- Provider capacity analysis;
- County agencies, including the Department of Social Services (foster care) and Department of Public Safety (corrections and police);
- Key informant interviews with key leadership and behavioral health staff of the Health Department, other County agencies, and the state, providers, vendors, and more.
    - Over 40 interviews were conducted
- Consumer focus groups
    - Two were conducted: one with behavioral health service recipients and another with their families

In addition, we carefully reviewed State and County documents, including the CSA annual and fiscal reports, the Project LAUNCH environmental scan, Health Enterprise Zone materials, and the Prince George's County Healthcare Action Coalition report. This assessment reflects a community- and consumer-oriented approach that considers both quantitative and qualitative data in developing an understanding of the current behavioral health delivery system. The focus groups and key informant interviews provided perspective and context for evaluating the quantitative data.

### 1.2.1 Data Sources

For this project, we collected data from several different sources. We used data supplied by Prince George's County, collected data from various sources online (including nationally representative, government administered surveys), and applied for and purchased relevant data sets. Information provided by the County included data on the schooling, safety, and stability for children from the Needs Assessment and Strategic Plan developed by the Local Management Boards (LMB); a needs assessment and gap analysis on the availability and coordination of care for children from the Maryland LAUNCH Environmental Scan Report; and data on various aspects of the foster care system for children in Prince George's County and Maryland. Data from numerous online sources were collected as well.

***Table 1: Online Data Sources Used in this Assessment***

| Data Source | Information Type |
|---|---|
| 2010 U.S. Census | • Demographics |
| Prince George's County Health Enterprise Zone (HEZ) | • Outcomes<br>• Socioeconomic Issues<br>• Environmental Factors<br>• Food Security<br>• Crime Rates |
| Health Services Cost Review Commission (HSCRC) Regional Partnerships | • Chronic Conditions<br>• High Utilizers<br>• Payers |
| Federal Bureau of Investigation | • Violent Crime<br>• Rape<br>• Murder |

In addition to this background and contextual data, we also downloaded the County-level data from the Behavioral Risk Factor Surveillance Survey (BRFSS, 2012), which we were able to use to compare Prince George's County to Maryland and the United States on several behavioral health factors. These data include demographics and socioeconomic status variables as well, so we were able to provide demographic breakdowns of each variable of interest. The limitations of BRFSS include that it is only representative of a sample of the population, it only covers adults, and it is self-reported, the latter of which is true for the above-mentioned data sources, excluding the HSCRC data.

In order to get data representative of the entire population in Prince George's County and Maryland, we applied for and purchased data from the Health Costs and Utilization Project (HCUP) on inpatient and emergency department discharges for the state of Maryland for 2012. These data include up to 16 International Statistical Classifications of Diseases and Related Health Problems (ICD-9) codes for each discharge, allowing our team to calculate frequencies and percentages for different diseases of interest, both behavioral and physical, as well as distinguish between primary and secondary diagnoses for our diseases of interest. These data also include demographic and a few socioeconomic variables, which allowed stratification of our variables of interest.

For our mapping and geographic information systems (GIS) analyses, we downloaded Topographically Indexed Geocoding, Encoding and Referencing (TIGER) line files from the United States Census for state, county, and zip code boundaries, as well as roads for Prince George's County, which were used to create a map layer of the Transforming Neighborhoods Initiative (TNI) neighborhoods of need. Demographic data for the Census was joined onto the TIGERline files in order to display each district (state, county, or zip code), characterized by its demographic variables. Data from Substance Abuse and Mental Health Services Administration (SAMHSA) on provider locations and classifications were geocoded and added to the map as a layer as well. This allowed us to evaluate where providers are located in relation to areas of need. All GIS analyses were conducted using ESRI's ArcMAP version 10.2, and all data cleaning and analyses were conducted using Stata version 13.

### 1.2.2 Focus Groups

Focus group recruitment was performed with the helpful assistance from the National Alliance on Mental Illness (NAMI), a consumer advocacy organization for individuals and families affected by behavioral health issues. A convenience sample of four behavioral health consumers participated in one consumer focus group, and a convenience sample of eight family members participated in one family member focus group. Each focus group participant completed a participant information sheet to provide some basic, self-reported background information (Appendix C: Focus Group Participant Information Sheet). Descriptive information for focus group participants is provided in Table 2 below.

Interview and focus group participants were sampled using non-probability methods, namely a combination of purposive, snowball, and convenience sampling techniques.

Focus groups with consumers and family members were co-facilitated by several project staff and moderated using a semi-structured, focus group guide (Appendix E: Semi-Structured Focus Group Guide). Due to the personal and sensitive nature of the information shared, all focus group participants completed a consent form to acknowledge privacy and confidentiality protections, as well as other terms of focus group participation. Each focus group was conducted for approximately one hour. During each focus group, project staff captured information shared by consumers and family members using summary field notes.

### 1.2.3 Key Informant Interviews

Key informants were selected purposively due to their specific knowledge, experience, and/or role in the behavioral health system, or related systems, in Prince George's County. At the conclusion of each interview, key informants were given the opportunity to refer HMA project staff to other potential interviewees with relevant information to share for the project. A total of 33 interviewees were selected through an initial purposive sample followed by referrals. Interviewees were classified in one of four categories for the purposes of the qualitative analysis and reporting. These categories included officials working in the Prince George's County Health Department, provider organizations (e.g., hospitals and health systems, Federally Qualified Health Centers, crisis intervention services), sister agencies (e.g., criminal justice and corrections, family services and social services, as well as state interviewees), and other organizations (e.g., public schools, consumer advocacy, faith-based organizations).

All interviews were conducted by one or more project staff using a semi-structured interview guide including questions and probes designed to gather rich descriptions and explanatory information about Prince George's County behavioral health system. Interview guides were tailored to address the specific role and area of expertise of each interviewee (Appendix D: Sample Semi-Structured Interview Guide). On average, interviews were conducted for approximately 45 minutes. During each interview, project staff captured information shared by key informants using summary field notes. Following each interview, notes were cleaned and prepared for analysis.

## 1.3 Findings from Behavioral Health Needs Assessment and Gap Analysis

### 1.3.1 Quantitative Data Findings

*Demographic Characteristics*

Prince George's County has many challenges and opportunities in ensuring the health of its residents. Apart from statewide fiscal constraints, *the County is facing challenges with the restructuring of Laurel Regional Hospital into an outpatient-only facility, concerns over provider adequacy, debate over the most effective way to revamp Prince George's Hospital Center into a modern teaching facility,* and an increasingly socioeconomically diverse population, with significant growth of Hispanic residents. At the same time, the County has pursued opportunities to positively affect the health of its residents, by securing grants and implementing key initiatives including a Health Enterprise Zone in Capitol Heights, a Transforming Neighborhood Initiative (TNI) "focus[ed] on uplifting six neighborhoods in the County that face significant economic, health, public safety and educational challenges,"[13] and a large Economic Development Fund designed to create jobs and increased tax revenue.[14]

Access to health care services is dependent upon many demographic characteristics, including age, gender, race/ethnicity, income, language, and geography (urban, suburban, rural). Examining a few key characteristics of Prince George's County provides context for the behavioral-health specific information.

The median household income in Prince George's County is $73,623, on par with the state median income of $73,538, but higher than the national median income of $53,046 (Census Bureau, 2009-2013).[15] Although Prince George's County's median household income is well above the U.S. median overall, there is a wide range from area to area. The American Community Survey divides Prince George's County into 21 districts. In 2013, the median household income ranged from $53,956 in District 17, Chillum, to $111,687 in District 11, Brandywine.[16] Despite the relative affluence of the county, 8.3 percent of households have an annual income below $25,000. Generally, County residents living within the Washington Beltway (a selection of Census-designated areas is below) have higher rates of poverty and lower levels of educational attainment than those in the southern part of the County. The districts in the table below were chosen because they have relatively high rates of poverty.[17]

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[13] Transforming Neighborhoods Initiative (TNI). *Prince George's County Maryland County Executive*. http://www.princegeorgescountymd.gov/sites/ExecutiveBranch/CommunityEngagement/TransformingNeighborhoods/Pages/default.aspx

[14] Roberts, D. (2011). Prince George's County Executive Addresses Small and Minority Businesses on Economic Development Incentive Fund. Prince George's County Maryland Supplier Development and Diversity. http://www.princegeorgescountymd.gov/sites/SupplierDevelopment/News/Pages/Prince-Georges-County-Executive-Addresses-Small-and-Minority-Businesses-on-Economic-Development-Incentive-Fund-.aspx

[15] State & County Quick Facts: Prince George's County, Maryland. (2015). *United States Census Bureau*. http://quickfacts.census.gov/qfd/states/24/24033.html

[16] American Community Survey (ACS). (2013). *United States Census Bureau*. https://www.census.gov/programs-surveys/acs/

[17] *Ibid.* See also http://statisticalatlas.com/county-subdivision/Maryland/Prince-Georges-County/District-6:-Spauldings/Overview

*Table 2: Percent of Households in Prince George's County with Annual Family Income Falling into Different Income Brackets*

| | District 6, Spauldings | District 17, Chillum | District 18, Seat Pleasant | District 19, Riverdale |
|---|---|---|---|---|
| **Less than $10,000** | 5.1% | 5.3% | 4.8% | 4.9% |
| **$10,001-$14,999** | 1.5% | 2.6% | 2.6% | 1.9% |
| **$15,000-$24,999** | 4.9% | 10.3% | 6.9% | 11.4% |

**Source:** American Community Survey, Annual Family Income, 2013; District 19 encompasses District Heights

When reviewing income, one must also consider housing costs. The median monthly housing cost for County residents is $1,504.[18] In renter-occupied housing units, low-income households are spending significantly more on housing; "housing expenditures that exceed 30 percent of household income have historically been viewed as an indicator of a housing affordability problem."[19] In Prince George's County, 93 percent of those with incomes below $20,000 and 98 percent of those with income between $20,001 and $34,999 are spending in excess of 30 percent of their income on housing; nationally, the figures are 89 percent for those with incomes below $20,000 and 75 percent for those with income between $20,001 and $34,999, respectively. By contrast, only six percent of those with incomes in excess of $75,000 spent more than 30 percent of their income on housing both in the County and nationally.[20]

Some 15.4 percent of Prince George's County residents were uninsured in 2013, about the national average, representing more than 132,000 County residents. By contrast, the neighboring counties had lower rates of uninsured residents, ranging from a high of 11.5 percent uninsured in Montgomery County to a low of 6.9 percent in Calvert County. As described in detail in Section 3, the County also had the lowest behavioral health Medicaid penetration rate in the state; just 7.2 percent of eligible beneficiaries used the public behavioral system in state fiscal year 2014.[21]

The low Medicaid penetration rate may be explained by several factors: mixed status families (where one or more members are undocumented) may be reluctant to enroll eligible family members since doing so includes interaction with government offices; when faced with a long wait to access care, beneficiaries may simply opt not to receive care or to use crisis or hospital systems; transportation to and from appointments is difficult for those in the rural southern County; and stigma remains a barrier to accessing behavioral health care. Apart from those factors, Medicaid beneficiaries may have difficulty in accessing respectful, culturally, and linguistically competent care.

Cultural and linguistic competency is more than having a racially and ethnically diverse array of providers. While some studies have found that people of color reported same-race physician

[18] American Community Survey (ACS). (2013). *United State Census Bureau.* http://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_14_1YR_B25105&prodType=table
[19] http://www.census.gov/housing/census/publications/who-can-afford.pdf
[20] American Community Survey (ACS). (2013). *United States Census Bureau*.
[21] Behavioral Health System Baltimore Behavioral Health Plan: FY 14 Report of Activities and Accomplishments FY 16 Strategic Goals and Objectives. http://bha.dhmh.maryland.gov/Documents/Baltimore%20FY%2015%20annual%20plan%20and%20report%20combined%20-%20FINAL%207-31-15.pdf

preferences and higher rates of satisfaction when seeing a same-race provider,[22] lack of respectful care was an oft-cited reason for refusing care. A composite example: a young mother endures a four-week wait to see a therapist at a community mental health center. She works in the service industry with a variable schedule; two days before the appointment she is scheduled to work. She calls the clinic and learns she can reschedule, but will face a long wait to be seen. Rather than reschedule, she calls in sick to work; she has no paid leave and will lose her wages for the day. She relies on public transportation and arrives to the appointment 15 minutes late. The receptionist tells her she has missed her appointment time and must wait. She is warned that if she is late again, the practice won't continue to see her. She waits, and is seen for intake. The appointment takes only 15 minutes. She wonders if it is worth her time to come again.

### *Behavioral Health*

Although statewide behavioral health indicators such as depression prevalence,[23] rate of binge drinking,[24] and the age-adjusted suicide mortality rate[25] exceed those of Prince George's County for adults, data show significant numbers of adult residents with a behavioral health diagnosis seeking inpatient and/or emergency treatment. In 2012, as shown in the table below, 3,877 inpatient discharges in Prince George's County (PGC) had a primary behavioral health diagnosis. Of those discharges, 29.5 percent had a diagnosis of schizophrenia, 20.1 percent major depression, and 12.2 percent bi-polar disorder. Additionally, of those with a primary diagnosis outside of behavioral health, 16,322 (23.4 percent) had at least one secondary behavioral health diagnosis; 1,180 had a secondary diagnosis of bi-polar disorder. Of the 260,312 emergency department (ED) visits across that same period, 2.6 percent had a primary behavioral health diagnosis and 9.4 percent had a secondary behavioral health diagnosis.[26]

These findings make it clear that a large number of Prince George's County residents have a behavioral health diagnosis. Indeed, about 20,000 people discharged from the hospital in 2012 had a behavioral health diagnosis, either a primary or secondary. Approximately another 31,000 people who went to the ED during the year had a behavioral health diagnosis. (Of course, some individuals likely had both one or more ED visits and one or more inpatient stay so these figures are not additive). While some of the individuals who were hospitalized and had a behavioral health problem as a secondary diagnosis may not have serious behavioral health problems, these large numbers suggest that a larger number of County residents do have such problems, particularly those with behavioral health problems as a primary diagnosis. Further, there are likely numerous individuals in the County with serious behavioral health problems who did not have either an ED visit or an inpatient stay. Thus, it seems likely that well

[22] Malat J & van Ryn M. (2005). African-American preference for same-race healthcare providers: the role of healthcare discrimination. *Ethnic Disparities* 15(4):740-7; Chen et al. (2005). Patients' Beliefs About Racism, Preferences for Physician Race, and Satisfaction With Care. Ann Fam Med. 2005 Mar; 3(2): 138–143.

[23] In PGC, 10.4 percent of adults reported depression in 2013, lower than statewide of 15.4 percent and significantly lower than the US prevalence rate of 38.5 percent (BRFSS 2013)

[24] In PGC, 10.4 percent of adults surveyed said they binge drink compared to 14.2 percent statewide (BRFSS 2013)

[25] The age-adjusted death rate due to suicide was 5.8 per 100,000 in PGC compared to 9.0 per 100,000 statewide (Maryland Department of Health and Mental Hygiene 2011-2013)

[26] Healthcare Cost and Utilization Project (HCUP). (2012). *U.S. Department of Health & Human Services, Agency for Healthcare Research and Quality*.

over 30,000 people in the County had serious behavioral health problems, as measured in 2012. It is useful to keep these numbers in mind when we present program enrollment information in Section 5.

***Table 3: Behavioral Health ED Discharge Data***

| Prince George's County | Inpatient Discharges | | Emergency Department Visits | |
|---|---|---|---|---|
| Behavioral Health Diagnosis: | **Primary** | **Secondary** | **Primary** | **Secondary** |
| **Total Number** | 3,877 | 16,322 | 6,642 | 24,354 |
| **BH Diagnoses as a percent of Total** | 5.5 % | 23.4 % | 2.6 % | 9.4 % |
| **Diagnosis of Schizophrenia** | 1,145 | 742 | 336 | 662 |
| **Diagnosis of Bipolar Disorder** | 476 | 1,180 | 308 | 1,177 |
| **Diagnosis of Major Depression** | 782 | 598 | 231 | 93 |

**Source:** Healthcare Cost and Utilization Project (HCUP). (2012). U.S. Department of Health & Human Services, Agency for Healthcare Research and Quality.

Behavioral health data for adults collected through the Behavioral Risk Factor Surveillance Survey (BRFSS) relies on self-reported data, and may capture additional undiagnosed behavioral health conditions. In the 2013 BRFSS, in Prince George's County, 83.6 percent responded that they experienced good mental health compared to 85.0 percent statewide. Additionally, the average number of reported poor mental health days in the last 30 days in the County was 10.3 days. Of those who reported that they experienced any poor mental health days in the last 30 days, a large portion (18.3 percent) reported poor mental health for 21-30 out of those 30 days. This illustrates the persistent nature of the mental health issues that County residents face.

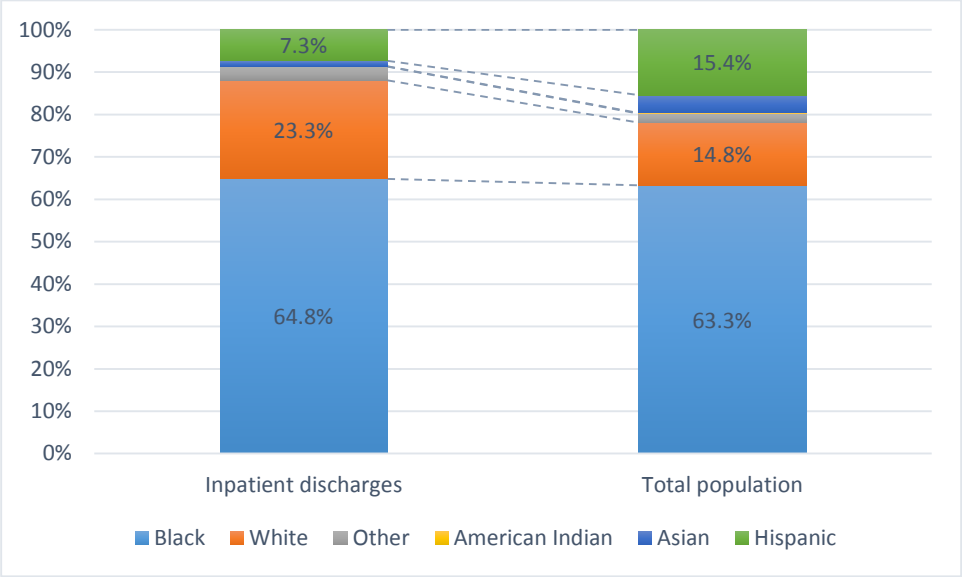
### *Racial and Ethnic Disparities*

Disparities in behavioral health prevalence and treatment exist across the County. The figure below shows the racial and ethnic breakdown of the 3,877 inpatient discharges with a primary behavioral health diagnosis[27] compared to that of the general population.[28]

[27] Healthcare Cost and Utilization Project (HCUP). (2012). *U.S. Department of Health & Human Services, Agency for Healthcare Research and Quality*.

[28] American Community Survey (ACS). (2013). *United States Census Bureau.* https://www.census.gov/programs-surveys/acs/

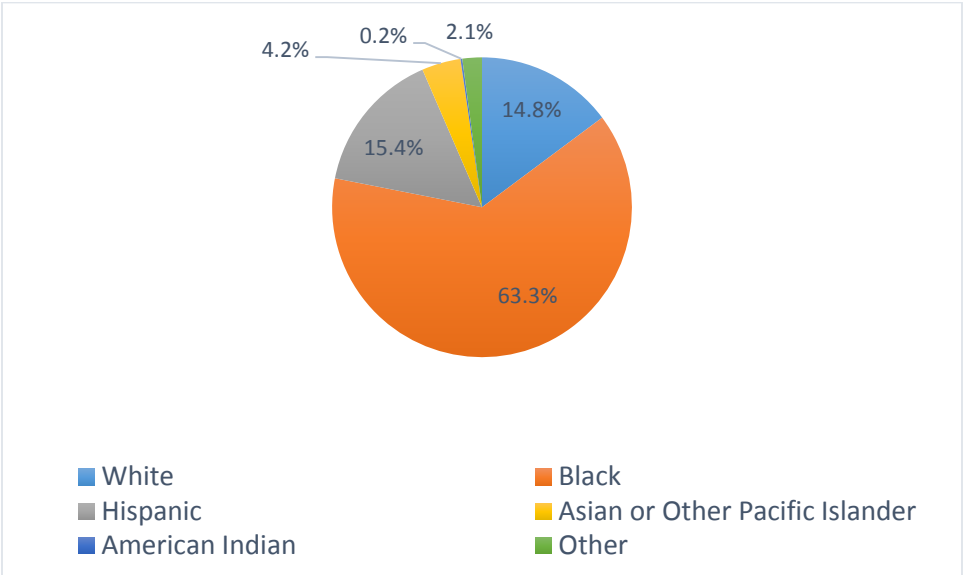
***Figure 1: Prince George's County Inpatient Discharges with Primary Behavioral Health Diagnosis, by Race and Ethnicity***




**Source:** Healthcare Cost and Utilization Project (HCUP). (2012). U.S. Department of Health & Human Services, Agency for Healthcare Research and Quality.

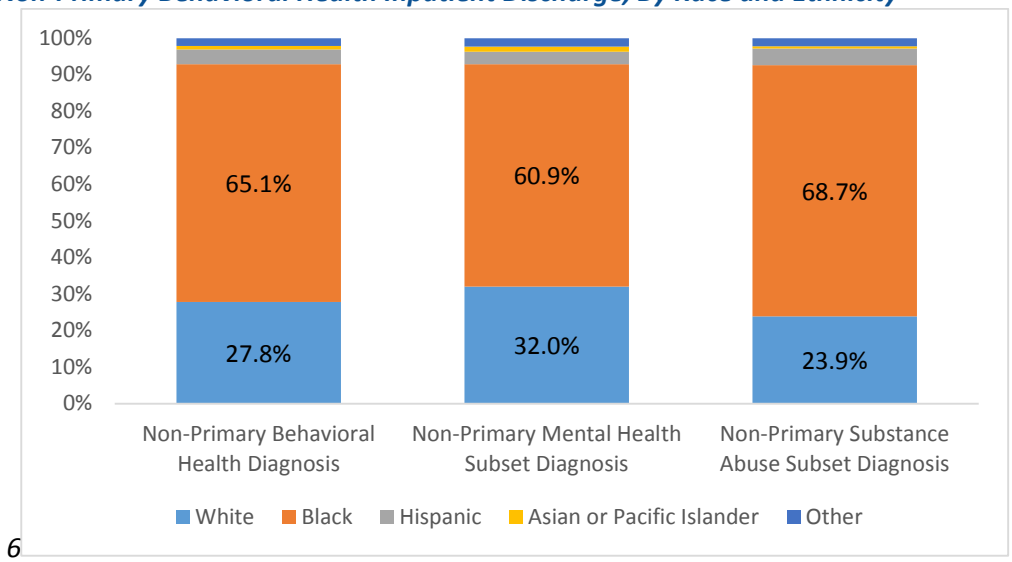
In reviewing the 16,322 inpatient discharges with a non-primary behavioral health diagnosis, racial disparities become more pronounced: In particular, blacks have the highest utilization of hospital services but also a comparably high proportion of the County population. Whites are using hospital services at a rate that is much higher than their proportion of the County population, while Hispanics are using hospital services at a rate that is much lower than their share of the County population.

***Figure 2: Prince George's County Population, by Race***




**Source:** American Community Survey (ACS). (2013). *United States Census Bureau.* https://www.census.gov/programs-surveys/acs/

***Figure 3: Non-Primary Behavioral Health Inpatient Discharge, By Race and Ethnicity***



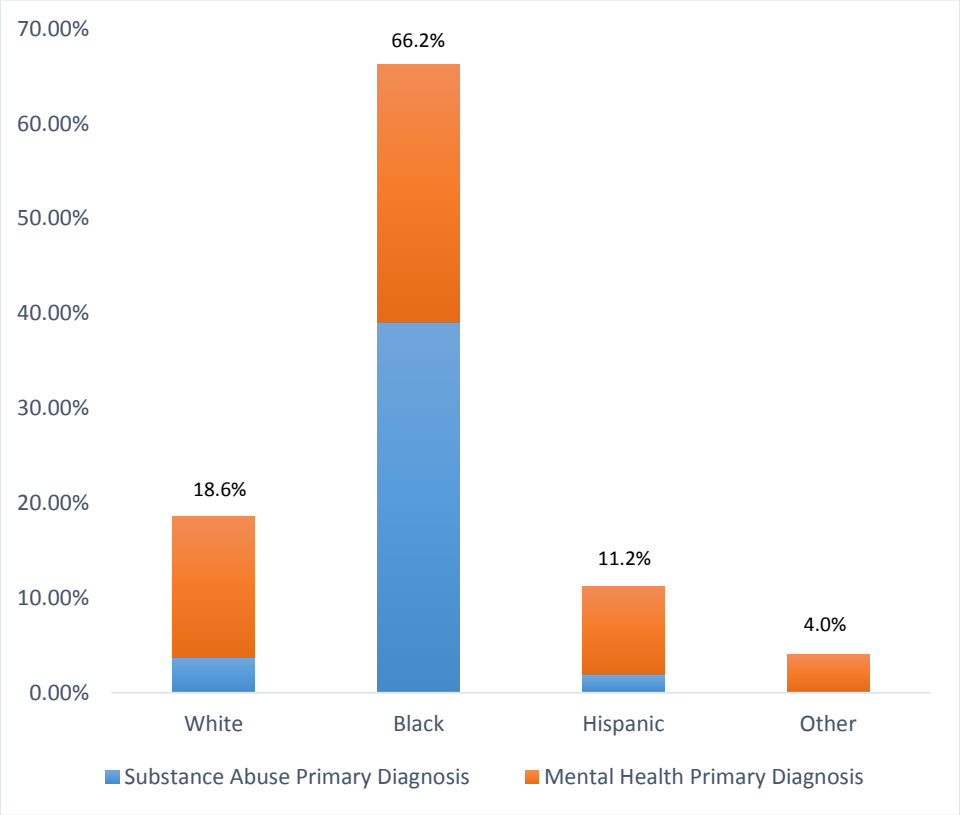

*6*

**Source:** Healthcare Cost and Utilization Project (HCUP). (2012). *U.S. Department of Health & Human Services, Agency for Healthcare Research and Quality.*

### *Emergency Department Use*

A key indicator of accessibility of behavioral health services is emergency department (ED) utilization. Although ED usage is sometimes necessary, many ED visits include care for medication management or non-critical services that could have been accessed in a community, outpatient setting. Other ED visits result from illnesses that progressed from not accessing care in an outpatient setting. Other reasons for ED utilization for behavioral health conditions include: no regular source of behavioral health care; un- or underinsurance; transportation issues (the ED being closer or more easily accessible than an outpatient provider); a lack of community practices with extended or weekend office hours; undocumented citizenship status; and lack of urgent or crisis care beds. The figure below illustrates the racial and ethnic breakdown of ED visits in the County with a primary behavioral health diagnosis by race and ethnicity, and shows that substance use condition as a primary diagnosis is a much greater proportion of total behavioral health diagnoses in the Black population (i.e. well more than half).

***Figure 4: ED Visits with Primary Behavioral Health Diagnosis, By Race and Ethnicity***



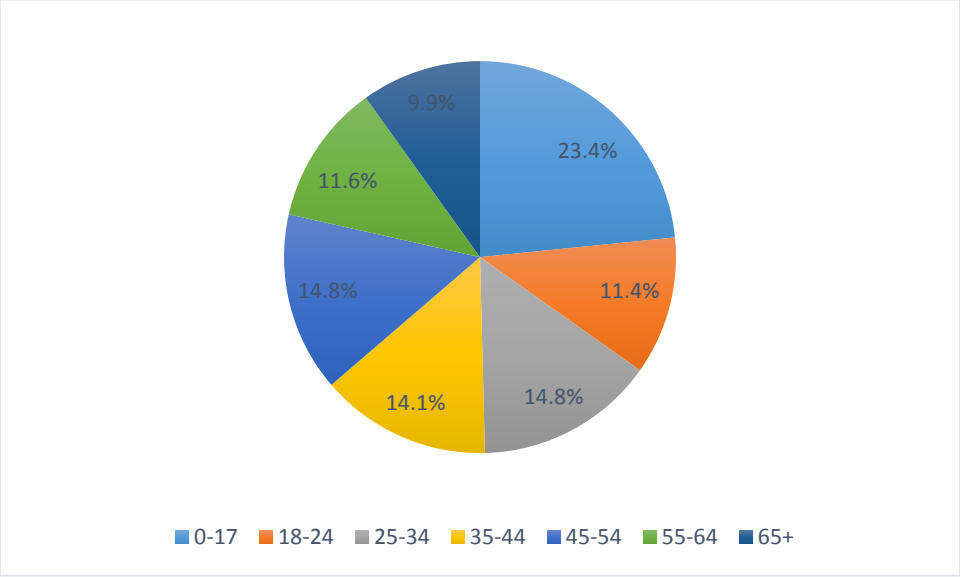

**Source:** Healthcare Cost and Utilization Project (HCUP). (2012). *U.S. Department of Health & Human Services, Agency for Healthcare Research and Quality.*

### *Age*

Although 17.0 percent of inpatient discharges for a primary behavioral health condition in Prince George's County were for those ages 18-24 compared to 12.5 percent statewide, only 1.1 percent (N=38) were under 18 compared to 4.3 percent (N=2062) statewide. The rate of those 65+ matched statewide rates at 7.5 percent, but 9.6 percent of the total of those with a mental health primary diagnosis were 65+ compared to 6.8 percent statewide. Of those with a non-primary behavioral health diagnosis, 40.1 percent were 65+, and of those with a non-primary mental health diagnosis 62.4 percent were 65+.

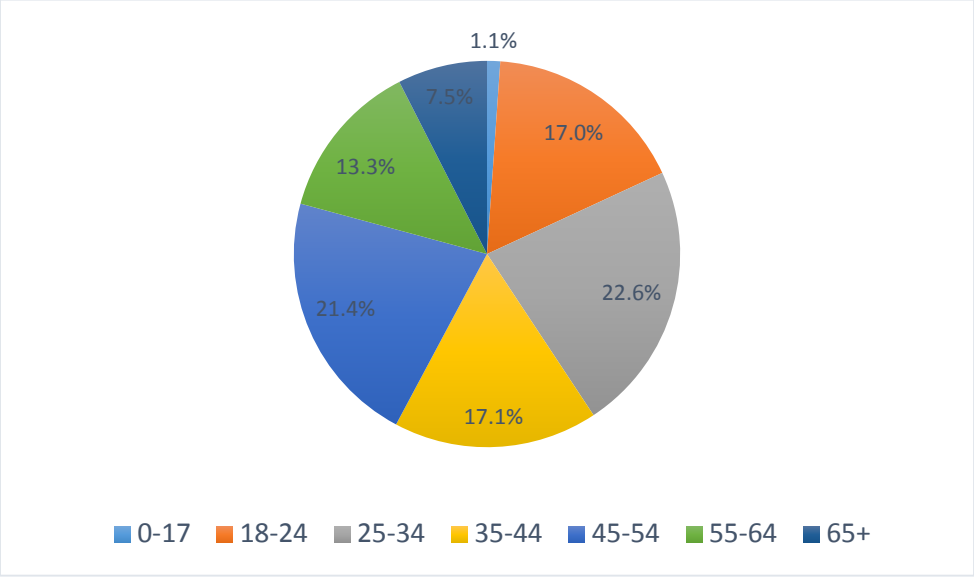
The figures below show the breakdown across ages of inpatient discharges and emergency department visits for behavioral health primary diagnoses as compared to the age breakdown of the general population. Behavioral health conditions are spread across the age groups, but for many senior citizens, their behavioral health conditions may be caused by or related to chronic medical conditions.

### *Figure 5: Prince George's County Population, by Age Group*



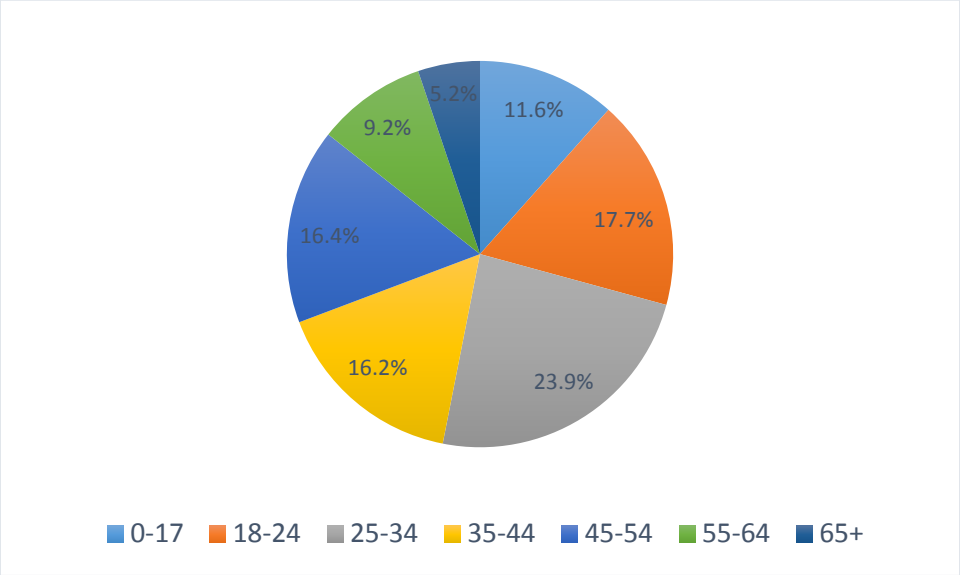

**Source:** People QuickFacts: Prince George's County. (2013). *United States Census Bureau*.

### *Figure 6: Prince George's County Inpatient Discharges with BH Diagnosis, by Age Group*




**Source:** Healthcare Cost and Utilization Project (HCUP). (2012). *U.S. Department of Health & Human Services, Agency for Healthcare Research and Quality.*

***Figure 7: Prince George's County ED Visits, by Age Group***




**Source:** Healthcare Cost and Utilization Project (HCUP). (2012). *U.S. Department of Health & Human Services, Agency for Healthcare Research and Quality*.

*Gender*

Behavioral health primary diagnoses accounted for 7.3 percent of the total male inpatient discharges in the County, compared to 4.4 percent of the female inpatient discharges. Of the total 3,877 discharges with a primary behavioral health diagnosis, 52 percent were male and 48 percent female, matching the breakdown of the general population; however, of the 16,322 inpatient discharges with a non-primary behavioral health diagnosis, 55 percent were female. Similarly, 47 percent of emergency department visits with a primary behavioral health diagnosis were female, and 52 percent with a non-primary behavioral health diagnosis were female.

In the 2013 BRFSS, women accounted for 75 percent of those reporting depression in Prince George's County. Women also reported 0.8 more days of poor mental health in the past 30 days, and one fewer day of binge drinking than males. Additionally, 60 percent of those who smoke every day and 57 percent of those who smoke occasionally were female. Of those who reported smoking every day, 63.5 percent were black and 31.8 percent white, while those who reported smoking occasionally were 76.1 percent black and 15.2 percent white.

### 1.3.2 Qualitative Data Findings

Summary field notes for key informant interviews were analyzed following a grounded theory approach to identify emergent themes regarding various aspects of the behavioral health system in Prince George's County. Primary codes were developed *a priori* based on the key focus areas of the project. Secondary codes were developed based on emergent categories that surfaced during the analysis. All codes were combined into a comprehensive coding framework (Appendix F: Coding Framework). MAXQDA version 11, a qualitative data and analysis management software, was used to apply codes to the summary field notes and add analytic memos. Consensus discussions were conducted by members

of the project team to verify the appropriateness of codes and their definitions. During the coding process, codes commonly applied together were merged for parsimony of the coding framework. After completing the coding process, initial themes were identified based on the frequency that common ideas were shared across interviewees and the salience of those ideas. A series of consensus discussions were held among the full project team to select final themes.

Given there were two targeted focus groups, field note taking and consensus discussions were used to analyze focus group data for emergent themes. Consistent with later stages of the approach for analyzing key informant interviews, initial focus group themes were identified based on the frequency of common ideas that were shared across focus group participants, as well as the salience of those ideas. A series of consensus discussions were held among the full project team to select final themes for the service recipient and family member focus groups.

This section provides key themes from key informant interviews, organized into sections for gaps/barriers, facilitators, and solutions/recommendations related to the performance of the Prince George's County's behavioral health system. Within each section, themes are sorted into one of three levels of a socioecological framework, including individual and community level factors, organizational and provider level factors, and behavioral health systems level factors. Key themes from the consumer and family member focus groups are provided separately. Table 4 provides a summary of key themes across key informant interviews and focus groups. Further explanation of these themes is given in the sections that follow.

*Table 4: Key Themes Summary Table*

| | Gaps/Barriers | Facilitators | Solutions/Recommendations |
|---|---|---|---|
| **Individual and Community Level** | • Lack of access to care due to uninsured and undocumented status<br>• Loss of benefit/coverage after aging out of programs for children/youth and not enrolling in programs for adults<br>• Overuse of hospital and emergency services for non-emergency care<br>• Recidivism among individuals with behavioral health needs | | |
| **Organizational and Provider Level** | • Difficulty with discharge planning for transition from hospital to community<br>• Lack of fully integrated physical and behavioral health services as well as fully integrated mental health and substance use disorder services<br>• Low cultural competency<br>• Loss of flexible health department block grant funding and low revenues for behavioral health services | • Intensive outpatient programs/partial hospitalization services<br>• Legal authority for court-directed behavioral health care with warm hand-offs | • Develop hospital discharge and transition support services for behavioral health patients<br>• Expand behavioral health services and recruit additional provider staff |
| **Behavioral Health Systems Level** | • Shortage of behavioral health services and providers<br>• Lack of transportation to care delivery sites<br>• Lack of housing for individuals with behavioral health needs<br>• Lack of behavioral health performance measures, quality assurance measures, and accountability mechanisms<br>• Lack of a continuum of behavioral health services, including inadequate coordination of care and provider communications | • Insurance coverage expansion under ACA<br>• Maryland healthcare spending targets, finance reform, and penalties for underperformance on quality measures<br>• Special projects and initiatives(e.g., SOC, TNI, HEZ, Project LAUNCH, 4E Waiver)<br>• Generous Medicaid eligibility thresholds and robust coverage of behavioral health services<br>• Directives for integration of substance abuse and mental health systems/services | • "No wrong door" point of entry into the behavioral health system<br>• Create incentives to attract clinics and providers to the County<br>• Improve training for professionals that engage with individuals who have behavioral health needs (e.g., school teachers and administrators, police officers; identify two people to become train the trainers in Mental Health First Aid)<br>• Increase housing placements and subsidies for individuals with behavioral health needs<br>• Develop monitoring, outcome measurement, quality assurance, and data-sharing strategies |

## Gaps and Barriers

Gaps and barriers present in the County behavioral health system were perhaps the most commonly discussed ideas during key informant interviews. Key themes related to "Barriers" include those most commonly referenced and salient descriptions of "factors that diminish the effectiveness of Prince George's County's behavioral health system". Similarly, key themes related to "Gaps" include the most commonly referenced and salient descriptions of "important features of a behavioral health system that do not currently exist in Prince George's County."

The qualitative analysis revealed that these two concepts were highly correlated. Text segments coded with the "Barriers" code were almost always double-coded with the "Gaps" code, and vice versa. As per the approach used for the qualitative analysis, the two codes were merged due to their high degree of overlap. Accordingly, themes for "Gaps" and "Barriers" are presented as a single category below.

### Individual and Community Level Gaps and Barriers

- **Lack of access to care due to uninsured and undocumented status**. Being uninsured and having undocumented status were named as individual-level barriers to an effective behavioral health system. For example, it was noted that undocumented individuals frequently do not seek health services due to fear of being reported to authorities. Lack of access to medical, dental, and behavioral health care was partially attributed to a lack of available providers and organizations in Prince George's County that serve uninsured and undocumented individuals.
- **Loss of benefits/coverage after aging out of programs for children/youth and not enrolling in programs for adults**. Failing to transition from public programs for children/youth to programs for adults was also noted as an individual-level barrier. For example, aging out of foster care can result in loss of certain types of support for housing. Also, aging out of children/youth programs means becoming eligible for adult behavioral health services covered under Medicaid. However, many individuals fall through the cracks and do not enroll. The County intends to create this bridge through the implementation of its System of Care plan.
- **Overuse of hospital and emergency services for non-emergency care**. Repeat hospitalization and the use of the emergency room for non-emergency care/usual source of care were listed as individual-level barriers to an effective behavioral health system. Although the Affordable Care Act has increased Medicaid and private insurance coverage in Prince George's County, a substantial proportion of newly enrolled are not connected to a medical home and continue to rely on emergency services. This was noted as being especially true for specific populations like the homeless and Medicaid beneficiaries. Notably, the lack of behavioral health services was indicated as an important contributor to this problem, as individuals tend to resort to the emergency room when alternative sources of care are limited or unavailable.
- **Recidivism among individuals with behavioral health needs**. Recidivism was also listed as an individual-level barrier in the behavioral health system. This might involve repeat calls to police and crisis services from the same businesses, families, and individuals requesting intervention

for someone with behavioral health issues. Similarly, repeat petitions from family members for court-ordered care was cited as a problem. Also indicated was frequent arrest and diversion or incarceration of the same individuals, typically for short periods of time and for simple offenses. It was noted that such short time periods are usually inadequate to properly evaluate, stabilize, and determine the appropriate medication and dosage for an individual. The County has robust Mobile Crisis Response capacity and is evaluating how this service could be used to reduce recidivism.

### Organization and Provider Level Gaps and Barriers

- **Difficulty in discharge planning for transition from hospital to community**. Interviewees explained difficulties with discharge planning, especially among hospitals, for transitions of behavioral health patients from hospital to community-based care. Such difficulty was attributed in part to a lack of available affordable housing options in the County, a lack of behavioral health providers and services in the County, as well as an absence of family members to provide informal support and transition assistance.
- **Early stage development and implementation of integrated physical and behavioral health services as well as integrated mental health and substance use disorder services**. Integrated care and co-occurring programs referenced during interviews were described as new and developing in the County. For example, the health department was noted as providing trainings, engaging in organizational restructuring, and taking other steps to fulfill a mandate for integrated mental health and substance use treatment. However, interviewees explained that, in practice, it is still a prevailing problem for individuals with behavioral health issues in the County to visit separate providers for mental health and substance use treatment. Additionally, although a Federally Qualified Health Center reported offering a newly developed, integrated primary care and behavioral health care program, it reportedly does not serve many patients, program services are offered only once a week, and the behavioral health acuity of patients is relatively low.
- **Low cultural and linguistic competency**. A low level of cultural competency among hospital and health department staff in the County was identified as an organizational barrier. There was a noted gap in County staff assigned to address the linguistic and cultural competency needs of behavioral health services in the County. Other gaps in personnel include a lack of racially and ethnically diverse staff members, a lack of linguistic capacity among staff members to communicate with non-English speaking patients, and a lack of understanding of cultural practices and attitudes of diverse patients in the County.
- **Loss of flexible health department block grant funding and low revenues for behavioral health services**. The forthcoming shift from block grant to a fee-for-service payment system for addiction services was listed as a barrier, especially due to a loss of flexibility in block grant funding including covering indirect costs of care. However, the one-year delay in transitioning the payment system was noted as helping to reduce this barrier. Other noted barriers included the health department's inability to bill Medicare and the use of a sliding scale, which generated little revenue due to most patients qualifying for care at the lowest payment bracket.

## Behavioral Health Systems Level Gaps and Barriers

- **Shortage of behavioral health services and providers**. A lack of behavioral health services and providers by type of service, type of patient, and geographic location was commonly listed as a systems-level barrier. Interviewees noted a lack of residential, inpatient, outpatient, co-occurring, and therapy services. They mentioned a lack of psychiatrists and psychologists as well as difficulty retaining psychiatrists and social workers. Additionally, interviewees mentioned a specific lack of services for children, adolescents, Medicaid beneficiaries, uninsured, and undocumented individuals. Combined with the overall shortage of behavioral health providers, the mal-distribution of behavioral providers was noted as compounding the barrier to accessing care. Shortages were described as most pronounced in the eastern and southern region of the County; the majority of providers are located in the northern and western parts of the County.
- **Lack of transportation to care delivery sites**. Interviewees highlighted the lack of transportation as a key systems-level barrier for patients accessing behavioral health care. Health and behavioral health organizations may not provide transportation assistance for individuals to travel from their home to the location of services. This lack of transportation services was noted as especially problematic for elementary/high school students who have working parents and individuals living in the southern region of the County, where there are substantial provider shortages and no public rail or bus service.
- **Lack of housing for individuals with behavioral health needs**. Interviewees also identified several factors contributing to an overall lack of sufficient housing stock and support services for individuals with behavioral health issues. For example, interviewees mentioned insufficient funding for temporary and long-term housing assistance. A County decision to forgo federal matching funds for participation in a housing assistance program was noted as a key contributor to the lack of affordable housing in the County. Furthermore, landlords show a pattern of resisting renting to individuals with behavioral health issues due to fear of incidents taking place in the building, home, apartment, increased probability of eviction, and other challenges.

  The scarcity of housing resources leads to favoring transitions of individuals with behavioral health issues from state facilities, which further restricts housing options for non-institutionalized individuals with behavioral health issues, including the homeless. The interviewees who stressed the importance of this problem noted that it posed a real dilemma. On one hand, interviewees noted that those in institutions greatly benefit from returning to the community. On the other hand, giving them top priority over those who are homeless denies the latter group a chance to move from the street to safe housing. Our respondents stressed the importance of increasing total resources so that these difficult tradeoffs could be avoided.

- **Lack of behavioral health performance measures, quality assurance measures, and accountability mechanisms**. A lack of performance measures, quality assurance measures, and accountability mechanisms were listed as adversely affecting the performance of the behavioral health system. Interviewees noted that this barrier contributes to a lack of focus/emphasis on

quality of services, lack of assurance that vendors are appropriately delivering care that they are paid to provide, and lack of tracking patient follow-up care and outcomes.

- **Lack of a continuum of behavioral health services, including inadequate coordination of care and provider communications**. The County's behavioral health service system was described as disconnected and fragmented, with duplication and overlap of services. This disjointedness was noted as contributing to issues with accountability among providers. A lack of coordinated funding streams, especially for public health and social service agencies, was listed as a possible contributor to duplication and overlap of services. Several examples of this barrier were given by interviewees, such as when students who have behavioral health crises in schools receive emergency services, but little information is shared back with their schools about follow-up treatment. Lack of coordination of outreach to homeless individuals with behavioral health issues results in duplicative contacts with and services by multiple agencies provided to the same homeless individuals. Individuals in the corrections system often have an option for release on bond, if it is set at relatively low levels. However, these individuals frequently choose to remain in the corrections system, often on the encouragement from their family members, in order to receive more comprehensive and coordinated care than available in the community.

### Facilitators

Key themes related to "Facilitators" include those most commonly referenced and salient descriptions of "factors that improve the effectiveness of Prince George's County's behavioral health system".

#### Organizational and Provider Level Facilitators

- **Intensive outpatient programs/partial hospitalization services**. Intensive outpatient and partial hospitalization programs were described as key services in the behavioral health system. Partial hospitalization services follow a step-down approach to community transitions from inpatient care, which helps stabilize the patient and avoid readmissions. Intensive outpatient programs were described as being effective at addressing unmet social needs, such as stable housing, and unmet health needs to prevent inpatient admission.
- **Legal authority for court-directed behavioral health care with warm hand-offs**. Several interviewees affiliated with the corrections and criminal justice system referenced legal mandates and authority to place individuals in behavioral health care as important elements within an effective behavioral health system. One such example is the authority of a mental health judge to place an individual in court-ordered treatment. Having a warm hand-off to behavioral health providers (e.g., sheriff's deputy transports court-ordered individual to the emergency room) was listed as an especially effective, albeit resource-intensive, method of placing individuals with behavioral health needs into care.

#### Behavioral Health Systems Level Facilitators

- **Insurance coverage expansion under the Affordable Care Act (ACA).** Several providers reported substantial reductions in uninsured as a proportion of their post-ACA payer mix. As explained in greater detail in Section 5, greater public and private insurance coverage among County residents improves the ability of patients to access and pay for behavioral health care provided within the system.

- **Maryland healthcare spending targets, finance reform, and penalties for underperformance on quality measures**. Several policies related to behavioral health finance were identified as facilitating an effective behavioral health system. Policies that penalize hospitals for high readmission rates and repeated emergency department visits, as well as financial targets to reduce Medicare spending, encourage hospitals to effectively address behavioral health issues. For example, global budgets for hospitals under the All-Payer Model, implemented in January 2014, provide hospitals with an incentive to avoid costly patterns of hospital services use. Working with partners in the community to better treat patients with mental illness and substance use disorder is now in the direct financial interest of hospitals, as it may reduce admissions and readmissions, as well as ED use. Financial incentives through value-based payments and patient-centered medical home participation have the potential to lead to better, more efficient care, mainly through enhanced payments for performance and the ability to bill for multiple health and behavioral health services delivered in the same day. However, providers characterize these financial incentives as small, useful for special projects or upgrades, and not a substantial funding source for their organizations. Global budgeting and readmissions penalties are facilitating coordination of care for patients with behavioral health issues. The payment policies have helped providers identify unmet social needs, such as unsafe housing or none at all, that are key contributors to readmissions. Additionally, an interviewee reported that the transition from a block grant to a fee-for-service payment system for certain addiction services will create incentives to private providers to offer care in the County, thereby creating greater access to care for residents.
- **Special projects and initiatives** (e.g., SOC, TNI, HEZ, Project LAUNCH, 4E waiver). Funding and efforts to improve behavioral health under special projects in Prince George's County were listed as key facilitators of an effective behavioral health system. For example, the Transforming Neighborhoods Initiative (TNI) was described as a source of funding/resources and a broad context where behavioral health fits in as a component of reducing crime and unemployment, and improving educational achievement and other outcomes in the County. As another example, the health department collaborates with roughly 10 organizations in the County as well as with Montgomery County to coordinate with ACA navigators to help enroll eligible individuals in Medicaid and qualified health plans. Such efforts improve access to behavioral health care through higher coverage rates among County residents. Other initiatives that facilitate effectiveness of the behavioral health system include the Systems of Care (SOC) and Health Enterprise Zone (HEZ). See ***Box 1 – Prince George's County Special Projects and Initiatives.***
- **Generous Medicaid eligibility thresholds and robust coverage of behavioral health services**. Medicaid coverage of behavioral health services was reported as being robust and comprehensive. Additionally, Maryland income eligibility levels for adults and children in Medicaid and CHIP were described as relatively high/generous, as compared to other states. As a related facilitating factor, the payment portal for Medicaid providers was described as streamlined so that authorized providers can be reimbursed for services within seven days.

These factors facilitate the effectiveness of the Medicaid program as part of the behavioral health system in the County.

- **Directives for integration of substance use disorder and mental health systems/services**. Interviewees reported that recent directives for the health department to integrate mental health and substance use services foster an effective behavioral health system. The health department is increasing its capacity to provide substance use and mental health (i.e., co-occurring) services through staff training, integration of treatment services, and plans to further develop co-occurring programming. Additionally, the Administrative Services Organization in the County is now responsible for both mental health and substance use disorders, whereas the two were previously divided.

***Box 1: Prince George's County Special Projects and Initiatives***

- The Systems of Care Expansion Implementation Grant, which was awarded to Prince George's County Health Department in August 2015, is $4 million over four years to help to expand and improve access to community-based services for youth and children with serious behavioral health challenges. Specifically, Prince George's County will utilize the funding to help county youth, children, and families with serious behavioral health challenges to function better at home, in school, and within the community.[29]

- The Prince George's County Health Enterprise Zone (HEZ) strives to bring quality and affordable healthcare to residents within the 20743 zip code of Prince George's County. Currently, individuals within the 20743 area have limited access to medical providers, but through the collaboration of the Maryland Community Health Resources Commission (MCHRC), the Maryland Department of Health and Mental Hygiene, and the Prince George's County Health Department, the HEZ is expanding and bringing more practices to the area. By 2016, HEZ is attempting to institute five new practices that will serve over 10,000 individuals in the 20743 zip code.[30]

- The Transforming Neighborhoods Initiative (TNI) within Prince George's County is working towards lifting up six neighborhoods (East Riverdale/Bladensburg, Hillcrest Heights/Marlow Heights, Glassmanor/Oxon Hill, Kentland/Palmer Park, Langley Park, and Suitland/Coral Hills) that face significant challenges in the public safety, health, economic, and education settings.[31]

[29] Prince George's County Health Department Awarded Grant to Expand Behavioral health Services for Children and Families. (2015). *Prince George's County Health Department*. http://www.princegeorgescountymd.gov/sites/Health/News/Pages/County-Health-Department-Awarded-Grant-to-Expand-Behavioral-Health-Services-for-Children-and-Families.aspx

[30] About the Health Enterprise Zone. *Prince George's County Health Department*. http://mypgchealthyrevolution.org/HEZ/Health-Enterprise-Zone.asp

[31] Transforming Neighborhoods Initiative (TNI). *Prince George's County Maryland, County Executive*. http://www.princegeorgescountymd.gov/sites/ExecutiveBranch/CommunityEngagement/TransformingNeighborhoods/Pages/default.aspx

## Key Informant Recommendations

### Organizational and Provider Level Recommendations

- **Expand and integrate behavioral health services, recruit additional provider staff**. Perhaps the most common recommendation among interviewees was to expand behavioral health services and provider availability in the County. Examples of suggested direct program services included Thinking for Change, Men's Trauma Recovery and Empowerment Model, Targeted Case Management under Medicaid for homeless people with behavioral health needs, long-term treatment programs, outpatient mental health with daycare, enhanced crisis programs, inpatient beds, tele-psychiatry and telemedicine, mobile services, and treatment for co-occurring disorders. Examples of service providers to target for recruitment included licensed support staff members/case managers to identify and coordinate services to patients and families, including in-home delivered services, housing, access to primary care, and enrollment in benefits programs. Several interviewees specifically suggested further developing behavioral health care in school settings. This would integrate behavioral health therapy and referrals to treatment of mental health and substance use disorders with traditional school-based health services (e.g., immunization, medication management). One example involves wellness and education services delivered by a social worker or trained teachers, counselors, and coaches in schools to address behavioral and physical health issues together. Interviewees stressed the importance of developing evidence-based practices and focusing on quality of care in order to help alleviate school system concerns about liability, which is a potential barrier to expanding services to students.
- **Develop hospital discharge and transition support services for behavioral health patients**. Interviewees explained that referral services should ensure that a patient is connected to care. Given high rates of hospital and emergency room utilization, it was recommended that hospitals improve discharge and transition support services for behavioral health patients and families. However, interviewees did acknowledge that behavioral health provider and service shortages in the County create difficulties for hospitals in identifying appropriate places to refer patients.

### Behavioral Health Systems Level Recommendations

- **"No wrong door" point of entry into the behavioral health system**. Interviewees recommended structural changes so that any point of entry into the behavioral health system would lead to effective assessment, referral, and care coordination. A key feature of this system would be using a warm hand-off referral method, especially between primary care, hospital and emergency room care, and behavioral health care providers. The concept of "no wrong door" was consistent with suggestions by interviewees regarding inter-organizational care management and coordination models. For example, detailed descriptions of such approaches were given for homeless individuals who have behavioral health needs. An interviewee recommended developing a care management and coordination system in which a collaboration of agencies serving homeless individuals would alert a case manager when a homeless individual with behavioral health needs has an encounter with law enforcement, a homeless shelter, an emergency room, the child welfare system, or a foster care office. In this model, the case

manager could collaborate and confer with various individuals across agencies to devise an appropriate plan of care to be stored and shared electronically. This would serve as a kind of integrated health and social services medical home.

- **Create incentives to attract clinics and providers to the County**. Interviewees commonly recommended that Prince George's County develop incentives to attract behavioral health providers and services to the County, especially those serving Medicaid and the uninsured. For example, interviewees called for actions leading to higher participation rates in Medicaid behavioral health services, particularly given increased enrollment under Medicaid expansion in Maryland and the transition from block grant funding to fee-for-service payments for addiction services.
- **Improve training and capacity to engage with individuals who have behavioral health needs**. Increased training was recommended for people frequently engaging with individuals who have behavioral health issues, including teachers, school administrators, and professionals in the justice system. It was suggested that training focus on properly identifying behavioral health problems and connecting individuals and families to care. Notably, a model was described for improved capacity to address behavioral health within the police department, such as the Crisis Intervention Treatment (CIT) model. Key features included additional training, additional staff dedicated to behavioral health issues, and additional funding to pursue a shift from reacting to emergency calls to front-end prevention strategies. These strategies would draw on community policing techniques and include locating sources of repeat calls related to individuals with behavioral health issues, regular visits to high-risk locations to help reduce behavioral health-related incidents, and coordination with the health department, social services, and other providers.
- **Increase housing placements and subsidies for individuals with behavioral health needs**. Increasing the availability of short-term and long-term affordable housing options and improving access through greater funding for housing subsidies for individuals with behavioral health needs were listed as key recommendations. Such housing should be flexible to include residents in recovery, who are not yet fully clean and sober, and should provide onsite support services or linkages to community-based services. Additionally, effective housing programs should be linked and coordinated with landlords to ensure that tenant rules are followed, and that interventions occur immediately to prevent or respond to incidents among individuals with behavioral health needs.
- **Develop monitoring, outcome measurement, quality assurance, and data sharing strategies**. Various interviewees recommended that the County adopt monitoring, outcome measurement, quality assurance, and data-sharing approaches to be incorporated into the behavioral health system. Specific suggestions included strategies that capture fidelity to evidence-based programs, patient outcomes following hospital discharge, outcomes for patients that discontinue participation in behavioral health services prior to completion, as well as metrics and measures of access and service use. An interviewee suggested modifying contractual language with providers and vendors with explicit and improved requirements for monitoring and reporting. Other suggestions focused on fully developing information-sharing capabilities

within the County by leveraging health information technology infrastructure, such as the Health Department's electronic health record system and the Chesapeake Regional Information System for our Patients (CRISP). Given proper functionality and interoperability, the Health Department and other providers could more easily document and share patient information, which could improve care coordination.

### *Findings: Consumer Focus Group*

Four key themes emerged during the consumer focus group. These themes touched on quality and accessibility of behavioral health care, satisfaction with care, and consumer support and advocacy services. Each theme is discussed in detail below.

**Provider shortages in certain regions of the County and the use of behavioral health and other services outside of the County**. Through both our extensive interviews and our focus groups, we learned that consumers residing in the southern region of the County emphasized a lack of behavioral health and other services, in their community. Available services listed in the region include hospital care, through MedStar Southern Maryland Hospital Center, and medical care, through Greater Baden Medical Services, a group of seven clinical sites and three Women, Infant, and Children (WIC) locations in Prince George's County, Charles County, and St. Mary's County.

Consumers reported clear gaps in residential and outpatient behavioral health services. Additionally, a lack of peer support services was noted as a key gap to social support and connectedness. Compounding this issue is the lack of transportation services necessary to travel to care locations outside the southern region of the County. Consumers reported a lack of public train and bus services, and the need to travel long distances using personal vehicles to access services in the northern region of the County, particularly Bowie and Largo, as well as to services outside of the County, particularly Baltimore County, Charles County, Washington DC, and Northern Virginia. Numerous consumers do not have a car of their own, or their car is in need of serious repairs that they cannot afford. These individuals depend on family or friends to drive them to appointments, and report that this can be very challenging.

Consumers also reported a lack of psychiatric services in the County that meet their individual needs. One consumer has a preference to receive care from an African-American psychiatrist, but could only identify one practicing in Silver Spring. Another consumer discussed the importance of the patient-provider relationship, and explained that it was necessary to switch insurance to access a larger pool of providers. After trying several providers, this consumer selected a psychiatrist practicing in Washington, DC. As a result, the consumer has to overcome the ongoing challenge of getting to appointments with the psychiatrist, due to the lack of transportation in the southern region of the County, where the consumer resides.

**Poor quality hospital services for behavioral health patients**. Consumers consistently reported low-quality hospital services for behavioral health care in the County. Consumers admitted to County hospitals with behavioral health conditions described common experiences of feeling "warehoused" with minimal consultations from psychiatrists, social workers, or other care providers. Consumers also reported being "overmedicated," and given games such as word puzzles to be kept occupied for

extended durations of time. Furthermore, consumers indicated the lack of adequate transition planning and continuity with community-based care, and linkage to needed community resources following discharge.

**Mixed feedback on the quality of behavioral health and related services provided by community-based organizations and public agencies**. Both parents and consumers in our focus groups shared both favorable and unfavorable opinions of the quality of behavioral health care and related services in the County. Of course, it is worth reiterating that our focus groups were small, and caution to not to draw definitive conclusions from them. They provided a window into the thinking of County residents with experience in the Prince George's County behavioral health system, but we do not claim that the opinions and suggestions that were shared in these focus groups reflect the views of large numbers of patients and parents. That said, many of the unfavorable opinions were shared with regard to vocational services delivered through the state. Consumers seeking assistance through vocational services noted significant difficulty finding jobs, in some cases after several years of receiving services. Explanations for this pattern included high demand for vocational services, low attention to their needs from staff members, and inappropriate job placements and trainings. Notably, based on their experiences and interaction with staff, some consumers suggested that services are prioritized for individuals with physical disabilities, and individuals with behavioral health conditions are perceived as less in need of support, and their cases are given less attention.

Additionally, consumers remarked about the lack of sensitivity and understanding among police to properly identify behavioral health issues and to refer/transport an individual with behavioral health needs to the appropriate care site. They acknowledged that police are trained to arrest and detain, while the more appropriate course of action is often diversion to inpatient or outpatient treatment in behavioral health cases. Consumers shared favorable opinions/experiences related to several community-based care providers. One consumer indicated greater ease accessing services because of transportation assistance. One consumer described the improvement in their health after their referral to behavioral health care followed proper assessment and treatment from a primary care clinic. One consumer noted satisfaction with an organization providing transportation support, in-home delivery of certain behavioral health services, and responsiveness of medical staff to adjust medication dosages.

**Importance of consumer advocacy services for providing resources, supports, and connections for consumers affected by behavioral health issues**. Consumers frequently remarked about the benefits of consumer advocacy services, especially regarding peer-to-peer support services, family support services, and advocacy services. Consumers report that certain organizations do well in connecting and advocating on behalf of consumers and families affected by behavioral health issues. The organization acts as a forum for sharing experiences, issues, and concerns and a mechanism for pursuing multi-level solutions on behalf of consumers and families, such as the National Alliance on Mental Illness in Prince George's County.

### *Findings: Family Member Focus Group*

Five key themes emerged during the family member focus group. These themes touched on behavioral health barriers and facilitating factors related to insurance, quality and accessibility of care, satisfaction with care, and family support services. Each theme is discussed in detail below.

**Difficulty accessing behavioral healthcare services due to lack of providers, few linkages to care, and insurance coverage limitations**. Family members emphasized the lack of behavioral healthcare services and effective linkages to care, especially from hospital to community. Additionally, provider participation in insurance was cited as a pivotal factor for accessing behavioral health care. Family members described several situations in which the type of insurance dictated their child's access to care and the amount of services received. In some cases, families reported that Medicaid-only provider organizations denied services to their privately insured children. Certain behavioral health support professionals, recognizing this restriction, encouraged family members to help their adult children drop private coverage and enroll in Medicaid in order to access services. This was most commonly reported for community-based behavioral health services, particularly inpatient residential treatment. Conversely, family members with private insurance coverage reported greater access and lengths of stay for inpatient hospital services. While the typical length of stay reported for mental health-related admissions was a few days, those with private insurance reported extended stays upwards of 18 days.

**Poor quality hospital services for behavioral health patients**. Perhaps the greatest consensus among family members was the poor quality of hospital-delivered care within the County. Several family members reported long wait times for emergency department assessment and intake services. One family member reported a lack of training and awareness of mental health issues among hospital security, resulting in a violent assault to restrain the family member's child, which continued even after their child was restrained (witnessed by the family member). Family members strongly agreed that their children were "overmedicated during their hospital stay." Short hospital stays were cited as a key contributor to overmedication, meaning that hospital providers were not able to determine appropriate medication dosages over an admission period of about two days. Some family members also indicated a lack of hospital discharge/transition services for coordination of care with community-based behavioral health providers. Family members noted that, as informal caregivers, they are essentially the key individuals who identify and coordinate behavioral health, physical health, social, vocational, and other services on behalf of their children.

**Behavioral health services utilization outside of the County**. Several families reported formal referrals and self-directed seeking of behavioral health services, particularly for inpatient and intensive outpatient care, from providers and organizations located outside of the County. Families cited several locations for these services including Montgomery County, Baltimore County, Frederick, and Washington DC. For example, success stories were shared by families whose children received co-occurring treatment in Rockville. Families also noted the disadvantages of behavioral health services utilization outside of the County. For example, one family member shared a story of a child who relinquished Maryland residence and became homeless in order to receive shelter services in Washington DC.

**Mixed feedback on the quality of behavioral health and related services provided by community-based organizations and public agencies**. Family members reported both positive and negative experiences with various community-based behavioral health service providers. Overall, the most commonly noted negative aspect of working with certain organizations was the lack of responsiveness to family member communications/concerns and, in some cases, resistance by organizations to fully involve family members in their child's treatment and recovery. These issues were widely reported despite family members acting in a formal role on behalf of their children, for example, serving as "power of attorney" and/or "payee representative" for Medicaid services. Providers' (including hospitals') failure to recognize families' formal role was consistently noted. Family members listed various challenges working with certain organizations, such as inaccessible/unresponsive staff members, including leadership, inadequate amount of counseling services, lack of coordination with other service providers, and lack of long-term planning.

There was a general sentiment that there are not sufficient accountability mechanisms in place to ensure organizations deliver a certain level and quality of care. Specifically, several noted the lack of appropriate medication monitoring. As a result, family members reported they must periodically take their child to other providers in order to monitor and adjust their medication, as needed. Similar challenges were expressed among family members working with vocational services provided by the state. Family members expressed difficulties being included in vocational services delivered to their children as well as improper assessment and job placements. Conversely, family members expressed positive experiences with certain other organizations including an appropriate amount of therapist, physician, and case worker services as well as being included in the treatment and recovery process.

**Importance of consumer advocacy organizations' initiatives in providing resources, supports, and connections for families affected by behavioral health issues**. Family members praised the work of these organizations, including NAMI in Prince George's County. They consider them to be a critical resource for informal caregivers of individuals with behavioral health needs. Family members cited classes connecting families affected by behavioral health issues for information sharing and social support as a key facilitator. Family members also cited the advocacy role of these organizations to address inadequacies among care providers in the County.

### 1.3.3 Provider Inventory and Workforce Capacity

At the state level, the Office of Workforce Development and Training leads the effort to build provider capacity and improve the quality of care delivery. The Office is tasked with designing and delivering training and education to meet the varied needs of substance use and mental health professionals across Maryland and to provide high quality continuing education. The State is assisted by the University of Maryland Training Center (formerly the Mental Health Services Training Collaborative) and the Institute for Innovation and Implementation, which provides training and technical assistance in implementing effective systems and practices to meet the needs of children with complex behavioral health conditions. At the County level, each Core Service Agency is tasked with promoting professional development of behavioral health providers based on the unique needs of their respective population.

Access to mental health and substance use services is inextricably linked to provider availability. The adequacy of behavioral health provider availability must be considered in light of demand; as the number of Medicaid enrollees has increased due to Medicaid expansion,[32] so too has the demand for somatic and behavioral health services.[33] This section will discuss behavioral health provider workforce issues in the County, including provider distribution, capacity, and state-level actions that may impact the future supply of high-quality behavioral health providers.

### *Methodology*

The purpose of the provider inventory is to capture behavioral health, mental health, and substance abuse and addiction treatment providers and key community resources in Prince George's County and surrounding areas.

The base of the inventory list is the SAMHSA Behavioral Health Treatment Services Locator, from which we pulled data in May 2015. We used a 25-mile radius around Upper Marlboro, MD, which is the seat of the County and approximately the center of the County. Twenty-five miles grabs the entire County, as well as every other adjoining County, including the District of Columbia and Montgomery. Facilities listed include eligible mental health treatment facilities, eligible substance use and addiction treatment facilities, and "health care centers".

We then added providers and organizations from other sources, including:

- Behavioral health provider listings from a Prince George's County Government website;
- FY 2015 Prince George's County CSA Funded Programs List;
- FY 2015 Program Monitor List;
- List of TNI schools with behavioral health counselors provided by Stephen Liggett-Creel, Chief of Staff, Prince George's County Department of Social Services;
- Interviews conducted by HMA; and
- A limited number of providers were also listed in the Maryland Psychological Association Membership Directory, Psychology Today Therapy Directory of Psychiatrists, and the Maryland BHA RecoveryNet Directory.

Determining provider capacity is challenging. Although there are state and federal data on the number of psychiatric beds, number of licensed or certified behavioral health practitioners, number of outpatient mental health centers, and FQHCs, the data do not provide a complete picture of service availability. Medicaid rate reductions may reduce the number of providers; some providers who are licensed to practice independently are instead working in related social service fields and not part of the public delivery system.

Although provider capacity largely relies on proxy measures such as total number of Medicaid-enrolled behavioral health providers, even then we do not know if such providers are accepting new patients. For

[32] Milligan, C. FY 2015 Medicaid Budget. *Maryland Department of Health and Mental Hygiene, Office of Health Care Financing*. https://mmcp.dhmh.maryland.gov/Documents/MMAC%20Budget%20Handout%20Pt%201%20Feb%2014.pdf

[33] Dickson, V. (2014). Reform Update: Flood of New Patients Worries Mental Health Workers. *Modern Healthcare*. http://www.modernhealthcare.com/article/20140812/NEWS/308129964

example, a 2014 report from the Mental Health Association of Maryland (MHAMD) assessed the accuracy and adequacy of psychiatric providers for Qualified Health Plans sold through the Maryland Health Connection. MHAMD found that "only 14 percent of the 1,154 psychiatrists listed were accepting new patients and available for an appointment within 45 days. Researchers spent six months calling multiple numbers for the listed providers to find that 57 percent of the 1,154 psychiatrists were unreachable – many because of nonworking numbers or because the doctor no longer practiced at the listed location."[34] The report observes that "[as] the number of newly insured continues to grow, wait times will increase, and individuals may forgo care or resort to paying high out-of-pocket costs to access critical care outside their insurance network if they have the means to do so."[35]

### *Distribution*

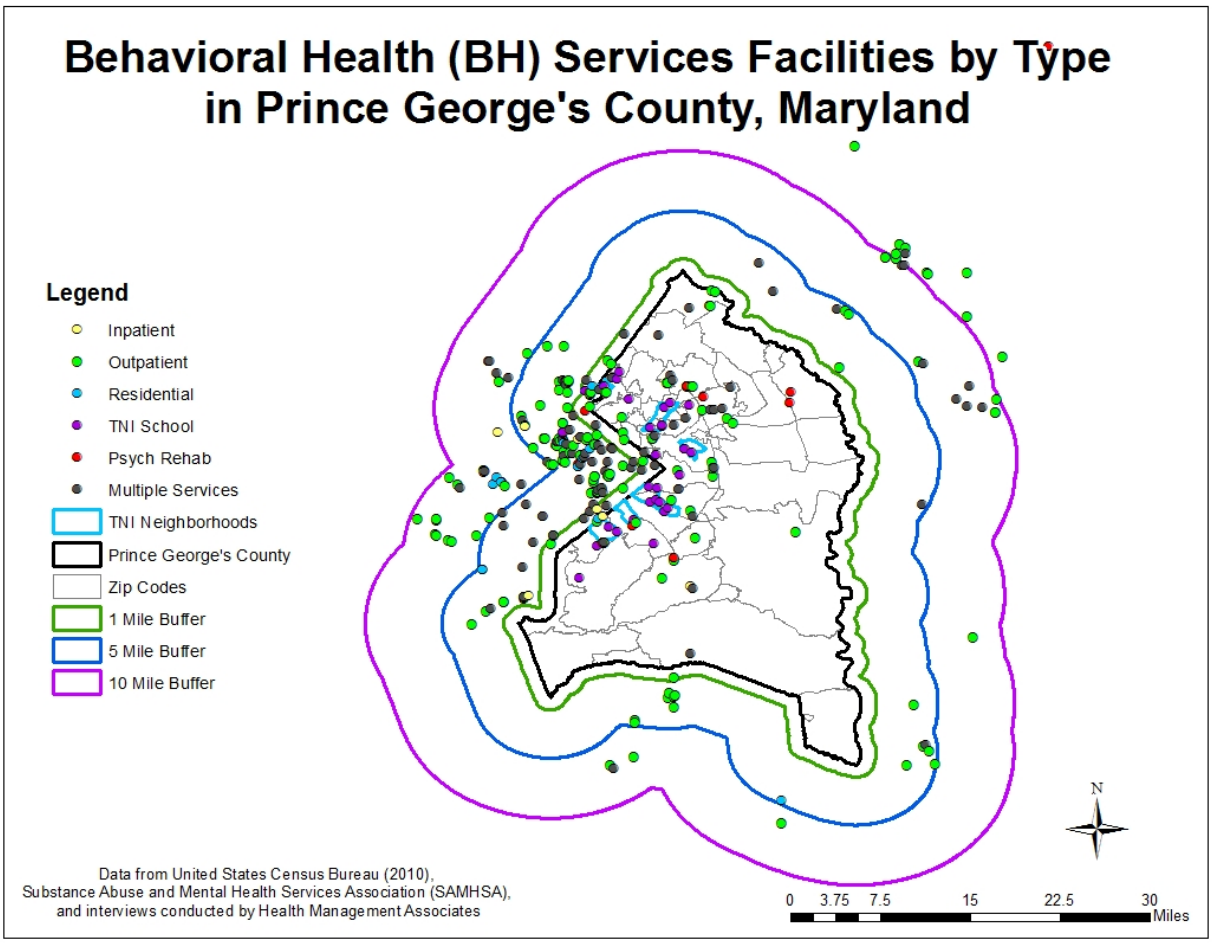
HMA conducted a review of the distribution of mental health and substance abuse providers in the County and adjacent areas as part of the needs assessment and gap analysis. As can be seen in Map 1, the majority of providers are clustered in the western part of Prince George's County, near its border with the District of Columbia, while the southern and eastern western parts of the County have fewer providers and facilities. This aligns with the County's overall demographic characteristics, presented above, which noted that County residents living within the Washington Beltway have higher rates of poverty and lower levels of education attainment than those in the southern part of the County.[36] The black line in the map below represents the County border; it is important to note that many of the service providers for County residents are not located in the County itself, but rather in Washington, D.C.

[34] Access to Psychiatrists in 2014 Qualified Health Plans: A Study of Network Accuracy and Adequacy Performed from June 2014 – November 2014. (2015). *Mental Health Association of Maryland*. https://www.mhamd.org/wp-content/uploads/2014/01/2014-QHP-Psychiatric-Network-Adequacy-Report.pdf

[35] *Ibid.*

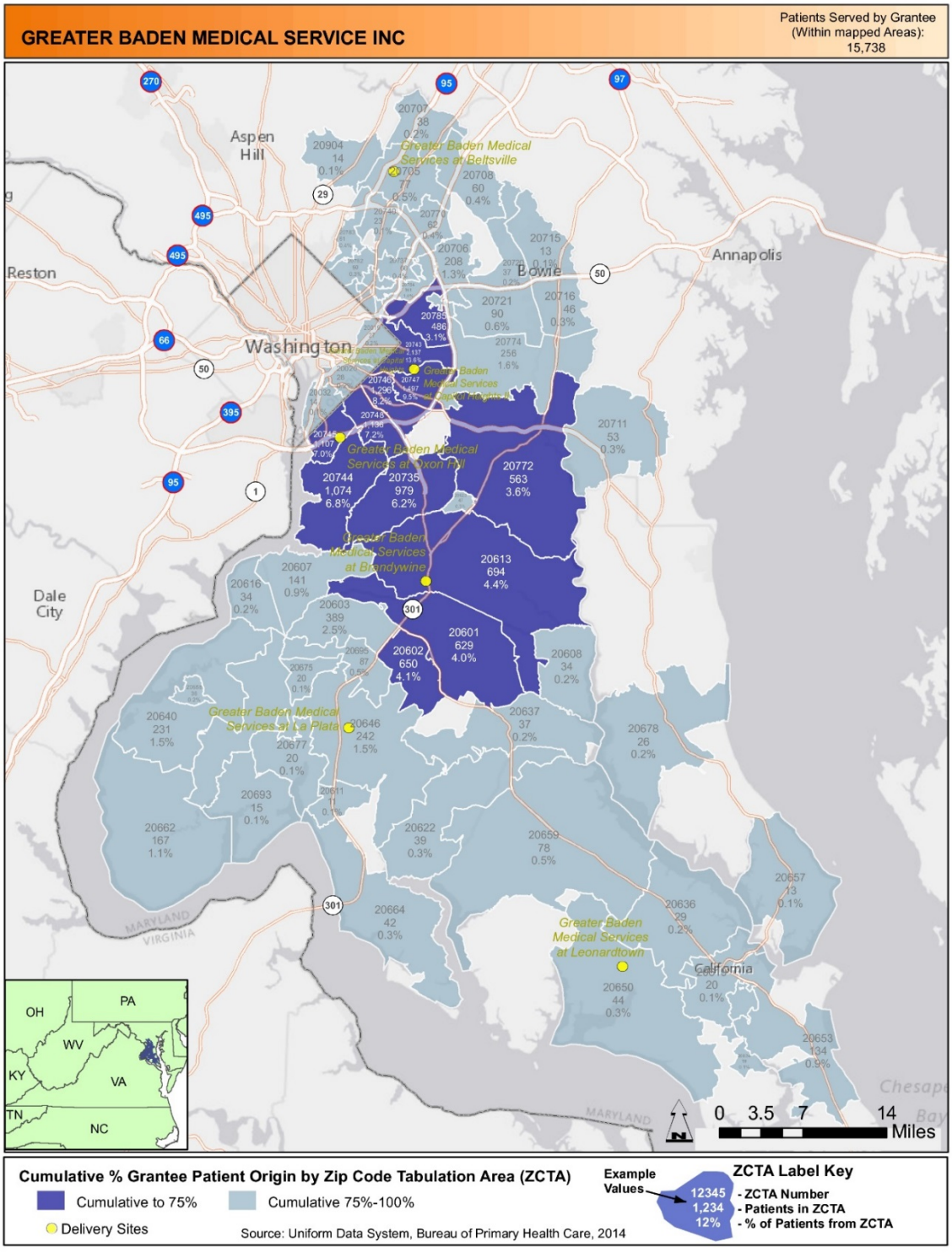
[36] American Community Survey (ACS). (2013). *United States Census Bureau.* https://www.census.gov/programs-surveys/acs/

*Map 1: Behavioral Health (BH) Services Facilities by Type in Prince George's County, Maryland*




An example of one safety net provider's patient population distribution is depicted below. The darker blue areas of the map below cumulatively represent 75 percent of Greater Baden's patient population; one can see the majority is drawn from zip codes near the Washington DC border where poverty is higher. The remaining 25 percent of patients, indicated in light blue, are drawn from other areas of the counties and the surrounding counties, including Montgomery (portions of 20904), Anne Arundel (portions of 20711), Calvert (20678 and 20657), and St. Mary's (20636, 20619, 20650, 20664, 20659, 20637, 20646, 20677, 20693, 20662, 20640, 20675, and 20616).

### *Map 2: Residence of Patients Using Health Services from Greater Baden Health Services*




Source: Uniform Data Systems, Bureau of Primary Health Care, 2014

*Findings*

As of May 2015, there were approximately 294 behavioral health providers listed in the SAMHSA Behavioral Health Treatment Services Locator within a 25 mile radius of Upper Marlboro, the County seat.[37] This radius captures providers within the entire County, as well as providers in adjoining areas (such as the District of Columbia and Montgomery County, MD), that could potentially provide services to County residents. Although the SAMHSA database includes eligible mental health treatment and substance use and addiction treatment facilities,[38] it does not include individual private practice mental health professionals, or those in small group practice who are not licensed or certified as a mental health clinic or (community) mental health center. [39] As can be seen in Table 5, almost all of the providers and facilities in the SAMHSA database within this 25-mile radius serve youth and adults, and more than half serve children. Additionally, most are private for-profit or non-profit organizations, and almost all of them accept Medicaid.

***Table 5. Snapshot of Mental Health and Substance Abuse Treatment Providers within 25-mile radius of Upper Marlboro (Based on SAMHSA data, May 2015) (N is approximately 294)***

| | |
|---|---|
| **Populations Served** | • 282 serve young adults<br>• 279 serve adults<br>• 170 serve children |
| **Ownership Type** | • 171 are private for-profit or non-profit organizations<br>• 91 are public/government organizations<br>• 85 are U.S. Department of Veterans Affairs organizations |
| **Services Provided** | • 188 provide Substance Abuse treatment services<br>• 186 provide Mental Health treatment services |
| **SED / SMI** | • 140 treat adults with serious mental illness (SMI)<br>• 106 treat children with serious emotional disturbance (SED) |
| **Payers Accepted** | • 263 accept cash or self-payment<br>• 245 accept Medicaid<br>• 212 accept private insurance<br>• 167 accept Medicare<br>• 147 have a sliding fee scale (based on income and other factors)<br>• 145 accept military insurance (e.g., TRICARE)<br>• 108 provide payment assistance |

[37] Figure is approximate because some providers or facility locations are listed multiple times (e.g., a health center with a separate mobile health unit that treats patients in the community is counted in the database twice.)

[38] **Eligible mental health treatment facilities** in the SAMHSA database include: facilities funded by the state mental health agency or other state agency; facilities funded by the U.S. Department of Veterans Affairs; private facilities licensed by a state agency to provide mental health treatment services or that are accredited by a national treatment accreditation organization. **Eligible substance abuse/addiction treatment facilities** in the SAMHSA database must either be licensed/credited/approved to provide substance abuse treatment from the state substance abuse organization or a national treatment accreditation organization; have staff with specialized credentials to provide substance abuse treatment; or are authorized to bill third-party payers for substance abuse treatment services using an alcohol or drug client diagnosis. https://findtreatment.samhsa.gov/locator/about

[39] The SAMHSA databased **does not include** facilities whose primary or only focus is the provision of services to persons with Mental Retardation (MR), Developmental Disability (DD), or Traumatic Brain Injuries (TBI) or facilities that provide mental health or substance abuse treatment exclusively to persons who are incarcerated. https://findtreatment.samhsa.gov/locator/about

**Source:** Health Management Associates tabulations, based on SAMHSA data and other sources

In looking beyond the SAMHSA database at other sources (such as the Prince George's County Government's listing of Behavioral and Mental Health Providers on its website, and the providers named during HMA interviews with key local stakeholders), the total number grew to more than 400 providers of key services.[40] Of these, approximately 164 were within Prince George's County itself. The cities and towns with the most behavioral health providers were Hyattsville, Lanham, Capitol Heights, Clinton, Laurel and Upper Marlboro.

Qualitative findings gleaned from key informant interviews and focus groups related to provider and system capacity may be found in the preceding section.

### *Workforce Adequacy*

Previous studies have shown that there is a need for additional behavioral health providers in Prince George's County. A 2012 report noted the county-wide need for behavioral health providers; despite the widespread need, the availability of and access to providers across the county varies by zip code. In particular, zip codes inside the Beltway (where the population is denser, lower-income, and less educated) have a lower supply per resident than those outside the Beltway. This same study found that "the supply of health care providers for Prince George's County is far below that of other jurisdictions, and for the state as a whole".[41]

***Table 6: Ratio of Providers to Population: Prince George's County Compared to State***

| Ratio of Provider Per 100,000 Population | | | | |
|---|---|---|---|---|
| **Jurisdiction** | Social Worker | Counselor | Psychologist | Psychiatrist |
| **Prince George's** | 45.9 | 42.2 | 13.2 | 3.6 |
| **Maryland** | 99.23 | 68.76 | 40.37 | 11.8 |

**Source:** Transforming Health in Prince George's County, Maryland: A Public Health Impact Study (2012)

A more recent study conducted in 2014 found that there was one mental health provider per 1,483 population and one primary care provider per 1,804 population in Prince George's County.[42] A 2013 Maryland Health Access Assessment Tool found that there was only one mental health safety net for every 3,214 uninsured county residents.[43] Due to the lack of primary care providers, the County has federally-designated Health Professional Shortage Areas in zip codes bordering the District of Columbia as well as in the southeast portion of the County.[44] Access not only to behavioral health care, but also to primary care in Prince George's County, will be critical as the number of consumers with co-occurring disorders continues to rise.

[40] Note that this inventory of providers was not intended to be exhaustive and includes only a limited number of private practices.
[41] Transforming Health in Prince George's County, Maryland: A Public Health Impact Study. (2012). *University of Maryland School of Public Health*.
[42] Prince George's County: Primary Healthcare Strategic Plan. (2015). *John Snow, Inc.*
[43] Maryland Health Access Assessment Tool: Prince George's County Profile. (2013). http://hsia.dhmh.maryland.gov/opca/Access%20to%20Care/PrinceGeorge040813c.pdf
[44] HRSA data warehouse, accessed 8/13/15. http://datawarehouse.hrsa.gov/

*Accreditation*

Provider qualifications and quality assurance play an important role in provider supply and capacity. Evidence-based programs such as Assertive Community Treatment demand low consumer-to-staff ratios. At present, behavioral health programs are licensed or approved by the Behavioral Health Administration and Office of Health Quality. Existing ADAA and MHA community program regulations will likely be repealed in 2016. Nearly all programs will be required to achieve accreditation and obtain a license under the new BHA integrated regulations, which will take effect in 2017 or 2018. While accreditation is likely to improve the overall quality of care, it requires a significant financial commitment by organizations, which may impact the supply of small community-based providers.

From a review of provider inventory data, the County's capacity to provide behavioral health care, particularly outpatient services, is limited. The southern and southeastern regions of the County lack access to primary and preventive care. In the absence of reliable community-based care, residents rely upon the emergency and crisis systems for treatment. The northwestern region of the County enjoys a greater number of care providers, but it also has the greatest population density, highest rates of poverty, and lowest levels of education. The County has a low Medicaid penetration rate, but only a single Federally Qualified Health Center (FQHC), Greater Baden, is available as a safety-net provider.

The County has several options for expanding its delivery system capacity, including improving its Medicaid penetration rate, infrastructure improvements, creating regional partnerships with neighboring county providers to share limited resources, and developing behavioral health career pipeline at County schools and with higher education institutions. Relying on the expertise and advice of the Behavioral Health Advisory Group will be critical to recruiting and retaining behavioral health providers and to connecting with primary care providers. Collaboration between somatic and behavioral health providers will be critical to improving the County's population health while maximizing limited treatment capacity.

# Section 2: Assessment of Current Behavioral Health Service Infrastructure, Policies and Monitoring

## 2.1 Behavioral Health Service Utilization in Prince George's County

The primary purpose of this section is to review the current service utilization in Prince George's County and to identify opportunities for their Behavioral Health Division to most efficiently and effectively serve residents, particularly in light of increased demand for services resulting from the ACA. This section is primarily focused on Medicaid and uses County-level prevalence data found in Section 1 to provide officials with a high-level view of current and projected service demand and related expenditures to assist them in future planning efforts. Particular attention is paid to population subsets with unique needs (e.g., transition-aged youth) or individuals with long-term, high-cost use patterns.

Our charge was not only to analyze the behavioral health system as it is and make recommendations, but also to assist the County in developing strategies to most effectively leverage existing resources to enhance fiscal sustainability, and produce better health and social outcomes. In reviewing utilization

patterns, we aim to present a data-driven portrait of system successes and challenges. There are opportunities to build upon those successes and to improve performance, even in the current fiscal environment.

Brief recommendations are presented below and will be expanded upon in the Recommendations Section. Briefly, the County must take a more proactive stance in monitoring ongoing behavioral health service delivery as a system, and not merely as independent service lines. Proactive planning and management will require the County to pivot from a passive stance to a more active engagement of areas that are largely under its control. The County will need to pivot slowly and deliberately, to avoid staff burnout and to use early improvements to bolster staff and stakeholder confidence.

### 2.1.1 Current Review Methods

Health care delivery systems increasingly use quality and utilization measures to assess and improve care. Prince George's County Core Service Agency (CSA) receives MARF0004 Total System Expenditures by Service Group, Coverage Type and Age Group and MARF5120 Expenditures and Consumer Count by Dual Diagnosis and Outcome Measurement System (OMS) Point in Time Observations from ValueOptions (VO), the Administrative Services Organization. Among the limitations of these data is a lag between utilization and payment, as providers have up to one year to submit claims to VO from the date of service. A further limitation is that the claims data are Medicaid-only. As noted, the County has the lowest Medicaid penetration rate in the state at 7.2 percent. Although an estimated 21 percent of County residents are eligible for Medicaid, a disproportionate number are unenrolled, suggesting if more individuals were to take advantage of the entitlement and become eligible for Medicaid, the County would experience a shift in utilization data, as Medicaid beneficiaries "use the emergency department at an almost two-fold higher rate than the privately insured" and "about 12.5 percent of all ED visits across payers are due to mental health and/or substance use condition treatment needs"[45].

The CSA analyzes claims data and reports its findings in an annual plan, and this annual plan is shared with the Maryland Behavioral Health Administration. In comparison to other CSAs, the annual report is neither available for public download on the CSA's website, nor are any of the findings contained within the report made readily available to the public. While utilization data may be shared with stakeholders and providers, it does not appear that there is a regular and routine review of utilization data apart from the annual plan.

### 2.1.2 Utilization Trends

The County saw a 9.1 percent increase in the number of consumers served from FY13 to FY14. This increase is in line with state trends, and with the decrease in the uninsured, as more individuals enroll in Medicaid or in a qualified health plan sold on the Maryland Health Connection.

Outpatient services comprise the majority of Medicaid expenditures, accounting for 35.1 percent of FY2014 expenditures overall in the County, compared to 39.6 percent statewide. However, when one looks at the utilization data at a more granular level, some worrisome trends emerge: 67.1 percent of

[45] Reducing Nonurgent Use of Emergency Departments and Improving Appropriate Care in Appropriate Settings. (2014). *Department of Health & Human Services, Centers for Medicare & Medicaid Services*. http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-01-16-14.pdf

adult consumers used some outpatient service in FY2014. While only 16.1 percent of adults – less than one in five – used a rehabilitative service (10.7 percent in psychiatric rehabilitation programs [PRP] and 5.4 percent in residential rehabilitation programs [RRP]), these services accounted for over 40 percent of expenditures in FY2014 (39.9 percent for PRP and 3.9 percent for RRP). This reflects a 13.4 percent increase in the number of consumers receiving PRP services from FY12 to FY14. Nearly half of expenditures are being directed to programs that should augment clinical services. Although the growth in PRP is quite large, there is no indication that the County currently monitors individuals in PRP/RRP to ensure that they are also receiving appropriate clinical services that develop life skills and aim to prevent destabilizing events that lead to crises as part of a continuum of care for people with serious mental illness.

PRP and RRP services are not clinical in nature; they are rehabilitative and designed to "facilitate an individual's recovery, including the individual's ability to make decisions about the individual's life and create opportunities for choice" in various life domains such as school, work, and home (see COMAR 10.21.21.04). In contrast to other behavioral health services, PRP and RRP services are billed monthly using a cascade structure, which ranges from $186.88 for two visits per month for a consumer with relatively fewer needs to $3,642.29 for 23 visits per month for a high-need consumer in RRP. Each level of PRP service stipulates a minimum number of face-to-face services to be provided. In the event the provider does not meet the service level minimum encounters for the authorized level of service, but does meet the minimum encounters for a lower level of service, the provider will bill using the originally authorized modifier, but will "cascade" down to bill at the lower allowed charge. Although the range in reimbursement is quite wide, the County's utilization review does not include the number of consumers at each level of PRP (i.e., community living, supported living, general, intensive), the average length of authorization for consumers at each level, or a review of providers who consistently deliver only the minimum number of encounters to bill for PRP/RRP services. While RRP tends to be a long-term service for individuals with significant illness, PRP is designed as an ameliorative rehabilitative service. It is unclear which PRP consumers are also receiving concomitant clinical, case management, or health home services.

Monitoring continuing eligibility for services, including medical necessity, is the responsibility of ValueOptions. However, Core Service Agencies are also responsible for planning, managing, and monitoring publicly-funded mental health services.[46] The CSA can request data on consumers receiving PRP/RRP services from the ASO and work with them to create a monitoring plan. For example, the CSA could request data on consumers with paid claims at the H2018 U3 or U4 level who received only the minimum number of encounters. The CSA could cross-match PRP/RRP data against individuals who frequently use mobile crisis, the emergency department, and/or have inpatient admissions. If individuals are using costly RRP services and still experiencing frequent crises or destabilizing incidents, the CSA could facilitate a warm hand-off to a health home or case management service. As the state moves to value-based purchasing of health services – already underway in the All Payer Global Budget Model for hospitals – localities and providers must become more comfortable with data, including cost-benefit analyses. High-cost services such as PRP will need to demonstrate their value to ongoing recovery, asbeginning to evaluate program effectiveness now will prepare the County for ongoing delivery system reform.

[46] Md. Health Gen. § 10-1201

Although case management services in the County increased substantially from 22 consumers (one child/adolescent, 22 adults) in FY2013 to 46 (three children/adolescents, 43 adults) in FY2014, as the County executed contracts with two new providers, Volunteers of America-Chesapeake, Inc. and Alek's House, to enhance the accessibility and quality of this service, considering the large population in the County, it is a small number. This followed a decline in case management enrollment from FY2012 to 2013; case management services are designed for consumers who are at risk of, or need services to prevent, inpatient treatment, homelessness, and/or incarceration. The accessibility and quality of case management services in the County are critical to ensuring consumers are served in the least restrictive setting and to managing the use of high-cost services, especially by individuals who are high-utilizers, and to avoiding the need for repeated intervention by crisis service providers.

Despite the laudable increase, case management appears to be underutilized, with less than one percent of persons served by the public system receiving the service, compared to 2.7 percent statewide. Case management is critically important to managing and coordinating the services and supports for individuals who have co-occurring mental illness and substance use disorder. Without case management, individuals must navigate a system of care where mental health and substance use services are not often integrated, and offered by different providers who do not obtain consent of the consumer to develop a single and unified care plan. Case management services can provide necessary support and efforts to engage the individual in person-centered, recovery-oriented, and more effective and efficient care, potentially achieving improved outcomes. Although less than 20 percent of consumers served by the public system have co-occurring disorders, they represent slightly more than a third of total expenditures. Of the total expenditures, consumers with co-occurring disorders accounted for nearly half of residential treatment expenditures and more than a third of inpatient care.

As the state has integrated behavioral health, more Medicaid-reimbursable services will be available. Specifically, Medicaid reimbursement for services that were almost exclusively grant-funded, such as those for substance use disorders, relieves some of the fiscal pressure, but also means providers must contend with a combination of service rules and the claims process. Behavioral health services at the state level are driven by Medicaid: recent growth in community mental health services is almost exclusively in the Medicaid-eligible category (11 percent between FY 2009 and 2013), with the non-Medicaid population *falling* by 8 percent during same time period.[47] Over $8 million in state general funds was withdrawn from the FY15 Behavioral Health Administration budget; the "reduction is justified based on an assumption that previously State-funded services will be available now to individuals who will be enrolled in Medicaid under the ACA expansion."[48]

Prince George's County must better position itself to effectively and efficiently serve residents *without* grant funds. Improving the County Medicaid penetration rate will make it possible to deliver more "upstream" early identification and intervention services to individuals. An emphasis on early intervention could enhance provider awareness of the opportunities they have to prevent poor

[47] Operating Budget Data. (2014). *Behavioral Health Administration, Department of Health and Mental Hygiene*. http://mgaleg.maryland.gov/pubs/budgetfiscal/2015fy-budget-docs-operating-M00L-DHMH-Behavioral-Health-Administration.pdf
[48] *Ibid.*

"downstream" outcomes, while improving the overall cost-effectiveness of care. The County must carefully monitor and coordinate with providers to avoid unnecessary utilization of high-cost services, especially treatment in a private psychiatric or treatment facility for adults 22-64 in facilities of 16 or more beds, which is not eligible for Medicaid reimbursement under the Institution for Mental Diseases (IMD) federal prohibition. Medicaid has maintained that this is a state responsibility. As we discuss later in the report, we recommend the County access and analyze the service utilization data for mental health and substance use disorder services that ValueOptions collects as the Administrative Services Organization for the State. Such analysis will support the County as it reviews the numbers of people in intensive and facility-based services, and provide greater understanding of the potential to shorten lengths of stay and/or avoid unnecessary inpatient hospitalization as community-based services become more available.

The largest single award from the County is for crisis services, at $1.112 million. Crisis services provide timely clinical assessment and intervention to individuals experiencing a crisis, which frequently can be addressed in the community, by offering supports and services to meet the individual's needs, and diverting the person from accessing an unnecessary hospitalization and/or emergency rooms visit. In FY2014, there were 1,252 mobile crisis dispatches in the County. The County set a target of 315 uninsured or Medicaid-ineligible individuals to receive emergency psychiatric services; it exceeded that target, serving 333. A count of persons who are uninsured versus ineligible would assist the County in determining if it is serving Medicaid-eligible individuals who are unenrolled, individuals who are eligible for subsidized coverage on the state health exchange, or those ineligible for coverage because of income or citizenship status. Given the low Medicaid penetration rate in the County, it is possible that some Medicaid-eligible individuals served by crisis response could be better served by establishing a relationship with a community provider. There is no indication as to what percentage of individuals are repeat users of crisis response year-over-year. Such data would be useful in assessing a consumer's ability to access community-based care and consumers that may benefit from an intermediate level of care (i.e., above outpatient therapy but below inpatient treatment).

### 2.1.3 Policy and Legislation

*State Agencies*

Behavioral health services are governed by several Maryland state agencies. The Division of Health Care Financing at the Department develops and oversees all policies relating to the public financing of somatic and behavioral health care, including covered services, individual and provider eligibility, and provider enrollment; its regulations can be found in COMAR 10.09 et seq. As of 2015, Maryland Medicaid is also the contract monitor for the ASO, a change from previous years when MHA oversaw the ASO's compliance. BHA is responsible for drafting regulations related to the overall administration of behavioral health services, including clinical and utilization standards.

Chapter 460 of the 2014 Laws of Maryland[49] required the Department to convene a stakeholder workgroup to make recommendations on issues related to behavioral health, including statutory and regulatory changes necessary to fully integrate mental health and SUD treatment and recovery support. The workgroup met seven times in 2014 and submitted a report to the General Assembly in December

[49] H.B. 1510, Chapter 460. (2014). http://mgaleg.maryland.gov/2014RS/chapters_noln/Ch_460_hb1510E.pdf

2014. Among other changes, existing ADAA and MHA community program regulations will likely be repealed in 2016. Nearly all programs will be required to achieve accreditation and obtain a license under the new BHA integrated regulations, which will take effect in 2017 or 2018. Draft regulations are available on the Behavioral Health Administration's website.[50] Accreditation introduces new quality requirements for programs, while preserving state resources by freeing the Behavioral Health Administration and Office of Health Care Quality from conducting site visits and verifying staff credentials. Programs seeking licensure will also have to collaborate and enter into a written agreement with their respective CSA, LAA, or Local Behavioral Health Authority. The collaboration agreement could include the provision of granular utilization data by providers to the local authority.

### *Local Control*

In 1986, the Robert Wood Johnson Foundation provided $29 million in grants over five years to nine cities, including Baltimore, to consolidate the administrative, fiscal, and clinical responsibility for mental health in a single authority.[51] Following that grant, MHA developed a network of Core Service Agencies (CSA) who were charged with planning and managing the local mental health system. Initially, the CSA managed the outpatient services provided by local health departments (LHDs), as well as administrative functions. In 1997, when the HealthChoice waiver was implemented, many LHDs stopped providing direct services, as they lacked administrative capacity to bill Medicaid for services that were now reimbursable on a fee-for-service basis. Today, less than half of the LHDs offer mental health outpatient services, and nearly half of those offer outpatient services on a very limited basis to a limited population.[52]

In parallel to the development of CSA, Local Addictions Authorities (LAA) were developed. Similar to CSAs, LAAs were charged with the planning and management of local programs. As with CSAs, LAAs serve as a point of entry to the behavioral health system and a resource for consumers and families. In 2013, the 19 CSAs responded to over 12,000 calls per month, spending an average of 7.25 minutes on each call.[53] The Prince George's County CSA assisted 8,148 callers in FY14, a seven percent drop in the number of calls received from FY 2013.[54]

Both LAAs and CSAs work with many partners, such as local management boards, children and family-serving agencies, public safety, and recovery-oriented, consumer-led groups. Despite the merger of MHA and ADAA into a single behavioral health agency, the State has not mandated that CSAs and LAAs integrate, preferring instead to let local jurisdictions decide on the pace and measure of integration in response to local community needs. As with many other local jurisdictions, Prince George's County has

[50] Behavioral Health Integration Stakeholder Workgroup. *Maryland Department of Health and Mental Hygiene*. http://dhmh.maryland.gov/bhd/SitePages/Behavioral%20Health%20Integration%20Stakeholder%20Workgroup.aspx

[51] Goldman, H.H., Morrissey, J.P., Ridgely, M.S., Rank, R.G., Newman, S.J., Kennedy, C. (1992). Lessons from the Program on Chronic Mental Illness, *Health Affairs*, 11(3), p. 51-68. http://content.healthaffairs.org/content/11/3/51.full.pdf

[52] JCR behavioral health 2014

[53] System Structure. (2015). *Maryland Association of Core Service Agencies*. http://www.marylandbehavioralhealth.org/system-structure

[54] Fiscal Year 2014 Annual Report & Fiscal Year 2016 Annual Plan. (2015). *Prince George's County Health Department, Behavioral Health Services, Core Service Agency*.

moved to integrate mental health and SUD by relocating the CSA from the Department of Family Services to the Health Department, under the Behavioral Health Services Division.

## 2.2 Effectiveness of Behavioral Health Measures

### 2.2.1 Assessment of Measures Used

Few outcome measures are in use at the County level. The Behavioral Health Administration (BHA) maintains the Outcomes Measures Systems (OMS), an online "DataMart" that tracks how individuals who are receiving outpatient mental health services are faring across several life domains, including school, work, housing, functioning, legal system involvement, and general health. BHA also maintains the Statewide Maryland Automated Tracking System (SMART) to which all Maryland Department of Health and Mental Hygiene certified or Joint Commission on Accreditation of Healthcare Organization accredited alcohol and drug abuse treatment programs are required to report. SMART includes data on treatment, intervention, and prevention programs across the State for substance use conditions, including populations served, initial and repeat admissions, demographic data, source of referral, etc.

Apart from OMS, there are performance and outcome measures specific to health homes. Those measures include: the percentage of adolescent and adult members with new episodes of alcohol or other drug dependence with initiation and engagement of treatment; percentage of members 18 and older who remain on antidepressants following a new episode of major depression; and percentage of health home members who had outpatient visits, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner who received follow-up within seven and within 30 days of inpatient discharge.

Maryland's State Health Improvement Process (SHIP) includes three measures related to behavioral health: the rate of emergency department visits related to mental health per 100,000 population; the suicide rate per 100,000 population; and the rate of emergency department visits related to substance use per 100,000 population. Prince George's County has the lowest county rate of emergency department visits for mental health, reflecting the County emphasis on crisis services. However, Prince George's County has the lowest percentage of County residents who reported they had a personal doctor or health care provider. With a rate of 73.5 percent, it is likely due to a combination of factors including a low Medicaid penetration rate and a dearth of providers in the southern half of the County.

### 2.2.2 Recommendations for Improvement

Performance improvement within the delivery system must be aligned with the ultimate goal of realizing healthier communities through a broad focus on population health. Leveraging identified and standardized measures, based on a process of tracking and monitoring measures, and anchored in an overall quality improvement program, offers the County the capability to report on the measures regularly. Prince George's County has many effective measurement tools at its disposal, including utilization data from ValueOptions. In addition to ValueOptions' MARF data report as described at the beginning of this section, the County can request specific utilization reports. Accessing what is already available at the State and County level is a cost-effective, less administratively burdensome, and easily available approach to use utilization and performance data on an ongoing basis to monitor progress on

strategic priorities. Leveraging ValueOptions and partner data systems provides Prince George's County with immediate and long-term information which the County can use to report on the results of programs and initiatives and create greater transparency.

Partnership with the Local Health Improvement Coalition (LHIC)[55] can also enhance behavioral health data collection and service delivery and would strengthen the County's relationship with providers and stakeholders. In 2011, Maryland launched the SHIP. SHIP was initiated to provide a framework for local action and engagement to advance the health of all Maryland residents; at a local level, this is implemented by LHICs. LHICs choose public health goals based on the needs of their community, and include partners from LHDs, hospitals, clinics, academic institutions, faith-based organizations, schools, and consumers.

In Harford County, the LHIC identified behavioral health as one of its three priorities; specifically, the LHIC wanted to further the integration of mental health and substance use services at the local level.[56] The County focused on four low-income, high-risk areas, similar to the way Prince George's County has focused on the Health Enterprise Zone. Harford County set three S.M.A.R.T goals – specific, measureable, actionable/assignable, realistic, and time-specific. For example, the number of individuals enrolled in care coordination and the number of individuals who accessed behavioral health services during the calendar year. The County used a LHD nurse as a care connector and leveraged the existing resources of Medicaid and the health connector to transition individuals into care.

Even the most data-driven CSA will be frustrated if there are too many layers between the unit of analysis and the authority to effect change. To that end, the County Behavioral Health Division should look to measure and improve outcomes in areas which are largely or substantially under its control. Early improvements bolster confidence to assume larger projects and more effectively support consumers and families in their recovery.

The County should use its Behavioral Health Work Group (BHWG) and LHIC to ready providers for accreditation. Accrediting bodies such as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the Commission on Accreditation of Rehabilitation Facilities (CARF) include performance measurement and management standards, such as using inter-rater reliability assessments to ensure its data collection system is reliable, and includes efficiency measures such as service delivery cost per unit and consumer satisfaction measures.

Apart from local efforts and accreditation standards, Prince George's BHWG may want to see which of the measures collected by ValueOptions or community partners align with the Atlas of Integrated Behavioral Health Care Quality Measures from the Agency for Healthcare Research and Quality, to the extent possible.

[55] http://www.princegeorgescountymd.gov/sites/Health/PGCHI/Coalitions/Pages/default.aspx Prince George's Healthcare Action Coalition.
[56] Kelly, S. and Moy, R. (2014). Harford County Local Health Improvement Coalition Update. *Harford County Health Department*. http://dhmh.maryland.gov/mchrc/Documents/LHICs/Harford%20LHIC%20Statewide%20Annual%20Meeting%2011.12.14.ppt

### 2.2.3 Behavioral Health Work Group

Prince George's County has established a large Behavioral Health Work Group (BHWG) with broad representation drawn from the local communities and stakeholders, including members from the University of Maryland, the Health Department, the State Attorney's office, sister County agencies, provider groups, social services, the school system, advocacy organizations, and faith-based communities. The larger group formed nine committees, each with an identified leader and action that is matched to a goal on the Behavioral Health Strategic Plan. The creation of the BHWG has been very well-received as an approach to developing ongoing engagement and inclusion of the Health Department with its potential partners and establishment of shared priorities. The joint planning and sharing of information is creating improved communication and opportunity for regular reporting on progress associated with initiatives. The addition of an inter-agency task force or work group, which includes agencies such as Family Services, Social Services, Justice, Housing, Health Department, and Law Enforcement, would further strengthen and broaden the effectiveness of the Behavioral Health Work Group, and add another dimension of collaboration across the County.

The strategic plan is a thoughtful document with six overarching goals, each with a strategy. Many of the strategies are assigned to the Health Officer, Pamela Creekmur, or to Elana Belon-Butler, or Christine Waddler, each of whom are employed by the Health Department. To avoid overtaxing any one individual, the BHWG should look to use the resources of the LHIC in implementing each of the strategies needed to accomplish one or more of the goals. While the goals are visionary, the Behavioral Health Work Group is likely to benefit from narrowing its scope. A goal to "identify the population at risk for mental health and substance use disorders, the services currently available, and the barriers and gaps" is overly broad and may be too high-level for assignability. Breaking the goal into actionable steps would allow for a clear identification of the necessary actions and changes and greater likelihood of achievement of the goal.

The County can leverage existing resources such as the University of Maryland's 2012 Public Health Impact Study,[57] Dimension Healthcare System's Community Health Needs Assessment,[58] BRFSS, and YRBS data to expedite development of a comprehensive behavioral health needs assessment (CBHNA). Once the CBHNA is complete, strategies and goals should be S.M.A.R.T. (specific, measureable, actionable/assignable, realistic, and time-specific), and the indicators for those goals should, where possible, include a numerator and denominator (e.g., numerator: number of persons admitted into outpatient substance use disorder treatment within seven days from the date of first contact; denominator: number of persons admitted into outpatient substance use disorder treatment). The strategies and goals should be developed in conjunction with stakeholders, and prioritized to develop an

[57]Transforming Health in Prince George's County, Maryland: A Public Health Impact Study. (2012). *University of Maryland School of Public Health*. http://www.princegeorgescountymd.gov/sites/CountyCouncil/Services/BoardHealth/Documents/SPH_ImpactStudy_fullreport.pdf

[58] Community Health Needs Assessment: Prince George's Hospital Center. (2013). *Dimensions Healthcare System*. http://www.dimensionshealth.org/wp-content/uploads/2013/07/FINAL-PGHC-CHNA-REPORT.2013.pdf

actionable plan that can be phased in with realistic and achievable timeframes, based on measures and ongoing monitoring and reporting of progress.

### 2.2.4 Opportunities for Collaboration

*Current partnerships*

Prince George's County has several strong partnerships within the Health Department and with community agencies. The Health Department divisions collaborate to serve women and children (e.g., Healthy Start) to identify potentially eligible Medicaid clients and streamline their entry into the public insurance system. The County also has Maryland LAUNCH, which is designed to coordinate key child-serving systems and integrate somatic and behavioral health services. This project is of particular importance, as the County saw a 15.8 percent increase in the number of children aged 0-5 served from FY13 to FY14.

The County also maintains strong partnerships with crisis services providers, the Department of Corrections, the Commission for Veterans, the Department of Social Services, the Mental Health Association of Prince George's County, the National Alliance for the Mentally Ill, and On Our Own. As substance use disorder services transition from primarily grant-funded to Medicaid-reimbursed, the County should look to the Maryland Association of Core Service Agencies, BHA, and ValueOptions as collaborators who can offer technical assistance and training on best practices for Medicaid billing.

*Opportunities for new or more effective partnerships and collaboration*

As the County looks to make existing partnerships more effective and initiate new collaborations, it should look to data to inform opportunities, where possible. For example, the County has a significant number of adults and children receiving costly PRP services, but relatively few of those PRPs have become health homes – Family Services, Inc., People Encouraging People, Psychotherapeutic Services, and Vesta[59] – only one of which serves children or adolescents. The County provided $224,048 in funding in FY2015 to support a transition age youth (TAY) with families programs to "provide psychiatric rehabilitation services to transitional age youth with families… [services] include housing assistance, childcare, mentoring and linkage to services".[60] The program is designed to serve six family units headed by a parent 16-23 who has mental illness. Although the intent of the TAY program is laudable, health homes must provide care management and coordination, health promotion, transitional care, individual and family support, and referral to community and social supports. It is unclear what portion of funds went to support non-reimbursable services such as housing, as opposed to services that can be reimbursed through a behavioral health home. If the County had more child-serving health home providers, transition-aged youth may have already been served by a PRP health home and be receiving

[59] Approved Health Home Sites. (2015). *Maryland Department of Health and Mental Hygiene*. http://dhmh.maryland.gov/bhd/Documents/APPROVED%20HEALTH%20HOME%20SITES%206.8.15.pdf

[60] Fiscal Year 2014 Annual Report & Fiscal Year 2016 Annual Plan. (2015). *Prince George's County Health Department, Behavioral Health Services, Core Service Agency.*

coordination services. Ensuring that youth with high needs are enrolled in all services for which they are eligible allows the county to stretch its limited grant dollars.

Prince George's County Public Schools has a partnership with the University of Maryland's Center for School Mental Health (CSMH) to provide individual and group therapy, crisis intervention, family engagement, and case management activities.[61] The Health Department may want to consider leveraging the resources in Project LAUNCH to identify students who are likely to need continued services in the school setting, and with ValueOptions to explore billing for school-based mental health services. The County has relatively few school-based health centers (four, and located only in high schools). Developing a partnership with the school district's chief of health policy to expand existing school-based services would align with Goal 3.0 to "develop a coordinated response to behavioral health issues across all sectors in the county government".

As the County evaluates its partnerships and ongoing collaborations, it should consider efficacy and efficiency. Prince George's County collaborated with the Department of Corrections to provide treatment and alternatives to incarceration for adult inmates diagnosed with mental illness and/or co-occurring substance abuse disorders. The treatment was delivered via a grant for a Trauma Addiction Mental Health and Recovery (TAMAR) program women, a jail mental health assessment, and a 2nd Chance Reentry Program. The TAMAR program served many fewer women than anticipated (target of 80, served 39). The reduction in women served could be a reflection of the overall reduced census at the detention center over the past two years, and/or that more female inmates are entering the detention center charged with more violent crimes, which makes participation more difficult. However, the 2nd Chance Reentry program exceeded its target, serving 485 individuals, 185 more than anticipated.

For FY2016, Prince George's County is requesting $70,800 for corrections programming and $56,000 for TAMAR. Those requests are identical to FY2015, despite the clear need for more capacity in 2nd Chance program and the lower cost-per-individual served in corrections programs (TAMAR $56,000/80 individuals served=$700 per person; Corrections $70,800/530 individuals=$133.58 per person). When considering its year-to-year budget requests, the County should consult partners in programs that have under- or over-performed in the previous fiscal year, and direct funds to areas of clear need identified by community partners.

## Section 3: Improving Access to Behavioral Health Services and Best Practices

This section has two objectives. First, we determine the key elements of providing timely access to behavioral health services. Second, we identify the best practices in treating people with mental illness and substance use disorders.

Two themes emerge in this section of the report. First, it is vital that residents of Prince George's County who have mental illness and/or substance use disorders obtain timely and affordable access to services. This involves ensuring that those eligible for public programs such as Medicaid and Maryland Health

[61] Prince George's School Mental Health Initiative. *University of Maryland School of Medicine.* http://csmh.umaryland.edu/SMHProgams/PGSMHI/PGSMHI.html

Connections, the State's ACA Marketplace, actually enroll in the programs and remain enrolled as long as they remain eligible. It also involves overcoming other barriers to access, such as helping people find a provider who will treat them, and ensuring that barriers related to housing, transportation, and other problems do not block access to behavioral health services.

Second, once people gain access to important services that they need, it is vital that those services are delivered in a way that follows evidence-based practices. We provide many examples of such practices in this section.

## 3.1 Key elements of providing timely access to behavioral health services

There are several key elements of access to behavioral health services. The starting point is with early detection of behavioral health problems.

### 3.1.1 Early detection

Just as such early detection is critically important to managing somatic diseases such as diabetes, asthma, hypertension, and heart disease, it is also crucial to the effective management of mental illness and substance use disorders (SUD).

Individuals with serious mental illness live from 10-20 fewer years than the general population without serious mental illness. This finding, reported in June 2014 by researchers at Oxford University, is based on 20 major studies covering 1.7 million people and 250,000 deaths.[62]

Many somatic health conditions provide warning signals that are frequently rather clear. For example, individuals who develop heart disease often experience such symptoms as shortness of breath in walking uphill, chest pains, and numbness in an arm. Primary care physicians routinely ask individuals they are seeing if they have experienced such symptoms, and if so, they are immediately sent to a cardiologist or in some cases, to the emergency department of a hospital.

In contrast, the symptoms of mental illness and substance use disorder can be more subtle, and frequently masked. People may also hide them from family, friends, and health care providers, out of stigma, embarrassment, or lack of awareness of organizations and providers who could be of assistance.

In addition to the difficulty of detecting a behavioral health problem, there is frequently a long lag between the onset of a behavioral health problem and the beginning of treatment. The median delay in initial treatment contact across an array of mental, emotional, and behavioral disorders (MEB) is *nearly a decade.* Ultimately, about 80 percent of people with a mental disorder seek treatment. The problem is the long delay at the front end, from onset to treatment.[63]

[62] Cheney, E., Goodwin, G.M., Fazel, S. (2014). Risk of All-Cause and Suicide Mortality in Mental Disorders: A Meta-Review. *Work Psychiatry*, 13(2), p. 153-160

[63] Wang PS, Berglund P, Olfson M, Pincus HA, Wells, KB, and Kessler R. Failure and delay in initial treatment contact after first onset of mental disorders in the National Comorbidity Survey Replication. *Arc Gen Psychiatry* 2005; 62(6):603.

### 3.1.2 Integrating primary care and behavioral health services

Primary care physicians and nurse practitioners can play a very important role in mitigating this problem. Although they may be knowledgeable about the symptoms of MEB, typically, the individuals they see in their practices will present somatic and physical health problems, and it takes careful probing and discussion to uncover what may be the signals of emotional and psychological distress. A challenge for primary care practitioners is that they operate under a rigid schedule and patient visits are brief, and should the practitioner identify behavioral health needs, he or she may not feel prepared to address the issues or have easy access to a behavioral health specialist. Primary care practices frequently express frustration with the lack of access to behavioral health providers in a timely manner. However, they also appreciate the stigma attached to seeking treatment for mental illness and substance use disorders and the preference for treatment within the primary care practice. In many cases, the primary care physician or nurse can help individuals directly, through prescribing medication as well as providing a referral for counseling. There is some controversy about primary care physicians being too quick to prescribe medication at a lower-than-effective dosage.[64] Also, because they may not have sufficient time to evaluate an individual's need fully, they may overlook their behavioral health problems, whether they be acute or of longer duration.

For primary care practices to identify behavioral health conditions in an effective and efficient manner, the addition of simple, valid, universal screening, and brief evidence-based interventions for those with mild to moderate behavioral health needs is essential. Screening tools for behavioral health conditions as well as medical conditions will improve early detection of depression, substance use disorders and other mental health conditions. For example the Patient Health Questionnaire (known as the PHQ-9) is based on a nine item depression scale, reflective of the diagnostic criteria for major depressive disorder. It provides a mechanism to evaluate an individual's overall depression severity and monitor improvement in symptoms with treatment. Some practices ask the first two questions of the PHQ-9 (PHQ-2), and if the response is affirmative, continue with all the questions.[65] Similarly the Screening, Brief Intervention, and Referral to Treatment (SBIRT) is an evidence-based practice to screen, identify, conduct a brief intervention as indicated to assist individuals at risk of substance use disorder (SUD) and who would benefit from education about modifying behaviors associated with SUD. A referral is made for individuals who need more extensive and specialized treatment for SUD.[66] The County could identify and recommend inclusion of a minimum set of tools such as the PHQ-2, PHQ-9 and SBIRT included in primary care practices, built into the practices' standard processes and reimbursed by Medicaid and other insurance plans.

The recognition of the necessity for access to effective behavioral health treatment is established. Roughly half of all lifetime mental disorders demonstrate onset by mid-adolescence and nearly three-

[64] Eisenberg, L. (1992). Treating depression and anxiety in primary care: Closing the gap between knowledge and practice, *New England Journal of Medicine*, 326(16), p.1080-1084.
[65] Li, M.M., Friedman, B., Conwell, Y., Fiscella, K. (2007). Validity of the Patient Health Questionnaire 2 (PGQ-2) in Identifying Major Depression in Older People, *Journal of the American Geriatric Society*, 55, p. 596-602.
[66] SBIRT: Screening, Brief Intervention, and Referral to Treatment. *SAMSHA-HRSA Center for Integrated Health Solutions*. http://www.integration.samhsa.gov/clinical-practice/sbirt

quarters by the mid-20s;[67] the median age of onset for major depressive disorder is 32.[68] The high prevalence of individuals with behavioral health conditions in primary care practices and the incidence of individuals with mild-moderate behavioral health conditions, combined with the reluctance of many individuals to seek assistance from a specialist, make a compelling statement for some providers to try out new arrangements.[69] Primary care practices are co-locating behavioral health clinicians within their sites, and similarly, behavioral health providers are co-locating primary care practitioners into their sites. These arrangements hold considerable promise for integrating somatic and behavioral health care. They also lead to more successful coordination and warm handoffs between primary care and behavioral health providers, and support early identification, collaboration, and ease of access to behavioral health services in the location most available to the individual in need. Successful organizations have merged their cultures and practices into a single organization, for clients and staff, anchored in workflows, shared processes and joint care planning and coordination.

They also attend to health and behavioral health screening, cross-training practitioners to assess level of care needs, development of a collaborative care infrastructure, and models for integrated care and cross-system consultation. Integration is supported by the electronic health record and other elements of information technology across primary care and behavioral health providers. The privacy provisions of the law are different between somatic and behavioral health care providers, and must be addressed in support of an integrated delivery system. Thus, although co-location should be seen as a key element, it is not the only element of a truly integrated delivery system.

## 3.2 Overcoming barriers to enrolling in and retaining insurance coverage

Enrollment in Medicaid, CHIP, and the health insurance marketplace (Maryland Health Connection) offers financial protection for people who need behavioral health services. As will be discussed below, although obtaining an insurance card is not a guarantee of access, it opens the door and is helping many people in Prince George's County gain access to affordable care.

### 3.2.1 The County benefits when people eligible for Medicaid actually enroll

Medicaid covers a wide range of behavioral health services. Beneficiaries do not have to contribute to the premium cost, there are no deductibles, and the co-payments for services are typically nominal. This largely removes the financial barrier to services, including mental health and substance use disorder services. As a result, individuals can afford to see therapists (assuming they can find ones that accept Medicaid), receive rehabilitation services, access the emergency room without significant charges, and receive inpatient care when it is needed, all with a very small or no cost contribution. Further, with Medicaid coverage, more people obtain primary care because it is affordable, and as noted above, that pathway can frequently lead the individuals to behavioral health providers.

[67] Kessler, R.C., Amminger, G.P., Aguilar-Gaxiola, S., Alonso, J., Lee, S., Ustun, T.B. (2007,) Age of Onset of Mental Disorders: A Review of Recent Literature. *Curr Opin Psychiatry,* 20(4), p. 359.
[68] Kessler, R.C., Berglund, P., et al. (2005). Lifetime Prevalence and Age-of-Onset Distributions of DSM-IV Disorders in the National Comorbidity Survey Replication, *Arc Gen Psychiatry,* 62(6), p. 593-602.
[69] Heath, B., Wise Romero, P., Reynolds, K. (2013). A Standard Framework for Levels of Integrated Healthcare. *SAMHSA-HRSA Center for Integrated Health Solutions*.

The County benefits in a number of ways when a person eligible for Medicaid enrolls in health care coverage, rather than remaining uninsured. One important benefit is that the hospitals in the County will experience less uncompensated care when Medicaid-eligible individuals actually enroll, and remain enrolled as long as they are eligible, rather than being dropped for reasons that have nothing to do with their actual eligibility. Physicians and other providers also experience less charity care and obtain some payment for their services, albeit at levels below those provided by other payers. This is particularly important since Disproportionate Share Hospital (DSH) payments are being reduced under ACA in light of Medicaid expansion reducing the need for DSH.

Further, when Medicaid opens the door to an array of services, downstream costs are avoided. Fewer behavioral health patients will go to the Emergency Department (ED), and fewer will be hospitalized, when Medicaid coverage enables people to get primary care, see therapists, obtain case management, receive psychiatric rehabilitation services including pre-hospitalization screening in the community, and benefit from crisis intervention. By paying for these services, Medicaid reduces hospital costs. In addition, access to such services may provide the needed interventions to support individuals, who without treatment, spend time in jails and prisons for misdemeanors; avoidance of this occurrence saves the County money. Other benefits could include fewer days of school missed for children, and less work missed for parents, as for example, when access to health and social services through Medicaid helps families manage their children's asthma, reducing unnecessary ED visits and inpatient spending.

In the FY 2014 Annual Report, the Prince George's County Core Services Agency (CSA) reports that 13,486 people were enrolled in Medicaid. Yet, CSA also reports that 188,176 people, or 21 percent of the County population, were eligible for Medicaid in FY 2014. *This means that the "Medicaid penetration rate" in Prince George's County was only 7.2 percent. This penetration rate is the lowest of any County in Maryland.*[70] The situation was actually better in 2014 than in 2013, due largely to the Medicaid expansion under ACA. The number of uninsured fell by 17.8 percent from 2013 to 2014, and Medicaid enrollment increased by 7.9 percent.[71]

CMS reports that as of June 30, 2015, 120,517 people in Maryland had "effectuated coverage" in the Maryland Health Connection, the State's health insurance marketplace. This means that they were fully paid up on their premium contribution and had an active health insurance policy. Of this group, 85,225 (70.7 percent) were receiving advanced premium tax credits (APTC), with an average value of $221 per month, and 60,200 were receiving cost sharing reduction (CSR) payments (50 percent).[72] However, we have learned that many people who are eligible for the Marketplace are not yet participating, while others enroll but then lose coverage by becoming more than 90 days late in making their premium contributions.

[70] Fiscal Year 2014 Annual Report & Fiscal Year 2016 Annual Plan. (2015). *Prince George's County Health Department, Behavioral Health Services, Core Service Agency.*
[71] *Ibid.*
[72] June 30, 2015 Effectuated Enrollment Snapshot. (2015). *Department of Health & Human Services, Centers for Medicare & Medicaid Services*.

### *Measures to increase enrollment*

The facts noted above make it clear that Prince George's County could be doing a better job of enrolling people who are eligible for Medicaid, and retaining them if they continue to be eligible. There is ample evidence on best practices in this area. A report by the Kaiser Commission on Medicaid and the Uninsured stresses the importance of the following strategies:

1. Providing accessible, welcoming, and family-friendly application and enrollment processes helps reduce enrollment barriers for families. Simplifying enrollment procedures, offering multiple enrollment avenues, eliminating face-to-face interviews, and reducing documentation requirements all contribute to higher Medicaid enrollment. The use of electronic data to verify information and automatically enroll people reduces the burden of paperwork.
2. One-to-one enrollment assistance provided by trusted individuals in the community works successfully. Thirty-five states have out-stationed eligibility workers to hospitals, clinics, schools and other locations. People who can walk a person through the application process are very helpful.
3. Facilitating renewals of coverage is important for continuous eligibility. Many adults and children across the country who remain eligible for Medicaid or CHIP are nonetheless dropped.
4. A combination of broad-based, community-wide, and targeted messaging is important to increasing enrollment for those eligible and not participating.[73]

*Prince George's County should review its application processes, media messaging, outreach/out-stationing processes, and eligibility determinations and re-determinations to make the best effort possible to enroll and retain those who are eligible for the major health programs.*

A study by Benjamin Sommers found that more than one of four (26.8 percent) of *all* uninsured children had been enrolled in Medicaid or CHIP the previous year: 21.7 percent in Medicaid and 5.1 percent in CHIP.[74] Among children who were *eligible but uninsured*, this study indicates that more than a third (35.5 percent) had been enrolled in Medicaid or CHIP during the prior year—28.6 percent in Medicaid and 6.9 percent in CHIP – and were still eligible but not enrolled.

Thirty-three states have adopted a twelve-month continuous eligibility for CHIP enrollees, while 23 states are using 12-month continuous eligibility for children in Medicaid. This means that there are no re-determinations during this one-year period even if family income changes. Maryland is not one of the states using 12-month eligibility for either program.[75] Only New York offers continuous 12-month eligibility for adults in Medicaid.

[73] Key Lessons from Medicaid and CHIP for Outreach and Enrollment Under the Affordable Care Act. (2013). *Kaiser Commission on Medicaid and the Uninsured*.

[74] Sommers, B.D. (2010). Enrolling Eligible Children in Medicaid and CHIP: A Research Update. *Health Affairs*, 29(7), p. 1350-1355

[75] Continuous Eligibility for Medicaid and CHIP Coverage. *Medicaid.gov*. http://www.medicaid.gov/medicaid-chip-program-information/by-topics/outreach-and-enrollment/continuous.html

One study found that 62 percent of Medicaid beneficiaries experienced at least one interruption in coverage during a four-year study period. Interruptions in coverage were associated with a higher risk of hospitalization for ambulatory care-sensitive conditions.[76]

Another promising strategy is Express Lane Eligibility, under which states use information and eligibility findings from other public benefit programs such as SNAP (food stamps), child care, or school meals programs—and from state tax forms—to facilitate an eligibility determination for children's health coverage.[77]

Prince George's County cannot by itself adopt all of these policies and processes; some will require working with the State. However, every effort should be made to turn the enrollment and re-determination policies away from burdensome requirements and toward "passive" enrollment and retention policies that use State data and modern information technology to do most of the work. If people are actually no longer eligible, then logicallythey should not continue receiving benefits. But the research shows that much more frequently, people remain eligible; they just miss notifications, fail to assemble the paperwork, and so forth. As a result, many lose coverage and a large number of those become and remain uninsured even though they are still eligible. This includes many people with behavioral health conditions.

ACA calls for navigators, in-person assisters, and certified application counselors. All states, even those choosing not to expand Medicaid, are eligible to receive an enhanced federal match (90 percent until December 2015) to develop new eligibility systems and a 75 percent match to operate and maintain those systems if they meet federal standards.[78] In our interviews, some noted that more work needs to be done in Maryland to connect people to the navigators, assisters, and application counselors.

### 3.2.2 Marketplace coverage

With regard to enrolling more people into the Maryland Health Connection, there are models that Prince George's County can learn about. First, safety net hospitals can play a role in reducing the cost-sharing obligations for people toward the lower end of the income scale in Maryland Health Connections (beyond the reductions that enrollees may obtain from Cost Sharing Reductions for those with incomes below 250 percent of the federal poverty line).

Many people who enroll in the Marketplace cannot afford their premium contributions. Some models of addressing this problem are emerging. For example, in Chicago, Cook County Health and Hospital System (CCHHS) is helping enrollees in the state-operated Marketplace with their deductibles. Particularly for enrollees who selected bronze plans in an effort to reduce their premium contribution, the deductibles can be very steep. CCHHS has implemented a program under which it pays a portion of

[76] Bindman, A.B, Chattopadhyay, A., Auerback, G.M. (2008). Interruptions in Medicaid Coverage and Risk for Hospitalization for Ambulatory Care-Sensitive Conditions. Annals of Internal Medicine, 149(12), p. 854-860

[77] Smith, V.K., Gifford, K., Ellis, E. (2010). Hoping for Economic Recovery, Preparing for Health Reform: A Look at Medicaid Spending, Coverage, and Policy Trends. *Kaiser Commission on Medicaid and the Uninsured*.

[78] Kristine Goodwin and Laura Tobler. Medicaid and Marketplace Outreach and Enrollment Options for States. NCSL. 2014. Goodwin, K., Tobler, L. (2014). Medicaid and Marketplace Outreach and Enrollment Options for States. *National Conference for State Legislatures*.

the deductible to lower-income enrollees on a sliding-scale basis related to income. In Dallas, where a Federally Facilitated Marketplace is being used in the state, Parkland Memorial Hospital, another large safety-net hospital system, is also operating a program that assists Marketplace enrollees with their cost-sharing obligations. In San Francisco, the Healthy San Francisco program is using city funds to assist Marketplace enrollees with cost-sharing.

Maximizing Marketplace coverage is also helpful to Prince George's County. As noted above, when individuals have a source of coverage, uncompensated care for hospitals and other providers is reduced. Many people working for small firms that are not required to contribute to health coverage under ACA are unable to afford buying coverage on their own. The cost of a family health coverage plan, for example, would require a family with the US median income to use about one-third of their income to buy coverage. By enrolling in the Maryland Health Connections, this type of insurance, people with moderate incomes could obtain private health insurance with substantially less than 10 percent of income spent on the premium contribution. As noted above, the Marketplace coverage will lead individuals to get their regular check-ups, immunizations, and health screenings. This will help prevent disease, manage disease when it occurs, and avoid late-stage diagnoses of diseases that can frequently be fatal. Avoiding or reducing such bad outcomes increases work place participation, reduces public benefits, and provides a cash flow from workers paying taxes, all of which benefits counties.

## 3.3 Translating enrollment into actual access to health services

While becoming and remaining insured is the critical first step in obtaining the behavioral health services that individuals need, it must be followed by a much stronger effort to ensure that these individuals can find the providers they need to help them. Both our extensive interviews and our focus groups drove home the point that many mental health providers do not accept Medicaid and in fact, many do not accept any insurance. So individuals would face a "pay now and file later" situation requiring up-front cash outlays that are frequently unaffordable. Even under this pay now and collect later scenario, the amount reimbursed by the plan for out-of-network use frequently will be much lower than the cost of the visit, leaving a substantial out-of-pocket commitment for the individual.

We learned that many individuals with mental health and/or substance use disorders go out of Prince George's county for services. This might involve residents in the southern part of the County going into Charles County, or residents throughout the County going into the District of Columbia. One person in our focus group drove all of the way from the southern part of Prince George's County to Georgetown in the District, where she had found a psychiatrist who she said "really got her problems" and was fabulous. Although he did not accept her Medicaid coverage, he worked out a sliding fee scale that was quite nominal. She reports using a church parking lot nearby for free parking. She had a car, while many people may not, and she was resourceful enough to find this physician who did not want to turn her away. But many others give up the search for a provider who will see them at an affordable cost.

*We recommend that the Health Department work with the Prince George's County Medical Society in Severna Park along with MedChi, the Maryland state medical society and the Maryland Psychiatric Society (MPS), as well as the other professional associations in the state including the Maryland Psychological Association, Maryland Chapter of the National Association of Social Workers, the Licensed*

*Clinical Professional Counselors of Maryland and the Nurse Practitioner Association of Maryland to develop an action campaign to get more behavioral health providers to agree to serve low- and moderate-income individuals who are enrolled in Medicaid or uninsured.*

In addition, the County needs more community health centers that include additional mental health services on site. As noted above, this can be done by having a behavioral health provider agree to be on site in the clinic certain days or certain hours. It can also involve situations such as Mary's Center in Adelphi, which does not have these services on-site, but is located within walking distance of a facility.

As stated earlier, another option is to co-locate a primary care physician at a behavioral health provider site. Individuals with serious mental illness, for example, may want to go to one site for care, and that will often be the behavioral health site. By placing a primary care physician and nurse practitioner at that site, these individuals can get the benefit of primary care without making another appointment at another site, which they frequently will not follow-up on. Such primary care physicians and clinicians can attend to their physical health needs, which may otherwise be neglected.

Another option is tele-psychiatry. Under this arrangement, an individual visiting a community health center can proceed to a room within that center where he or she can have a virtual visit with a psychiatrist or other behavioral health professional through teleconferencing, in a secure environment. This could lead to a direct follow-up with that provider.

## 3.4 Increase enrollment in County behavioral health programs

Prince George's County operates a large number of behavioral health services, including wellness and recovery services; trauma, addiction, mental health, and recovery; youth crisis hotlines; emergency psychiatric services, a Mental Health Court, residential rehab programs; a jail mental health program; mobile crisis stabilization; and initiatives to place homeless individuals into assisted housing units with wrap-around health and social services.

Although many of the continuum of care and programs are there, the number of people participating in treatment services seems low, in comparison to the needs. For example, data provided by the Core Services Agency, CSA, indicate that for FY 2015, a total of 169 people were served in the "On our Own" program over the course of a full year. In any given month, about 18-24 people were being served under this program.[79] QCI Behavioral Health's Outreach and Treatment Services reached on average about 12 people per month, for a total of 143 people for FY 2015. The Department of Corrections' Trauma, Addiction, Mental Health, and Recovery (TAMAR) program served a total of 68 people in FY 2015. In fact, the average daily census in this program has dropped from 100-110 in 2004 when the program began, to about 55 now. However, staff believes that some of this drop is actually an indication of the success of the jail diversion programs in the County, such as Mental Health Courts and Drug Courts. The Mental Health Court is discussed below.

[79] Briefly describe On our Own. Then: It should be noted that no enrollees were reported being served in the last two months of the fiscal year, possibly reflecting the fact that data is lagged and the number for the fiscal year would actually be a little higher if enrollees in those months had been included in the data.

People Encouraging People (PEP) serves about 100 people a month. This program uses the nationally recognized Assertive Community Treatment (ACT) program, which has a solid evidence base for successful performance. ACT incorporates wraparound services for individuals with serious and persistent mental illness, as well as those with co-occurring disorders. The main focus is on people who have had several hospital stays, and those who have been in jail more than once because of their mental illness, do not adhere to treatment, and those who are homeless (some people fit into more than one of these categories). The ACT team has a psychiatrist, vocational specialist, housing coordinator, peer counselor, nurse, licensed therapists, and substance use counselors. Team members provide face-to-face contacts and assessments as needed, and complete outreach to individuals who require additional efforts to maintain engagement. The Crownsville Project provides funds to subsidize housing for participants in this program (FY 2014 CSA Annual Report).

Villa Marla, an in-home intervention program for children, served 16 families during the year.

Other programs had much higher levels of people served. Affiliated Santé Group's Crisis Response System triaged 4,159 calls during the year and dispatched 1,201 mobile response teams. This Mobile Crisis Response initiative is considered a hospital diversion program. Individuals served are seen quickly, provided an evaluation and/or clinical interventions to stabilize the situation, and connected to community services. Such assistance may frequently help serve them outside of EDs and divert them from unnecessary inpatient admissions.

The Maryland Youth Crisis Hotline, run by Community Crisis Services, Inc., was serving about 1,200 to 1,400 youth a month. Although services are targeted for youth, the hotline staff will respond to individuals of any age who contact the hotline. Trained specialists respond to a range of concerns such as depression, loneliness, thoughts of suicide, separation or divorce, abuse, relationship problems, financial, or employment problems, gay and lesbian issues, and grief and death. The Specialists are trained to listen without judgment, respond to the individual and help the person find alternative and positive options including coping strategies, a safety plan, and other ways of addressing the identified issue(s). If it is determined the person is in danger, the Specialist will discuss how to seek emergency services.

While some of the programs are serving a significant number of people, and others a much smaller group, a comparison of the figures above to the number of children and adults discharged from an inpatient hospital may be an indicator of the disparity between need and treatment. Data from the H-CUP survey conducted by the Agency for Healthcare Research on Quality (AHRQ) shows that 20,199 children, youth, and adults were discharged during the year 2013 with either a primary or secondary behavioral health diagnosis (either mental illness and/or substance use disorder).[80] Of those discharges, 100 were children/youth between the ages of 0-17; 13,255 individuals were between the ages of 18-64 years old and 6,844 individuals were 65 years or older.

[80] Healthcare Cost and Utilization Project (HCUP). 2012. *U.S. Department of Health & Human Services, Agency for Healthcare Research and Quality.*

There are probably many others with behavioral health conditions who were not admitted to a hospital during the year, and the actual number of individuals in need of behavioral health services is likely to be substantially larger than 20,000.

Another indication of the need to bring programs and services to scale can be found in the area of housing and homelessness. There is a clear link between homelessness and poor health. People living on the street and/or in shelters are by the very nature of their situation (e.g. being exposed to the elements of weather such as heat waves and bitter cold) at risk of illness. Life on the street can also be highly dangerous in terms of the risk of assault. Shelters may heighten the risk of communicable diseases. Oral health is neglected, which can lead to dangerous infections.

Being homeless also greatly increases the risk that people with serious mental illness will either not get any medications, or will not refill them when they do. A $25 cost of a refill paid for by the County will be a lot less than the cost associated with homelessness and long-term unemployment. The list of risks to health is long.

According to one study of Prince George's County, in FY 2011, 1,932 persons of all ages who are homeless received housing assistance through emergency shelter, temporary motel placement, or shelter diversion services. *This number represented 33 percent of all households requesting assistance.*[81] Many people in the County are turned away from shelter requests. In one year, there were 6,008 individuals who made shelter requests, and 1,015 were served in emergency shelters. Another 629 were served in motels/shelter diversion. This left 4,364 who were turned away.[82]

The County developed a ten-year plan to address its housing crisis in 2012, and it would be useful to track the degree of success in meeting the long-term goals.

*The bottom line is that the need is much greater than the actual program participation. While no program will serve everyone in need, the gaps here between need and service appear to be large. This theme recurred regularly in our interviews. We recommend that a greater effort be made to identify more individuals requiring help, and conduct an extensive outreach to help them obtain the therapy, medications, and social supports they need.*

## 3.5 Directing more resources to prevention and community-based treatment

*Prince George's County should direct more resources into prevention and community-based treatment. The adult system is heavily focused on crisis intervention, is very facility-oriented, and rather weak on prevention and early intervention; in this sense, it is a microcosm of our health system generally. The exception within the County is Project LAUNCH. Through Project LAUNCH the County has been building an early childhood infrastructure, leveraging existing plans such as the Core Services Agency Annual Plan,*

[81] Non-Emergency Medical Transportation. *Maryland Department of Health and Mental Hygiene*. https://mmcp.dhmh.maryland.gov/communitysupport/sitepages/ambulance.aspx

[82] Ten Year Plan to Prevent and End Homelessness in Prince George's County 2012-2021. (2012). *Prince George's County Government, Office of the County Executive*. http://www.princegeorgescountymd.gov/sites/SocialServices/Resources/ResourcesGuide/Documents/HomelessnessPlan.pdf

*Health Action Plan and the Transforming Neighborhood Initiative (TNI) as well as meeting with stakeholders to identify resources and gaps.*[83]

The County seems to have a "downstream" system heavily concentrated on responding to and treating crises more than to avoiding them. An example is the lack of a community-based mental health clinic. Though the County seems to lack much accountability, performance and outcomes information, the crisis response and emergency systems do seem to function, and perhaps in some respects, function well. *But, again like much of health care, there is scant attention to, and resources devoted to, addressing the forces in the community and in people's lives that are driving individuals with mental illness and substance use disorders into the crisis system in the first place.*

*The County needs more substantial attempts and more resources devoted to getting out in front of behavioral health problems through prevention, early diagnosis, and community-based treatment.* A notable example of doing this involves the programs in TNI neighborhoods where therapists come into the schools (e.g. Suitland Elementary). As noted above in linking Project LAUNCH to TNI and the development of the early childhood infrastructure, the County is focused on promoting positive mental health, preventing mental health disorders and intervening early for young children and youth. *Such types of initiative should be brought to scale.*

A lot of families in the County are in crisis, and the onset frequently starts with a teenager with serious and untreated behavioral health problems. Such youth are frequently having trouble in school, using drugs, and perhaps have had one or more encounters with law enforcement. Although hotlines are important, *the County also needs more resources devoted to family preservation and family support to avoid and intervene earlier in crises.*

## 3.6 Greater coordination across service areas

Prince George's County has programs operated by many different agencies—the Health Department, the Department of Social Services, the Department of Family Services, the Sheriff's Department and the Police Department, the Mental Health Court and the regular juvenile and adult justice systems, the correctional system, and the Department of Housing. Many dedicated staff members are engaged in these programs. However, a key problem is insufficient coordination across the programs. Since many people are touching multiple programs and need an array of health and social services, closer linkages are needed.

The Behavioral Health Work Group is a good starting point, and the people we interviewed uniformly said that they found this Work Group to be useful and an asset to the County. *It should be continued. The County also needs an active inter-agency task force that meets regularly to coordinate multi-dimensional interventions for people with complex behavioral health needs.* Tapping into the existing Local Care Team (LCT), a group of representatives from child serving agencies and a parent advocate that meets bi-weekly, the County has the potential to strengthen and coordinate efforts for youth. The LCT, in collaboration with the lead agency, reviews and implements the plan of care for youth with

[83] Maryland LAUNCH: Environmental Scan Report, 2013.Department of Health and Mental Hygiene and Department of Family Services.

special or intensive needs such as a residential placement or alternative to residential placement due to behavioral, educational, developmental, or mental illness.[84] By linking with the LCT, the BHWG has the opportunity to align efforts, and understand youth needs, resources, and gaps.

Additionally, adults who may be homeless and living on the street and in shelters may not be getting the disability benefits they need for basic income support; does not have a car or health insurance; lack an awareness of community health centers that might serve them; have a criminal record that makes it very difficult to get a job, and in many cases, to get a supported apartment. These individuals may need drug and alcohol treatment, placement into the County's Housing First program that can land them in an apartment even though they are not clean and sober, provided the individuals agree to start treatment thereafter; complete a successful application for SNAP (Food Stamps) benefits; enroll in Medicaid; and connect with a therapist who will see them regularly.

*As the examples illustrate, addressing many individuals' needs through the available resources of sister agencies will require the active cooperation across agencies. Individuals need a care plan that includes both clinical and social supports. The County needs an interoperable data system that allows a case manager to coordinate the services of the several agencies that are needed to meet people's diverse needs. The findings of one agency need to be shared with others electronically, with confidentiality securely protected. Individuals need team-based care that might include a psychiatrist, a drug treatment provider, a social worker, a housing assistance specialist, and peer counseling.*

*Care plans for individuals need to be in a format that can be shared by all agencies across different electronic platforms. Open sharing of critical information is needed for all members of the care team.* These care team members should be able to communicate securely and in real time. When a crisis situation is impending, interagency communication and collaboration could avoid a downhill spiral. Agencies sharing information, such as a crisis counselor communicating with a drug treatment provider or psychiatrist, may avert a hospitalization, or an eviction from a housing unit.

Maryland already has the Maryland First Responders Interoperable Radio System Team (Maryland First). This is an interoperable 700 MHz radio communications system for state and local public safety agencies. Motorola Solutions was awarded a contract from the State in 2010 to design and install this system. It enables all of the police and fire department officers to communicate with each other and their counterparts in other jurisdictions or departments, not only during large-scale emergencies but also for basic daily operations.[85]

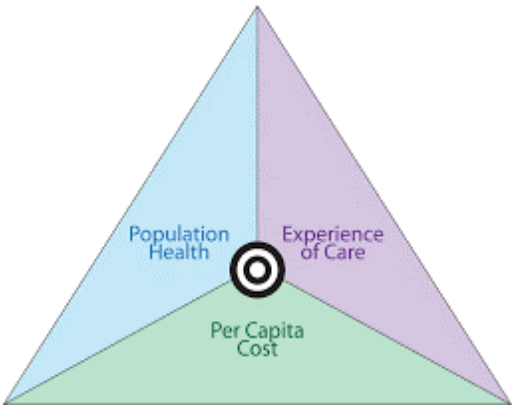
*Some of our interviewees suggested that this system could be used to connect people in various County agencies, including not only law enforcement, but those working with the homeless, family preservation, and social services, and this seems like a good place to start.*

[84] http://www.princegeorgescountymd.gov/sites/Family/Services/CFIC/ProgramsInitiatives
[85] Gov. O'Malley Makes First Call on Radio System Connecting Maryland's First Responders. (2012). *Motorola Solutions*. https://newsroom.motorolasolutions.com/news/gov-omalley-makes-first-call-on-radio-system-connecting-marylands-first-responders.htm

## 3.7 Optimizing Health System Performance

The Institute for Healthcare Improvement (IHI) developed the Triple Aim as a framework for constructing and optimizing health system performance. IHI believes that new designs and reforms must be developed to pursue three dimensions simultaneously:

- Improving the patient experience of care (including quality and satisfaction);
- Improving the health of populations;
- Reducing the per capita cost of health care.




States, Counties, health systems, and communities are quickly realizing that an integrated behavioral health strategy is essential to achieve the Triple Aim, and addressing behavioral health issues requires significant system changes to bring about meaningful improvement. The current healthcare landscape requires service provision to move toward greater integration, not just within the behavioral health system, but across the full continuum of care in a way that links behavioral and physical health care.

In 2011-2012, under the joint leadership of the Office of the County Executive, Prince George's County Board of Health and Prince George's County Health Department, the County engaged stakeholders and established a public and structured process to create a strategic plan to improve access to primary care for its residents. The plan was part of a larger effort and continuation of the County's evaluation and a RAND Report that highlighted the relatively poor health status of its residents, the lack of easily accessible primary care within the County, and the need for action. The County champions and is committed to launching a system that offers improved access to high-quality, patient-centered primary care, with the ultimate goal of improving the health status of the County residents and strengthening the local economy as a result. Within the strategic plan, the County identified seven overarching dimensions in its multipronged approach to improved access to primary care and health of its residents, in which the expansion of the behavioral health services system within the County plays a vital role.

## 3.8 Integration of Physical and Behavioral Health Services

Research findings, state and national public officials, and stakeholders have raised the alarm that there is a public health crisis for people with serious mental illness (schizophrenia, other psychoses, bipolar disorder and severe depression) as they experience higher rates of chronic medical conditions (diabetes, obesity, cardiovascular disease and hypertension) and more than twice the rate of premature death resulting from these conditions.[86] Many people with behavioral health conditions find that living with

[86] Kelly, D.L., Boggs, D.L., Conley, R.R. (2007). Reaching for Wellness in Schizophrenia. *Psychiatric Clinics of North America*, 30(3), p. 453-479.
Mauer, B. (2006). Behavioral Health/Primary Care Integration: The Four Quadrant Model and Evidence Based Practices. *The National Council for Behavioral Healthcare*.
Parks, J., Swendsen, D., Singer, P., Foti, M., eds. (2006). Morbidity and Mortality in People with Serious Mental Illness. *National Association of State Mental Health Program Directors.*

these co-morbidities has a negative impact on their quality of life and overall behavioral health, and can lead to additional functional impairment.[87] There are many reasons for the higher incidence of chronic medical conditions in people with serious mental illness, including limited enthusiasm to seek primary health care, side effects related to psychotropic medications, smoking, poor nutrition and limited exercise, and fears about visiting primary care providers.[88]

As discussed previously within the health care system, there needs to be a focus on 1) increased access to affordable health insurance for more individuals; 2) recognition of the importance of coordination and integration efforts within the health care system to address fragmented delivery systems that are difficult to navigate, particularly for individuals with complex needs; and 3) enhancing the role of primary care in detection and treatment for many adults with behavioral health conditions and pediatricians for children, youth, and families with mental health conditions.

In recognizing serious mental illnesses that affect many Americans, the ability to receive early treatment can result in a positive response, intervene in the severity of functional distress, and head off needless pain to the individual and family. For many in distress, the obvious person to contact is his or her primary care physician or provider, or pediatrician, if a parent is concerned about his or her child. Frequently, the individual does not feel well, and/or the child is demonstrating behavior that is of concern, and the assumption is that there is an underlying physical issue, and the natural point of entry is the primary care/pediatric health provider. Although the problem may be psychological, the person does not identify it as such.[89] A direct call to behavioral health is unlikely, as he or she may be unaware of available behavioral health providers and organizations, and/or because of the stigma associated with seeking behavioral health treatment creates a barrier to self-referral.

In the IOM Report, "Improving the Quality of Health Care for Mental and Substance Use Conditions," the authors identified a number of recommendations that link the importance of improvements in the overall health care system to advances in the behavioral health of all Americans. The IOM's recommendations identify a collective responsibility for implementation of a broad range of initiatives that reside with the federal, state, and county government, researchers, providers, insurers, and stakeholders. These initiatives all need to support: 1) increased efforts to conduct early screening, identification and treatment for all mental health and substance use conditions, using reliable, valid and practically designed diagnostic and monitoring tools, for the evaluation of behavioral health symptoms and functional status; 2) education to promote greater knowledge of the effectiveness of treatment for behavioral health conditions; 3) the significance of treating the whole person, as the mind/brain and the

Skolal, J., Messias, E. Dickersen, F.B., Kreyenbauhl, J., Brown, C.H., Goldberg, R.W., Dixon, L.B. (2004). Comorbidity of Medical Illnesses Among Adults with Serious Mental Illness Who are Receiving Community Psychiatric Services. *Journal of Nervous and Mental Disease*, 192(6), p. 421-427.

[87] Dixon, L.B, Pstrado, L., Delahanty, J., Fischer, P.J., Lehman, A. (1999). The Association of Medical Co-Morbidity in Schizophrenia with Poor Physical and Mental Health. *Journal of Nervous and Mental Disease*, 187(8), p. 496-502.

[88] Burman, M., Watkins, A., Watkins, K.E. (2006). Substance Abuse with Mental Disorders: Specialized Public Systems and Integrated Care. *Health Affairs*, 25(3), p. 648-658.

[89] Berkanovic, E., Telesky, C., & Reeder, S. (1981). Structural and Social Psychological Factors in the Decision to Seek Medical Care for Symptoms. *Medical Care,* 19, p. 693–709.

rest of the body are interconnected and the underlying depression associated with cardiac disease is well-documented, as one example of the interrelatedness ; 4) the importance of primary care and specialty behavioral health providers practicing in a continuum of coordination models including a) formal agreements among providers; b) case management services within primary care and behavioral health; c) co-location of providers in either location; and d) full integration within primary care and behavioral health provider practices and organizations.[90]

Such efforts are all needed within Prince George's County to build and implement a comprehensive behavioral health system responsive to all levels of behavioral health needs, and establish a continuum with the system inclusive of prevention, early identification and screening, and treatment within primary care and specialty behavioral health settings.

## 3.9 Serious Mental Illness

According to the Substance Abuse and Mental Health Services Administration (SAMHSA), "Mental disorders are generally characterized by changes in mood, thought, and/or behavior. They can make daily activities difficult and impair a person's ability to work, interact with family, and fulfill other major life functions." A SAMHSA report, *State Estimates of Adult Mental Illness from the 2011 and 2012 National Surveys on Drug Use and Health – 2014* shows that 42.5 million adults ages 18 and older have experienced some form of mental illness in the past year, or about 18 percent of the adult population. Approximately 21.5 million people aged 12 or older in 2014 had a substance use disorder (SUD) in the past year, or 8.1 percent of the population.[91]

Delay in accessing care leads to avoidable spending inside our health care system as some people with untreated mental illness and substance use disorder repeatedly end up in emergency departments (EDs) and are admitted to hospitals. Approximately 12.5 percent of all ED visits across payers are due to mental health and/or substance use treatment needs. Some states and health plans have had dramatic success in improving health care and reducing overall ED use by targeting the needs of this population.[92]

Delays in receiving needed care also lead to additional spending in an array of social services, e.g. in foster care, cash assistance, child welfare, and food assistance programs, special education programs. Such treatment delays can also increase social insurance payments outside of health care, such as disability insurance, because of the lack of screening and identification of need, and deferral of treatment until symptoms and behavioral issues escalate to a level of need that cannot be ignored.

In addition, deferred and neglected care for people with mental and emotional disorders leads to spending in the justice system, as people with serious mental illness and substance use disorder run

[90] Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders. (2006). *Institute of Medicine of the National Academies*, p. 11.
[91] Center for Behavioral Health Statistics and Quality. (2015). Behavioral Health Trends in the United States: Results from the 2014 National Survey on Drug Use and Health (HHS Publication No. SMA 15-4927, NSDUH Series H-50).
[92] Mann, C. (2014). Reducing Non-Urgent Use of Emergency Departments and Improving Appropriate Care in Appropriate Settings. *CMS Information Bulletin*. http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-01-16-14.pdf

afoul of the legal system. Such care forgone leads to reduced human capital, which can take the form of poor educational attainment and school dropout, a lack of job skills, absenteeism in the work place, and lower labor productivity. As stated by Dopp, Lipson, and Eisenberg, "Many of these factors are both the consequence and cause of mental health problems, as part of a downward spiral that is difficult to break."[93]

In recognizing the devastating effects of untreated mental illness and substance use disorder, an important focus for all behavioral health systems is to establish priority access to adults with serious mental illness and children and youth with severe emotional disturbance, and for all ages, ease of access to substance use disorder services. These illnesses have the most severe and disabling effects on the quality of people's lives, their functional status and ability to live independently and successfully as students, employees, family members and friends, and in their communities as they seek to fulfill their hopes and dreams. Common serious behavioral health conditions include:

- Major depressive disorder (MDD): a severe and persistent depression that interferes with daily functioning, characterized by deep sadness, feelings of despair and overall lack of interest in life.[94] According to Dopp, Lipson, and Eisenberg, MDD is an episodic disorder, with significant psychosocial stressors usually precipitating first episodes.
- Anxiety Disorders: Kessler and colleagues found that nearly three-quarters of people with anxiety disorders experience symptoms such as unease, worry, and nervousness associated with a sense of a pending untoward event, prior to the age of 22.[95] In the 18-29 year old age group, 30.2 percent of individuals experience some form of anxiety disorders.
- Schizophrenia: an illness that has an onset in late adolescence and early adulthood, affecting an individual's ability to think clearly, make decisions and manage life activities and relationships as the individual experiences disorganized thinking, hallucinations and psychotic symptoms. SAMHSA estimates that one percent of the population in the US has schizophrenia.
- Bi-Polar Disorder: characterized by dramatic shifts in mood and energy (depression and mania) that affect daily functioning in school and job performance and social relationships. The median age of onset for bipolar disorder is 25 years, and among adults 18 or older, the lifetime prevalence of bipolar disorder is highest among those younger than 29.[96]
- Substance Use Disorders (SUD): Some 16.7 percent of people in the 18-29 year-old age bracket have a SUD, including 14.3 percent with alcohol abuse; alcohol dependence, 6.3 percent; drug abuse, 10.9 percent; and drug dependence, 3.9 percent. SUD with alcohol commonly co-occurs with drug use, and males have higher rates of SUD than females. Serious psychological distress

[93] Dopp, R., Lipson, S., Eisenberg, D. (2013). Mental Health Among Late Adolescents and Young Adults from a Population-Level and Clinical Perspective. *Adolesc Med*, 024, p. 573-596.
[94] American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders. 4th ed, text rev. Washington DC: 2000.
[95] Kessler, R.C., Berglund, P., et al. (2005). Lifetime Prevalence and Age-of-Onset Distributions of DSM-IV Disorders in the National Comorbidity Survey Replication, *Arc Gen Psychiatry,* 62(6), p. 593-602.
[96] Dopp, R., Lipson, S., Eisenberg, D. (2013). Mental Health Among Late Adolescents and Young Adults from a Population-Level and Clinical Perspective. Adolesc Med, 024, p. 573-596.

in the past year seems to contribute to young adult males engaging in heavy alcohol use, binge drinking, and illicit drug use.[97]

- Co-occurring Disorders: it is well documented that individuals with mental illness frequently are at risk for substance use disorder, and many more individuals with substance use disorder experience mental illness at a rate that is higher than the general population in the US. According to SAMHSA, there is no particular group of diagnoses associated within co-occurring disorders; rather, the conditions cluster and are a combination of diagnoses identified in the *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition (DSM-5).

## 3.10 Evidence-Based and Promising Practices

Within the field of health and behavioral health services and many social and judicial systems, there is discussion about Evidence-Based Practices (EBPs) and Promising Practices, as government, community leaders, providers, and other stakeholders seek effective and efficient approaches to determining which services they will offer, and the likelihood of the associated outcomes of those services and interventions being positive. The determination of EBPs is anchored in several dimensions, including "clinical and expert opinion, external scientific evidence and client, patient, and caregiver perspectives so that providers can offer high-quality services that reflect the interests, values, needs, and choices of the individuals served."[98]

There is an extensive list of potentially applicable EBPs and Promising Practices for the leadership of Prince George's County to consider as it develops a comprehensive plan to transform the behavioral health system within the County. However, EBPs and Promising Practices do not exist in a vacuum. To be effective and relevant, they must respond to the community needs of the populations and subpopulations effectively and efficiently.

Recognizing these factors, SAMHSA's framework provides three key areas of importance to states, communities, and providers as systems evaluate EBPs within an established framework including:

- Review the alignment between the issue/problem the community is addressing and the EBP and/or Promising Practice
- Consider the resources available, the preferences and the willingness of the community to engage in the EBP and/or Promising Practice, and relationship of the EBP and/or Promising Practice to the cultural and linguistic preferences of the community(ies)
- The strength of the evidence of the practice.

Additionally, the framework must include a process for identifying measures to evaluate the EBPs and/or Promising Practices and their effectiveness in supporting the service continuum's ability to meet the needs of the populations and improve their health outcomes. The diversity and needs of Prince George's County's populations require particular attention to the capacity and competencies of

[97] *Ibid.*
[98] A Guide to Evidence-Based Practices (EBP). *Substance Abuse and Mental Health Services Administration*. http://www.samhsa.gov/ebp-web-guide

providers to implement prevention, promotion, early identification, and treatment of MEB within a sustainable plan.

The qualitative and quantitative analysis, and discussion of the prevalence of behavioral health conditions nationally, combined with the County population characteristics and demographics, is leveraged to determine the need for the below recommended EBPs and Promising Practices. As we describe each EBP and Promising Practice, we will cite the associated data that provides the rationale for how the selected EBP supports Prince George's County in achieving its objective of establishing a responsive behavioral health system of care.

Nationally, one of SAMSHA's strategic initiatives is to identify the need for a public health approach to address the pervasive incidence of trauma in people's lives, whether it be through child neglect and abuse, sexual abuse, the effects of poverty in contributing stressors, domestic violence on women, violence in communities, and returning soldiers who experience post-traumatic stress disorder. Trauma-informed care, implemented throughout the system and in conjunction with the juvenile justice and criminal justice system, supported by the recognition of the need to incorporate efforts to mitigate Adverse Childhood Experiences (ACES)within all prevention activities, can offer a two-pronged approach to establishing strong and healthy individuals, families, and communities. Trauma-informed care must be incorporated in every service offered and interwoven in all the activities of staff working at agencies, including providers, sister County agencies, the health department, and schools.

These ACEs have an effect on a child or youth's development and may increase the likelihood of health problems throughout the person's life. "These stressful or traumatic experiences, including abuse, neglect and a range of household dysfunction such as witnessing domestic violence, or growing up with substance use disorders, mental illness, parental discord, or crime in the home are ….(disruptive)."[99]

Additionally, a significant barrier to expanding access to behavioral health services for all populations is the inability to recognize and understand the background and experiences of the populations being served. The Issue Brief on Cultural and Linguistic Competence developed through the Building Bridges Initiative, a residential treatment program that serves youth with SUD, provides a primer relevant to youth and family-serving organizations. The Brief discusses approaches to strengthening needed cultural and linguistic competencies.[100]

We now turn to the needed competencies of staff in residential services as well as other services within the continuum. Staff must be grounded in many different aspects of a person's life and underlying youth and family's practices, their perceptions and behaviors, food and dress preferences, and ways of communicating within their culture and their preferred language. Staff's lack of understanding and recognition of the background of the youth and family can lead to misunderstandings and discomfort

[99] Anda, R. The Role of Adverse Childhood Experiences in Substance Abuse and Related Behavioral Health Problems. *Centers for Disease Control and Prevention*.
[100] BuildingBridges4Youth.org

with imposed practices that seem unfamiliar and disrespectful of the youth and family. Additionally, varying cultures have different knowledge, perceptions, and beliefs associated with identifying and seeking assistance for MEB.[101] The challenges in communicating in English further complicate ease of access, and the 2010 Census Reports identified the fact that 20 percent of the population over the age of five speak a language other than English at home and of those, 8.7 percent speak English less than well, including youth of families who are immigrants.[102]

It is well known that Latino youth and youth of color are overrepresented in comparison to Caucasians in the child welfare system, experiencing a greater number of out-of-home placements and longer involvement with the system.[103] A greater number of youth of color and Latino youth are also placed in residential services and have higher rates of contact with the juvenile justice system. [104] Furthermore, discrimination against youth who identify as lesbian, gay, bisexual, transgender or questioning (LGBTQ) creates challenges as the youth and family seek services.[105] All of these factors speak to the need for greater competencies within the larger health care system, anchored in a capable workforce aware of and respectful of the diversity of people they are employed to serve. A workforce that is knowledgeable, trained, and supported to be responsive to individuals and families in need is better positioned to offer interventions that are effective, efficient, and centered on engagement of the individual and family in services, offering the right treatment, at the right time, and in the right place.[106]

### The SAMHSA System of Care Implementation Grant

Through the System of Care (SOC) Implementation Grant, Prince George's County has identified the strategic plan and vision for wrapping community-based services around children, youth, and their families with severe emotional disturbance. The vision is nationally supported as an effective organizational construct as the system supports giving voice to the child, youth, and family, partnering with families to facilitate family- driven treatment plans. By wrapping services and supports around the child, youth, and family, the system brings resources that leverage the resiliency of children,youth, and their families to remain together in their communities, and is a significant shift in the approach to delivery of care.

Additional family therapy EBPs include Multisystemic Therapy (MST). This is a family-focused intervention program for youth with challenging behaviors and/or substance use disorders, and offers an approach to understand the multidimensional contexts of problems, including social-ecological factors in the individual, family, peer group, school, and community. *It is frequently used in working with youth with mental illness and /or substance use disorder and related difficulties within the school and*

[101] NAMI Multicultural Action Center
[102] U. S. Census Bureau, 2013
[103] Chapin Hall at the University of Chicago, 2009 and Church, 2006; Church, Gross, & Baldwin, 2005
[104] U.S. Department of Health & Human Services, 2013, September. Although the numbers declined among all major non-Hispanic race groups, reductions among African American youth were the most significant, decreasing by 47.1 percent. However, African American youth still remain in residential programs at almost twice the national average at 26%.
[105] Commonwealth of MA Commission on LBGT Youth, 2013
[106] Clancy, C.M. (2009). What is Health care Quality and Who Decides? Director, Agency for Health care Research and Quality, US Department of Health and Human Services, Testimony before the US Senate Committee on Finance, Subcommittee on Health Care.

*justice systems, and Prince George's County should include the intervention within its EBP and Promising Practices set.*

In light of the inadequate number of practitioners and child-serving behavioral health organizations, as part of the SOC implementation grant, *the County needs to consider how it can expand access to behavioral health services and medication therapy. Despite a number of challenges, the County should consider a review of how many pediatric practices are enrolled in Maryland's Behavioral Health Integration in Pediatric Primary Care (BHIPP). BHIPP provides a free consultative service for all pediatricians. Social workers, child psychiatrists, and other physicians are available to pediatricians, to evaluate the need for medication, diagnostic issues, developmental delays, school and learning issues, autism issues, trauma, and early mental health issues.*[107] Since BHIPP is a valuable resource to pediatric practices and children and youth and their families, it is important that the County identify and understand utilization County-wide, and whether or not there are gaps geographically that require additional focus and recruitment. BHIPP addresses the issue that is unlikely to change—the shortage of Child/Adolescent psychiatrists nationally and locally.[108]

Cognitive Behavioral Therapy (CBT) is an EBP for children, adolescents, and adults, and offers short-term treatments (six-20 sessions). The approach seeks to teach specific skills, focusing on the individual's cognitions, emotions, and behaviors, and the relationships among them. In learning new skills, the clinician using CBT directs interventions to different points in the cycle of cognition and behavior with the goal of developing new coping skills. CBT is one example of an EBP that shifts the system from a focus on long-term, open-ended treatment to one that is shorter-term, based on the provider and the individual working on mutually defined goals and continuous measurement of progress in meeting the goals, building on the strengths and resiliency of individuals and families. *The County should consider widespread use of CBT including trauma informed CBT.*

Integrated mental health and substance use disorder screening and treatment inclusive of Screening, Brief Intervention, Referral and Treatment (SBIRT) offers an EBP approach to early identification, screening, interventions, and treatment through primary care practices. Leveraging the primary care practices' ability to identify individuals in need of substance use disorder treatment provides an approach in which the primary care practice is part of the screening and assessment, and also refers to the substance use disorder system for individuals who need more intensive and specialized treatment. Further clarification about the Maryland Medicaid reimbursement for SBIRT is recommended, and the County could promote practices to incorporate SBIRT into their practices, provide training to expand its inclusion, and work with the State to offer reasonable reimbursement and referral to community services. With earlier identification, medical detox and facility stays can be minimized as community services offer the support and services needed to help individuals in their recovery.

The Governor's Heroin and Opioid Emergency Task Force, Interim Report released in August 2015, identified 10 recommendations developed through a public process inclusive of regional field summits organized to understand how heroin and opioid drug use impacted public health, law enforcement,

[107] http://www.mdbhipp.org/about-us.html
[108] Massachusetts Child Psychiatry Access Project, http://www.mcpap.com/

addiction treatment professionals, families, and communities. In December 2015, the final report will confirm and add recommendations. Prince George's County should continue its participation with the Task Force as it identifies the intersection and need for collaboration between public health, law enforcement, and substance use disorder providers, and strengthens the County's response to improved access to services. Of particular interest is the relevance of "naloxone training and distribution to local health departments and local detention centers, overdose survivor outreach programs in hospital emergency departments, prescriber education to improve quality of care, recovery housing for women with children, and detoxification services for women with children…"[109]

The State of Maryland contracts with ValueOptions Maryland, the Administrative Services Organization (ASO) that manages behavioral health services. We recommend that Prince George's County work with ValueOptions to review each of these EBPs services, the numbers of people served, their inclusion in the Medicaid benefit package, and shift supporting County funds to increase or decrease the amount of specific services available as needed. These services should not be static; rather, they should change to meet the needs. The services include:

- Assertive Community Treatment (ACT): An intensive integrated rehabilitative crisis, treatment, and rehabilitative support service for adults (18 years of age and older) provided by an interdisciplinary team to individuals with serious and persistent mental illness or co-occurring mental health and alcohol/substance abuse disorders. Many individuals in ACT are difficult to engage and the team helps them adhere to a treatment plan and services, promoting greater symptom stability, community tenure, and use of psychotropic medications.
- Case Management—Mental Health: Services include assessment, planning, coordination, and advocacy services for clients and families (all ages) who need multiple services and require assistance in gaining access to, and in using mental health, social, vocational, educational, housing, public income entitlements, and other community services to assist the client in the community. Case management activities may also include identifying and investigating available resources, explaining options to the clients and families, and linking them with necessary resources.
- Community Support (Individual, Group): Mental health rehabilitation services and supports for children, adolescents, families, and adults necessary to assist clients in achieving rehabilitative, resiliency and recovery goals. The service consists of therapeutic interventions that facilitate illness self-management, skill-building, identification and use of adaptive and compensatory strategies, identification and use of natural supports, and use of community resources. Community Support (CS) services help clients develop and practice skills in their home and community.
- Community Support: The support consists of interventions delivered by a team that facilitates illness self-management, skill building, identification and use of adaptive and compensatory skills, identification and use of natural supports, and use of community resources.

[109] Rutherfod, B.K. (205). Heroin & Opioid Emergency Task Force: Interim Report. *Office of the Lieutenant Governor*. https://governor.maryland.gov/ltgovernor/wp-content/uploads/sites/2/2015/08/Draft-Heroin-Interim-Report-FINAL.pdf

- Crisis Intervention: Interventions to stabilize a client (child, youth and family as well as adults) in a psychiatric crisis to avoid more restrictive levels of treatment, and with the goal of immediate symptom reduction, stabilization, and restoration to a previous level of role functioning. Crisis intervention services may also include, if appropriate, brief and immediate mental health services or referral, linkage, and consultation with other mental health services.
- Crisis Intervention— Pre-Hospitalization Screening: Interventions to stabilize a child, adolescent, and his or her family or adults in a psychiatric crisis to avoid more restrictive levels of treatment and that have the goal of immediate symptom reduction, stabilization, and restoration to a previous level of role functioning.
- Dialectic Behavioral Health Treatment (DBT): A form of cognitive behavioral health treatment specifically targeting behaviors of youth and adults with the goal of helping individuals modulate their emotional reaction to situations and relationships. DBT is supportive and educational in approach, and was originally developed by Marsha M. Linehan. It can be utilized in individual and group therapy, has been expanded to treat many different behaviors, and includes assignments to work on specific problem areas, learn from interactions and their analysis, and master skills through DBT.
- Psychiatric Rehabilitation Programs: Rehabilitative skill-building services for individuals 18 years of age and older with serious mental illness or co-occurring psychiatric disabilities and addictions. The interventions focus on identification and use of recovery tools and skill building to facilitate independent living and adaptation, problem-solving, and coping skills development.
- Therapy/Counseling: Treatment modality that uses interventions based on psychotherapy theory and techniques to promote emotional, cognitive, behavioral or psychological changes as identified in the individualized treatment plan. It is available to children, youth,families, and adults.

Thus, it is clear that there is a full spectrum of varying services, ranging from those of a mostly preventive nature, and those designed to avoid exacerbation of known conditions, through a cluster of services aimed at crisis intervention for individuals and families who are in dire situations. It is important not only to include the appropriate services all along this spectrum, but also to have the staff with the correct knowledge, training, and skills to provide the services.

It is important to understand that although Prince George's County does not directly provide mental health services, it provides substance use services directly through two clinics in northern and southern locations. As noted earlier, ValueOptions is contracted with the state to manage mental health services. Historically, the ASO was responsible for managing a range of mental health services to residents of Maryland and Prince George's County, including inpatient, outpatient services, case management and rehabilitation services. As of January 1, 2015, the ASO is also responsible for managing substance use disorder (SUD) services. Services include outpatient, medication and detox services.

### *Medication Assisted Treatment for Opioid Addiction*

Medication Assisted Treatment (MAT) is a clinically effective treatment that occurs adjunct to counseling, and integrates a holistic approach for individuals diagnosed with an Opioid Addiction. In treating their addiction through MAT and counseling, MAT can provide a cost-effective alternative to

inpatient services. MAT and Opioid treatment programs must meet many different requirements, including certification and federal regulations, and individuals must attend SUD programs that offer individual and group counseling to support and maintain their recovery.[110]

Fee-For-Service (FFS) and Managed Care (MC) plans in Maryland Medicaid cover methadone for the treatment of opioid use disorder for individuals receiving SUD counseling. For women who are pregnant, methadone is safe, as supervised by a physician. Maryland Medicaid covers Suboxone, buprenorphine/naloxone tablets, and buprenorphine tablets under both FFS and MC plans when individuals are receiving SUD counseling. Similarly, pregnant women may be prescribed these drugs. MAT is covered for use in Narcotic Treatment Programs (NTPs), organized specialty outpatient treatment programs (OTPs) and physician's offices under both FFS and MC plans.[111]

*Prince George's County is a direct provider of SUD services and we recommend that with the transition of SUD services to management under the ASO and Medicaid reimbursement, Prince George's County, in conjunction with the primary care strategic plan, explore how it will engage primary care practices, physicians in hospital and ambulatory sites, and other physicians with providing a robust array of services for individuals with opioid addiction, including MAT in conjunction with OTP/SUD programs. Such inclusion is significant to the County's efforts to expand its SUD services, leverage available funding and meeting the needs of its population.*

## 3.11 Financing Behavioral Health

For many years, Medicaid has become the foundational payer for public behavioral health services for the Medicaid-eligible populations within states. Services must meet medical necessity criteria, and states include a range of federally-identified mandated and optional services within their state plan amendment for the Medicaid program.

Departments of Welfare and Social Services, Juvenile and Criminal Justice, and Behavioral and Public Health have long realized that many of the individuals, children, youth, families, and adults they serve as separate agencies, are also receiving services within sister agencies. States have collaborated on many initiatives to bring together various agencies into a more integrated approach, often called "No Wrong Door" or a "Single Point of Access." This strategy helps the individual and family obtain access to the particular agency that can respond to the initially-identified issue, and as multiple services and multiple agencies are needed, an integrated approach to service assessment, planning and coordination occurs.

To support these collaborations, states and counties have identified fiscal approaches to braiding and blending funding streams to maximize the limited fiscal resources, avoid duplication of services between and among sister agencies, and optimize flexibility in funding of needed services. *Funding streams from multiple sources should be pooled and blended to maximize the impact of financial resources across*

[110] Medication and Counseling Treatment. *Substance Abuse and Mental Health Services Administration*. http://www.samhsa.gov/medication-assisted-treatment/treatment

[111] Medicaid Coverage of medication for the Treatment of Opioid Use Disorder. *American Society of Addition Medicine*. http://www.asam.org/docs/default-source/advocacy/state-medicaid-reports/state-medicaid-reports_md.pdf

*departments. Service strategies should be clearly defined, and each agency should contribute to the service plan for the person and agreed-upon service plan.*

A more formalized funding strategy braids funding, flexibly integrating the funding streams of sister agencies, anchored within a structure of close tracking and monitoring of the funds used to support joint initiatives. Data collection and reporting, as well as payment arrangements, are defined and implemented more effectively through establishment of clear accountability and reporting on the collaborative initiative.

The Maryland Department of Health and Mental Hygiene is leveraging Medicaid to reimburse all Medicaid-eligible services, and as of January 1, 2015, the ASO vendor, ValueOptions, is responsible for management and data collection related to SUD services as well as mental health services.

*Prince George's County has received a one-year extension to leverage Medicaid financing for its SUD services, and it is important that this work proceeds and the target is met.*

### Making the Transition to Medicaid Financing

*The County needs to develop a structure to transition to Medicaid financing of services. This should be accompanied by a comprehensive assessment of all services provided, with evaluation of their effectiveness and impact. The County needs to ensure that credentialed and licensed individuals are delivering the services. Another element of the overall strategy is the development of a billing process including submission of claims and procedures, as well as the documentation that supports the federal Medicaid requirements, including their ability to withstand a federal audit. This needs to be completed very quickly (e.g., three months) for substance use disorder services (SUD) to position the County to implement and make the appropriate changes associated with the new process.* Included in the assessment is identification of costs associated with the SUD services that will not be covered through Medicaid reimbursement. Prince George's County needs to compile a detailed plan of functions and associated costs that must continue and cannot be covered through Medicaid, and submit the plan to the State for review. The State will make the County whole for justifiable costs.

*Prince George's County has an opportunity to conduct a comprehensive review of all of its funding streams for behavioral health services. The County needs to assess the service areas in which it leverages current Medicaid reimbursement as well as potential (SUD); receives grant support and for what services; County-funded support (type of services, how many, contracted or County staff delivered). The County should also identify opportunities for more collaboration with sister agencies, leveraging County, Medicaid, and other State and Federal funds.*

*Once that baseline inventory has been completed, the County needs to evaluate and prioritize opportunities that are aligned with the recommendations for the behavioral health system transformation. Consideration of pay-for-performance incentives could help align incentives to provide care for individuals at their own customized level of need, rather than fitting individuals into slots of programs, with no incentive to transition services to less intensive need* which are insufficiently responsive to the person's current needs .The County contracts for some services and directly provides other services. All services should be evaluated to understand the costs and benefit of the services, e.g.,

what is provided, to what number of people, for what length of time, and the outcomes. Establishment of this baseline will be used as the County implements the plan for behavioral health services, as a guide to making decisions. The findings of assessments of the costs and effectiveness of various services will aid in shifting funds as needed to different areas and allow the County to make changes as it obtains more information about the County's population's needs and the service array offered.

*The more complicated, yet vital initiative is developing sister agency collaboration in a process of assessment, to identify common areas of interest within the behavioral health system and potential synergies if funding were braided together.* This process does not change a sister agency's authority and responsibility. Rather, it is a joint exploration of shared services to meet the complex needs of each agency's population, and together identify the services provided, contracted, or directly delivered by the County, financing for the services, population need, and the potential for joint purchase and/or provision by the County employees. To be successful, the sister agencies would need to agree that the discussion of the potential opportunities for joint funding is a "neutral" discussion, not one in which there is a winner or loser. Whether this could be sponsored through the Behavioral Health Work Group or some other mechanism will need to be considered.

Although there is a great deal of work to be done, Prince George's County has many opportunities to transform its behavioral health system to a more responsive, state-of-the-art, and evolving system of care for all populations. As we will discuss in following sections, there are specific actions that are required, completed within an overarching framework and plan, and within defined time periods. The necessary financing shifts, leveraging of Medicaid, combining funds across sister agencies when meeting shared needs of clients and families, and strategic investments of County funds hold the promise of providing better value to the County and the residents it is serving, and will support the County being good stewards of the public resources it oversees.

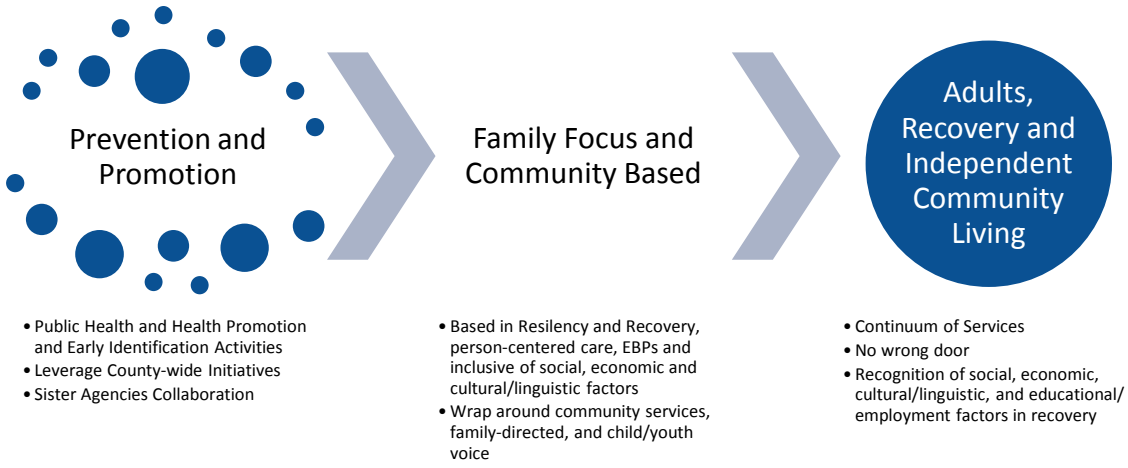
## Section 4: Recommendations and Action Plan

The extensive review of information for the Prince George's County community needs assessment created a solid foundation from which the following recommendations emanate. Publicly available information and reports, sister agency and other stakeholder interviews, and quantitative and qualitative analysis guided the development of a short- and long-term action plan to improve the behavioral health system for the County's population. Prince George's County has a long and important history, and a unique position in the state of Maryland, and the recommendations are intrinsic to the future of the County, a County that is poised to make the transformational changes and improve the health outcomes and quality of life of its residents.

A behavioral health system exists within a clearly stated mission and vision; one that speaks to establishing healthy communities sustained through strong prevention and promotion activities, early identification of behavioral health conditions, and a service continuum that embraces family-directed and community-based services. The system should be fortified by an underlying strengths-based philosophy of the resiliency of children, youth, families, and recovery in adults. It should include Evidence-Based Practices and person-centered care while incorporating individuals' and families' social,

economic, and cultural influences and linguistic preferences. The system should continuously evolve to meet the needs of the community. The diagram below depicts the framework that can be used to guide policy associated with the recommendations.

***Figure 7: A Behavioral Health Service System Continuum***




## 4.1 Short-Term Recommendations

### 1. Leverage the Behavioral Health Workgroup as Champion

Prince George's County Behavioral Health Workgroup (BHWG) is positioned to be the champion and identified body to oversee the behavioral health system transformation plan. As the chair of BHWG, the Health Officer should schedule a review of the current vison and mission statements of BHWG, and make the adjustments to incorporate into their scope of responsibility accountability for the oversight and implementation of the recommendations and action plan to transform the behavioral health system. As the BHWG assesses the existing mission and vision statement, membership and infrastructure, it can determine the BHWG's ability and adequacy of resources to fulfill the role of prioritizing, implementing, and overseeing the initiatives associated with the behavioral health system transformation plan. The BHWG will be the entity answerable for coordinating the planning and implementation process across behavioral health service providers and partnering agencies, including the justice system, social services, hospitals, community organizations, other stakeholders and providers. BHWG should work to strengthen its horizontal and vertical partnerships to create collective ownership of a comprehensive and integrated behavioral health system, promoting healthy and productive lives, from early childhood to old age, for the residents of Prince George's County.

To effect system transformation, Prince George's County needs a village, a growing and broadly representative group of committed partners and stakeholders who join together with a common vision and mission, based in a strategic plan and functioning through consensus-building processes. From the plan, actions emanate that are prioritized into specific initiatives, with clearly identified metrics, deliverables, and timelines. The BHWG will make recommendations about coordinating resources across the County in support of the initiatives, and establish the collective accountability associated with implementation of the plan. While the BHWG does not have formal spending authority, and its decisions would not be formally binding, the group includes leaders with decision-making authority and any consensus forged by BHWG can be leveraged to guide the respective expenditures.

The BHWG should also leverage and embrace other partners and mechanisms for planning, including the resources of the Local Health Improvement Coalitions (LHICs) in implementing each of the strategies needed to accomplish one or more of the goals. LHICs are panels of local health departments, hospitals, physicians, community organizations, and other local entities designed to integrate community health initiatives with medical care. They also develop data tools for population health monitoring and new mapping technologies to reach high-needs, high-cost individuals.[112] The BHWG's goals are visionary, and are translated into initiatives and actions with specific, measurable indicators. In choosing goals, BHWG should identify ones that are likely to be early successes. These early goals could include ongoing, collaborative projects to continue relationship-building with community partners. In selecting goals, it is important they distinguish the vision from the goal itself. For example, a vision might be to "end homelessness" and the goal may be "create 10 new supportive housing units during the calendar year." Small successes become significant if applied and based in a process of continuous quality improvement and strategic planning that identifies genuine goals. The goals cannot be too large, too complex, or ones that can only be solved by an outside-the-group entity (e.g., a problem that would require statutory change at the state or federal level). This realistic approach can build the momentum to maintain and grow participation. As the focus of the BHWG inevitably waxes and wanes, revisiting concrete successes can be more motivating than trend lines on a spreadsheet. Connecting the work of the BHWG to the population, and the improved health outcomes of the residents, will be critically important to ensuring continuous movement through an extended process that may, at times present difficult decision-making.

*In continuing the County's engagement of stakeholders, the County should create a Consumer Affairs Office similar to those in surrounding counties to help with access and quality assurance of behavioral health services. These offices are well-established nationally, and they assert the State and County's commitment to the principles of recovery and resiliency, employment of peer specialists, family members, and people with real world experience.* The office can support the County's effort to give a larger voice to consumers and family members, and provide a point of contact to aid individuals and families, problem-solve, raise issues, and participate in overseeing the delivery system. The office can

[112] SIM Local Health Improvement Coalition (LHIC) Stakeholder Group. *Maryland Department of Health and Mental Hygiene*. http://hsia.dhmh.maryland.gov/SitePages/lhic.aspx

also play an important role in policy discussions, recruitment of peers throughout the system, and the commitment to employment of peers throughout the provider system.

### Action Steps:

- Consider group formation: Identify workgroup participants, discussion of the mission and purpose of the group, and emphasize that success depends on developing a culture of shared responsibility.
- Communication: The workgroup should identify who will take minutes or notes, and how they will be distributed to internal and external partners.
- Meeting schedule: The meetings should be at a regular time with clear expectations for attendance and participation. Consider developing an attendance policy, since progress will be slow if the meetings are poorly or infrequently attended, or if partnering organizations frequently change their designee.
- Prioritize actions: The workgroup should identify some early and attainable actions for early success that will clearly demonstrate its value to stakeholders. For example, the County has an excellent relationship with its crisis services provider and has successfully reduced emergency department visits. The workgroup could leverage its relationship with the crisis provider to obtain data on frequent crisis service users. Once a small group is identified, the BHWG members could work in concert to strengthen non-crisis outpatient service delivery for these individuals. Starting with a small, geographically-contained problem that does not require outside-the-county intervention is ideal. Early wins bolster confidence for later, larger actions.

2. **Become a Data-driven Behavioral Health Delivery Systems**

The County should become a data-driven system, one that provides the foundation for identified actions to be taken, based in sound decision-making, quantifiable needs and priorities, and supported by defined metrics to measure progress against goal. Prince George's County does not have a current methodology for measuring behavioral health system performance. The County is relying on state data feeds from ValueOptions that are largely counts of consumers or services over a given time period. Development and implementation of a transformation plan requires performance and quality measures, supported by a quality management improvement infrastructure. Establishment of accountability mechanisms to determine and monitor the quality of services and interventions provided to individuals and families, health outcomes, and the overall plan of the system transformation will be critical to achieving the County's goals.

*Counts and performance metrics*: Prince George's County has the lowest statewide rate of emergency department (ED) visits related to mental health disorders. While the use of crisis services to avoid emergency department use is lauded, there is a tacit supposition that people not using the ED are well-taken care of through some other system elements. The important data point is not only the State measure of ED usage, or the current County-level count of persons served by the crisis system, but what is happening to people who are diverted from the hospital. That is, the County must not only be concerned with the number of individuals who are served by crisis providers, but rather are those same individuals connected to community-based care and continuing care that intervenes, brings stabilization, and promotes recovery?

*Consumer-oriented data collection*: Prince George's County is working with ValueOptions (VO) to identify individuals who are high-utilizers of behavioral health services. After identification, the County should continue to work with ValueOptions, the SOC work group, the network providers, and consumers and families to determine what services they need and want. Are these individuals being successfully diverted from the hospital and/or cycling from crisis to crisis? What do the individuals identify as a gap(s) or barrier(s) in getting from hospital diversion to recovery-focused care? In consulting with consumer-driven organizations like On Our Own and other providers, the County may be able to identify services most desired by consumers. The data should be shared across partners as part of the policy decision-making process in designing, delivering, and allocating resources to the behavioral health continuum of care.

Consumers and family members reported low-quality hospital services for behavioral health care in the County. They described a common experience of feeling "warehoused" with minimal consultations from psychiatrists, social workers, or other care providers. They also reported being "overmedicated" and many indicated minimal transition planning and continuity with community-based care following discharge. They described positive and negative experiences with various community-based behavioral health service providers. Overall, the most commonly noted negative aspect of working with certain organizations was the lack of responsiveness to family member communications and concerns and, in some cases, resistance by organizations to involve family members fully in their adult child's treatment and recovery.

Discussion of the anecdotal information underscores the importance of establishing sufficient accountability mechanisms to monitor organizations and their level and quality of care within a transparent and standardized plan. Without defined measures and regular reporting, the County, staff, provider organizations, individuals and their families, and other stakeholders are left with no formal means to monitor services, respond to needed improvements, and focus efforts continually to advance performance within the system.

*Data-sharing*: The Prince George's County Core Services Agency (CSA) has an underdeveloped approach to the use of data as it oversees, monitors, and identifies opportunities for improvement in the behavioral health delivery system. While the CSA receives data from the State, there are only limited and discrete initiatives to promote data-sharing and analysis of the delivery system. The County can develop information-sharing capabilities within the County by leveraging health information technology infrastructure, such as the Health Department's electronic health record system and the Chesapeake Regional Information Service Program (CRISP). Given proper functionality and interoperability, the Health Department and other providers could more easily document and share consumer information, which could improve care coordination.

Using the BHWG and LHIC to enhance data sharing and analysis will support the sister agencies and community partners in identifying strategies to blend and braid resources and gain funding efficiencies, more positive outcomes and leverage limited resources. Critical to any data sharing effort is the assignment of responsibility for data monitoring and distribution to specific individuals or team. Over time, as data are reviewed, the responsible parties will begin to identify patterns of outcomes and

successes, inadequacies, or gaps in services and quality, and they can leverage the data to identify opportunities for system advancement. BHWG can use the data findings to establish system partnerships for improvement, thereby reinforcing the relevancy of the BHWG and supporting the oversight for transforming the behavioral health delivery system.

### Action Steps:

- Begin with easier performance targets and data that are already collected by ValueOptions, the State, or County.
- Coordinate efforts with the work group responsible for the SOC implementation, as the approach should be the same for all ages.
- Develop a systematic performance-improvement approach. Although the State collects data on the highest behavioral health utilizers, such information does not include individuals with poor outcomes and high costs in other County agencies, such as the jail or public safety.
    - Consider cross-matching data from other County agencies with Medicaid utilization data to identify those with the highest overall utilization patterns.
- Develop performance indicators for high utilizer individuals. Such measures could include regular contacts with outpatient care (number of contacts per week or month) and condition improvement (apart from Outcomes Measurement System (OMS) data, improvement can be demonstrated by a reduction in use of crisis or acute care services, eventually reducing system cost). After a small start at using data across systems, begin to develop County-specific indicators. Over time, the County should move away from measuring only what is required. County-level indicators might include:
    - Number of individuals and families who receive services within seven days following a crisis service, by Public Use Microdata Area (PUMA) or zip code. Breaking up data into smaller catchment areas makes seeing trends and disparities easier.
    - Percentage reduction in the number of individuals with a behavioral health diagnosis and claim for service in the past six months or year who violate the conditions of their probation.
    - Reduction in the percentage of individuals who receive authorization for behavioral health services and never see a provider, or see a provider only one time.

**3. “No wrong door” Point of Entry into the Behavioral Health System**

Many interviews suggested that the County complete structural changes to support ease of access for individuals and families into the behavioral health delivery system, recognizing the existing multiple points of entry for individuals and families. Regardless of point of entry, develop a process to be inclusive of a standardized level of an assessment, referral for specific services, and supporting coordination. The SOC plan and implementation has also identified the no wrong door as one of its key strategies and this approach can become a system wide initiative, targeted to all individuals, regardless of age.

This is consistent with the acknowledgement nationally that new approaches are necessary to making a behavioral health delivery system easily accessible and responsive to children, youth, adults, and families in need. Regardless of point of entry, the County should develop a process that is inclusive of a standardized, brief assessment, and identification of service needs and the primary agency best able to meet those needs, referral of people for services, and coordination as needed to access additional services. A key feature of the process includes creation of procedures that establish a warm hand-off referral, particularly between primary care, hospital and ED care, and behavioral health care providers.

Interviewees consistently suggested the concept of "no wrong door" as individuals and families seek assistance, supported by inter-organizational care management and coordination models that are built into the system. As one example, detailed descriptions of such approaches were given for individuals who are homeless and have behavioral health needs. An interviewee recommended developing a care management and coordination system in which a collaboration of agencies serving individuals who are homeless alert a case manager when the individual who is homeless has a behavioral health condition and encounters law enforcement, a homeless shelter, an emergency room, or a child welfare or foster care office. In this model, the case manager would coordinate scheduling a "huddle" of various individuals across agencies to devise a plan of care appropriate to meeting the needs of the individual, and the plan would be stored, shared electronically, and monitored with a defined treatment team and points of contact. This would serve as an integrated health and social services "medical home." Similarly in wraparound services for children and their families, there are identified child and family teams to coordinate services, in conjunction with the local care team that reviews individuals with intensive needs.

The BHWG discussed the Maryland First Responders Interoperable Radio System Team (Maryland First), an interoperable 700 MHz radio communications system for state and local public safety agencies. During the BHWG meeting, enhancement of the 311 capacity was explored, and although there are many details to evaluate, it is a logical mechanism and system to leverage. It enables all of the police and fire department personnel to communicate with each other and other agencies, not only during large-scale emergencies, but also for basic, daily operations.[113] Some of our interviewees and the BHWG membership felt this system could be used to connect people in various County agencies, including not only law enforcement, but those working with individuals who are homeless, supporting family preservation, and in need of social services. This is an excellent discussion to continue, identify, and roll out an implementation plan, including metrics to monitor progress, the responsible team, and timeline for completion. BHWG would monitor the reported agreed-upon metrics, and as necessary, fine-tune the approaches as the data suggest unexpected challenges.

### Action Steps:

- Prioritize the development of interagency memoranda of understanding (MOU) based on workgroup priorities and data, above. While at least one interagency agreement is in-progress (i.e. DataLink for the Core Services Agency, ValueOptions, and the local detention center to share information), additional MOUs could formalize the blending or braiding of funds and

[113] Gov. O'Malley Makes First Call on Radio System Connecting Maryland's First Responders. (2012). Motorola Solutions.

integration of services and supports, while decreasing duplication of services or consumer burden (e.g., completing intake at multiple agencies).

- Develop a common intake form for County services so individuals can indicate which services they need assistance accessing.

**4. Improve Medicaid Penetration Rate**

Prince George's County has the lowest Medicaid penetration rate for behavioral health services in the state. Improving partnerships with the local social service agencies to increase application rates will improve the sustainability of public programs. As the County is missing opportunities to leverage Medicaid funds and increase total available behavioral health funding, it is also missing out on the non-clinical services that Medicaid provides, such as transportation to appointments. Given that transportation is a barrier for many residents, and especially for those in the southern part of the County, increasing Medicaid enrollment would increase the affordability and accessibility to critically important clinical and therapeutic services.

As a primary first step, the County should focus its efforts on enrolling parents. A number of studies have linked parent enrollment to children's health coverage. A Government Accountability Office report found that 84 percent of children had the same insurance status as their parents.[114] The Urban Institute found that children who live in states that expanded Medicaid, as Maryland did, have a 20 percent higher participation rate than those who do not.[115] By attempting to enroll parents, the County is almost certain to enhance coverage for children and transition-age youth, for whom eligibility criteria is more generous.

To expand use of Medicaid reimbursement, the County will require increased capacity for billing, and may need to expand the supporting infrastructure. As discussed in a later recommendation, the County is developing new billing capacity for the Medicaid reimbursement of substance use disorder services, as the State will no longer offer grant funding. Leveraging efforts to respond to that change creates a base for all Medicaid billing, and additional Medicaid reimbursement can be an efficient and effective approach to capacity development. The cost savings could be enormous. For example, the County is spending nearly a quarter of a million dollars on a program targeting transition-age youth; Medicaid-enrolled youth could receive services from a Health Home; and the County could redirect the state-only funds to services ineligible for reimbursement such as non-institutional housing. To achieve this capacity will require intense cross-system collaboration, discussion of shared populations, and service needs, and development of agreement on priorities between agency partners.

### Action Steps:

- Target parents for enrollment. Use back-to-school immunization clinics to reach out to unenrolled but eligible parents.

[114] Medicaid and CHIP: Given the Association between Parent and Child Insurance Status, New Expansions May Benefit Families. (2011). *United States Government Accountability Office*. http://www.gao.gov/new.items/d11264.pdf

[115] Dubay, L., Kenney, G. (2003). Expanding Public Health Insurance to Parents: Effects on Children's Coverage under Medicaid. *Health Services Research*, 38(5), p. 1283-1302. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1360947/

- Target enrollees with frequent cycling on and off Medicaid. County residents who enroll,dis-enroll, and enroll again incur higher administrative and clinical costs. Sampling providers and using state data to determine which consumers sought care but were not in the eligibility verification system (EVS) on any given date of service could reveal demographic patterns in churn, which could be overcome via outreach and public education.
- Examine differences in penetration rate by demographic group using data from ValueOptions and by service type. Stigma and denial are reasons why people do not access behavioral health services until they are in crisis. Are penetration rates significantly higher among individuals who are jail-involved, have accessed the crisis system, or been hospitalized?
- Work with somatic providers, particularly safety net providers such as Federally Qualified Health Centers (FQHCs), to market behavioral health to increase penetration rates. Behavioral health care is frequently delivered in primary care settings. Although Maryland has a carve-out for Medicaid behavioral health services, primary care providers prescribe the majority of antidepressants nationwide. Working with somatic providers to co-locate, contract with, or otherwise facilitate access to behavioral health services will increase penetration rates.
- Provide public outreach and education. Individuals who have been un- or underinsured may not know that Medicaid provides a behavioral health benefit. Information on benefits should be included in primary care settings, in schools, and through sister agencies.

## 4.2 Medium-Term Recommendations

### 1. Direct Resources to Prevention, Promotion and Community-based Treatment

Build on the existing Prince George's County public health approach, evaluate current activities and initiatives, and direct resources into prevention, promotion, and community-based interventions supporting greater emotional wellbeing and resiliency. The County should leverage public health county-wide initiatives, including Project LAUNCH as discussed previously, and establish strong sister agency collaboration to develop a single and unified plan that joins all the elements and plans together, one that enhances the overall health and well-being of the residents of the County.

In the spring of 2015, the County released the website, PGC Health Zone, an interactive source of up-to-date health data related to the Health Enterprise Zone. The PGC Health Zone reports on a broad range of indicators, including data on demographics, families in poverty, and status of Healthy People 2020 goals linked to disease prevention and health promotion activities, suicide rates, binge drinking, and insurance coverage. Although the PGC Health Zone is reflective of initiatives related to the Health Enterprise Zone, it offers a base that can be leveraged in the selected communities. Through evaluation of the data, the identification of needs within the larger County context and associated initiatives lends itself to coordinated planning and resources devoted to getting out in front of behavioral health problems through organized prevention, early diagnosis, and community-based treatment.

Funding and efforts to improve the behavioral health of County residents through special projects in Prince George's County were listed as key facilitators in the qualitative and quantitative findings to an

effective behavioral health system. For example, the Transforming Neighborhood Initiative (TNI) was described as a source of funding and resources and a broad context in which behavioral health fits in as a component of decreasing crime, unemployment, and improving educational achievement and other issues in the County. The focus on prevention, early diagnosis, and community-based treatment involves therapists working in the schools (e.g. Suitland Elementary). The Health Department also collaborates with roughly 10 organizations in the County, as well Montgomery County, to coordinate with Affordable Care Act (ACA) navigators to help enroll eligible individuals in Medicaid and qualified health plans. Such efforts improve access to behavioral health care through enabling increased coverage rates among County residents. Other initiatives that facilitate effectiveness of the behavioral health system include the Systems of Care and Health Enterprise Zone (HEZ). Under the auspices of the BHWG, bring together the BHWG and HEZ activities and planning through a formalized subcommittee. The subcommittee will specifically determine joint initiatives for consideration, in response to identified gaps and needs, develop a plan and indicators to monitor and report quarterly or semi-annually on progress. Such efforts can help to foster comprehensive and coordinated planning throughout the County, and support the initiatives as they are brought to scale.

Although it is appropriate that the County system leverages crisis intervention services as the center of the service continuum, the County has developed a "downstream" system that is heavily concentrated on responding to and treating crises disproportionally, rather than reaching a large population and aiding them in the recognition of behavioral health needs early on, seeking assistance promptly, and avoiding development of crises and hospitalization as appropriate. *One example is the insufficient numbers of community-based mental health clinics.* As discussed earlier, the County has not established a transparent process for determining and monitoring performance, based in identified metrics and regular reporting of outcomes information. Although the crisis response and emergency systems seem to function, and perhaps in some respects, function well, scant attention and resources are devoted to addressing the many forces, barriers, and issues driving individuals with mental illness and substance use disorders into the crisis system in the first place.

Action Steps:

- Link contracts to County goals. The County spends over $1 million on crisis services. Consider reducing the award and redirecting funds to community providers to increase urgent care/walk-in capacity. Crisis services are expensive and have limited Medicaid reimbursability. Favoring more open scheduling, after hours, and urgent care within community-based providers would promote less expensive services for which federal dollars are available.

2. **Strengthen Partnership between Mental Health and Addiction Services and Expand the Cultural and Linguistic Competency of Organizations.**

Prince George's County should change purchasing arrangements to reflect a move toward integrated care between mental health and addiction services. For FY 2016, the County largely funds programs and services at the same level as FY 2014, despite data that individuals with co-occurring disorders consume a disproportionate share of resources. The County should be a more discriminating purchaser of services

by soliciting vendors who can deliver high-quality integrated services based on community need. It also should consider the cost-per-unit and cost-per-person when contracting for services to maximize efficiency. The County has a year to develop the Medicaid payment system for addiction services, including determination of the associated indirect costs of care. It is critical that the County make this planning and transition a priority, as it establishes the needed infrastructure to participate fully in the state's reform efforts and the future under ACA.

Although the County offered two Dual Diagnosis Capability Trainings for 88 providers, an important step that is missing would be to establish an indication of how many of those providers are engaged in efforts to align their services to improve outcomes for individuals with co-occurring illness. It is imperative to link the initiative with the expected outcome, determine the measures associated with the outcome, and develop a process of monitoring the result. This is one example of how the County builds the structure to become a data-driven system.

It was reported that the transition from block grant to a fee-for-service payment system under Medicaid for substance use disorder services is viewed as a concern to the County, especially due to loss of flexibility in block grant funding. The State is willing to make the County "whole," should it identify the associated costs that will not be recovered under Medicaid. The County will identify these costs that can be related to the buildout of the billing infrastructure and administration, as well as inclusion of the provision of services for the populations not eligible for Medicaid.

Our qualitative data analysis suggested a low level of cultural and linguistic competency as an organizational barrier for behavioral health providers, which includes the Health Department. A gap was noted for personnel assigned to address the linguistic and cultural competency of behavioral health services in the County. Other gaps in personnel mentioned include a lack of racially and ethnically diverse staff members, a lack of linguistic capacity among staff members to communicate with non-English speaking consumers and family members, and a lack of understanding of cultural practices and attitudes of diverse individuals and families living in the County.

As the County partners with the Human Resources Department, it must review the positions and job descriptions within the Health Department, and the adequacy and competencies associated with the types of behavioral health positions available. Undergoing a major system transformation will require strong leadership, and a sophisticated and receptive team of individuals within the CSA and substance use disorder services. All staff working in the Health Department need to be engaged in understanding the implications of the transformation, facilitating the changes, problem-solving, and recognizing how his or her job must adapt in achieving a more effective and efficient, and high quality behavioral health system.

### Action Steps:

- Require organizations that contract with the County to build system capacity. Through its contracting process, the County could require all, or select categories of contractors to develop capacity for prevention, screening and brief intervention such as Screening, Brief Intervention

and Referral to Treatment (SBIRT) for substance use disorders, and identify metrics by which they demonstrate progress.

- Require organizations that contract with the County to build their linguistic and cultural competencies and identify metrics by which they demonstrate progress. Partner with SOC planning as expanding the adequacy and responsiveness of linguistic and culturally competent services for all ages of children, youth, and their families and adults seeking services in the County is needed.
- Partner with Human Resources Department to evaluate job descriptions and core competencies, including cultural and linguistic capacity.

## 4.3 Long-Term Recommendations

### 1. Greater Coordination across Service Areas

Prince George's County has programs operated by many different agencies—the Health Department, Department of Social Services, Department of Family Services, Sheriff's Department and Police Department, Mental Health Court and the regular juvenile and adult justice systems, the correctional system, and Department of Housing. Many dedicated staff members are engaged in these programs. A key problem is insufficient coordination across the programs. Since many people are touching multiple programs and need an array of health and social services, closer linkages are needed.

The BHWG offers an excellent forum, and the people we interviewed uniformly said that they found the activities and meetings useful. As discussed, the BHWG should continue and we suggest the County establish an active inter-agency task force, operating under the direction of the BHWG that meets regularly to coordinate multi-dimensional interventions for people with complex behavioral health needs that cross sister agencies' responsibilities. Tapping into the existing Local Care Team (LCT), representatives from child-serving agencies and a parent advocate that meets bi-weekly, the County has the potential to strengthen and coordinate efforts for youth with special or intensive needs such as a residential placement or alternative to residential placement due to behavioral, educational, developmental, or mental illness.[116] By linking with the LCT the BHWG has the opportunity to align efforts, understand youth needs, resources and gaps.

As part of the inter-agency task force, we also recommend that the Health Department meet individually with leadership from each sister agency, and identify joint priority projects and initiatives as part of the transformation of the behavioral health system. These meetings would consider priority touch points that intersect with the larger County public health model, e.g. prevention, promotion, early intervention, family-directed care and community-based treatment, independent living, and improved processes for identifying individuals who touch multiple agencies, have complex needs, many of which are provided by separate agencies.

[116] http://www.princegeorgescountymd.gov/sites/Family/Services/CFIC/ProgramsInitiatives

For example, an adult who may be homeless and living on the street and in shelters may not be getting the disability benefits he or she needs for basic income support; is without a car and health insurance, and lacks an awareness of community health centers that might serve him or her; may have a criminal record that makes it difficult to get a job, and in many cases, to obtain a supported apartment. This person may need treatment for substance use disorder, placement into the County's Housing First program that can offer an apartment even though he or she is not clean and sober, provided the individual agrees to start treatment thereafter; assistance in completing a successful application for SNAP (Food Stamps) benefits, enroll in Medicaid and see a therapist regularly.

As the example illustrates, to address many individuals' needs through the available resources of sister agencies will require the active cooperation across agencies. Individuals need a treatment plan that includes clinical coordination, case management, and social supports. The County needs an interoperable data system that allows a case manager to coordinate the services of the multiple agencies necessary to meet people's diverse needs. The findings of one agency also need to be shared with others electronically, with confidentiality securely protected.

It is essential that plans for individuals be in a format that can be shared by all agencies across different electronic platforms. Open sharing of critical information is necessary for all members of the care team. These care team members should be able to communicate securely and in real time. When a crisis situation is impending, interagency communication and collaboration could avoid a downhill spiral. Agencies sharing information, such as a crisis counselor communicating with a drug treatment provider or psychiatrist, may avert a hospitalization, or an eviction from a housing unit.

Nationally, mental health and drug courts are viewed positively as offering specialized approaches to working with a defined population that may be resistant to engagement in services. The corrections and criminal justice system have legal mandates and authority to place individuals in behavioral health care under defined circumstances, including court-ordered treatment from a mental health judge. The warm hand-off to behavioral health providers (e.g., sheriff's deputy transports court ordered individual to the emergency department) was listed as an especially effective, albeit resource-consuming, method of placing individuals with behavioral health needs into care.

We recommend additional trainings for all agencies that frequently engage with individuals who have behavioral health issues, including teachers, school administrators, and professionals in the justice system. Although many agencies feel they have received excellent training, those that focus on properly identifying behavioral health problems, and connecting individuals and families to care would enhance the system's response. Similarly, the receiving agency should reciprocate and provide information and training regarding their mission, vision, procedures, issues of confidentiality and challenges. Notably, the Crisis Intervention Training (CIT) model was described for improved capacity to address behavioral health among the police department. Key features included additional training, additional staff dedicated to behavioral health issues, and additional funding to pursue a shift from reacting to emergency calls to front-end prevention strategies.

### Action Steps:

- Establish an active inter-agency task force, operating under the direction of the BHWG to coordinate multi-dimensional interventions for people with complex behavioral health needs. Engage individual leadership from each sister agency, and identify joint priority projects and initiatives.
- Tap into the existing Local Care Team (LCT) to strengthen and coordinate efforts for youth with special or intensive needs such as a residential placement or alternative to residential placement due to behavioral, educational, developmental, or mental illness.[117]
- Develop a universal application and consent form for County agency services.
- Conduct a survey to understand the challenges and barriers that providers face when sharing client health information, including behavioral health diagnoses and treatment.

**2. Optimizing Health System Performance**

Leverage Prince George's County Primary Healthcare Strategic Plan (2014) to increase primary care for its residents, and support service provision to move toward greater integration, not just within the behavioral health system, but across the full continuum of care, and link behavioral and physical health care. Primary care can be a major provider of behavioral health services for children, youth, and adults with mild to moderate behavioral health conditions.

The Institute for Healthcare Improvement (IHI) developed the Triple Aim as a framework for constructing and optimizing health system performance. IHI believes that new designs and reforms must be developed to pursue three dimensions simultaneously:

- Improving the patient experience of care (including quality and satisfaction)
- Improving the health of populations
- Reducing the per capita cost of health care.

States, counties, health systems, and communities are realizing that an integrated behavioral health strategy is essential to achieve the Triple Aim, and addressing behavioral health issues requires significant system changes to bring about meaningful improvement.

Over the last several years, under the joint leadership of the Office of the County Executive, Prince George's County Board of Health and Prince George's County Health Department, the County engaged stakeholders and established a public and structured process to create a strategic plan to improve access to primary care for its residents.[118] The plan was part of a larger effort and continuation of the County's evaluation and a RAND Report that highlighted the relatively poor health status of its residents, the lack of easily accessible primary care within the County, and the need for action. The County determined the system must improve access to high-quality, patient-centered primary care, with the ultimate goal of improving the health status of the County residents and strengthening the local

[117] http://www.princegeorgescountymd.gov/sites/Family/Services/CFIC/ProgramsInitiatives
[118] Regional Medical Center. *Prince George's County Maryland, County Executive*. http://www.princegeorgescountymd.gov/sites/ExecutiveBranch/CommunityEngagement/RegionalMedCtr/Documents/Findings%20from%20Community%20Meetings%20June%202014.pdf

economy as a result. Within the strategic plan, the County identified seven overarching dimensions in its multipronged approach to improved access to primary care and health of its residents, in which the expansion of the behavioral health services system within the County plays a vital role.

Our discussions with the executive of one FQHC supported an opportunity for greater collaboration between the County and the FQHCs to expand and increase their behavioral health capacity, including their ability to co-manage individuals with co-morbid and complex medical and behavioral health needs. Additional outreach to the American Medical Society to recruit more primary care physicians into the County is important, as well as is the consideration of grant funding sources or other strategies to recruit physicians who are representative of the diverse populations in the County.

Greater Baden has a network of seven FQHCs, five of which are in located in Prince George's County and are interested in providing a more integrated model of primary and behavioral health care. In our discussion, it was apparent that they are not seeing a large number of individuals, as their behavioral health coverage (one day/week) and breadth of expertise is limited. They recognize they are early in the program development, and are creating processes for warm handoffs to a psychologist. Their descriptions of clients and families seen highlighted a relatively low acuity of behavioral health problems, and the majority of their visits are with children, youth, and families. Although they do not typically serve individuals who have a chronic mental illness, at times they do, since the individuals may not have any other place to go.

Of particular interest is the description of themselves as isolated and independent from County agencies. For example, they did not identify much support or collaboration in managing individuals with mental health issues. Transportation is a major barrier for individuals getting to appointments, and in their experience, Medicaid is reluctant to pay for transportation for mental health visits (although they pay for medical appointments). While Greater Baden has a van, they cannot expand its availability, as that has implications of competing with the Washington Metropolitan Area Transit Authority, which limits how much service they can provide.

As noted, research findings have identified that there is a public health crisis for people with serious mental illness (schizophrenia, other psychoses, bipolar disorder and severe depression), as they experience higher rates of chronic medical conditions (diabetes, obesity, cardiovascular disease and hypertension) and more than twice the rate of premature death resulting from these conditions.[119] There are many opportunities to build capacity for primary health care, and partner with behavioral health providers to increase access for individuals with serious mental illness and substance use

[119] Kelly, D.L., Boggs, D.L., Conley, R.R. (2007). Reaching for Wellness in Schizophrenia. Psychiatric Clinics of North America, 30(3), p. 453-479.
Mauer, B. (2006). Behavioral Health/Primary Care Integration: The Four Quadrant Model and Evidence Based Practices. The National Council for Behavioral Healthcare.
Parks, J., Swendsen, D., Singer, P., Foti, M., eds. (2006). Morbidity and Mortality in People with Serious Mental Illness. National Association of State Mental Health Program Directors.
Skolal, J., Messias, E. Dickersen, F.B., Kreyenbauhl, J., Brown, C.H., Goldberg, R.W., Dixon, L.B. (2004). Comorbidity of Medical Illnesses Among Adults with Serious Mental Illness Who are Receiving Community Psychiatric Services. Journal of Nervous and Mental Disease, 192(6), p. 421-427.

disorders, and help them with issues related to use of psychotropic medications, continued smoking, poor nutrition, and limited exercise.[120]

Proactive identification of individuals using programs like Maryland's Behavioral Health Integration in Pediatric Primary Care and Project LAUNCH offer increased possibilities for integrating mental health and somatic care. Primary care physicians are well known to families, and care takes place in a non-stigmatizing setting. Using the LHIC to promote these integration programs would strengthen intra-agency relationships and the "no wrong door" message, while building bridges between somatic and behavioral health, rather than reinforcing a siloed approach to treatment.

Action Steps:

- Partner with the Maryland Chapter of the American Academy of Pediatrics and MedChi to encourage enrollment in the Maryland Behavioral Health Integration in Pediatric Primary Care program.
- Provide incentives for integration across all County funding streams. When purchasing or contracting for services, the County should favor organizations that are data-driven, capable of sharing data, and provide integrated care. Contracts that span multiple years could build in continuous quality improvement targets with some risk and/or reward to follow.
    - Such procurement and contracting changes should be made gradually, and must have realistic goals to avoid demoralizing or punishing providers interested in piloting innovative practices.
- Foster competition. The County tends to fund the same providers for the same services year after year. Consider reserving some funds for competitive pilot or demonstration projects, or for competitive Requests for Proposals (RFPs).

3. **Provider Capacity Building**

Critical to a high quality, responsive, and flexible behavioral health system is a continuum of services provided by accessible, well-qualified, and linguistically and culturally sensitive and competent providers who are available to provide the right service in the right place at the right time.

Our information-gathering process included the behavioral health inventory and meetings with many people and organizations who noted insufficient levels of services at every point of the continuum: a lack of residential, inpatient, outpatient including ACT and intensive outpatient services, co-occurring, and therapy services. There is also a lack of psychiatrists and psychologists, as well as difficulty retaining psychiatrists and social workers in organizations, with a specific lack of services for children, adolescents and their families. Shortages were described as most dramatic in the southern region of the County. Improving the Medicaid penetration rate of individuals enrolled in Medicaid could attract some practitioners and organizations to accept Medicaid, particularly those in larger group practices or medical centers where centralized billing and economies of scale may ease the administrative burden of

[120] Burman, M., Watkings, A., Watkins, K.E. (2006). Substance Abuse with Mental Disorders: Specialized Public Systems and Integrated Care. *Health Affairs*, 25(3), p. 648-658.

billing. Medicaid coverage is viewed as being robust and comprehensive of behavioral health services, and income eligibility thresholds for children and adults were described as favorable and generous. Although we appreciate that the adequacy of Medicaid payment is a relative term, for many community providers, they are accustomed to billing Medicaid, and accept the reimbursement for services. The portal for Medicaid providers is described as streamlined, and authorized providers can be reimbursed for services within seven days.

As a first priority, the County needs to improve its overall supply of community-based and outpatient/ ambulatory providers. The County delivery system can better support the crisis intervention and rehabilitative services by enhancing outpatient services that could prevent a crisis or the need for long-term intervention such as through Psychiatric Rehabilitation Programs (PRP) and Residential Rehabilitation Programs (RRP). Individuals noted significant difficulty finding jobs, in some cases after several years of receiving services. Although it is understood that there is high demand for vocational services, the County can define the expectation for community organizations to devote more time to identifying more appropriate job placements and trainings to support employment. Notably, some consumers suggested that services are prioritized for individuals with physical disabilities, and individuals with behavioral health conditions are perceived as in need of less support, and their situations are given less attention.

Through the System of Care (SOC) Implementation Grant, Prince George's County has identified the strategic plan and vision for wrapping community-based services around children, youth, and their families with severe emotional disturbance. The vision is nationally supported as an effective philosophy and approach, as the system supports giving voice to the child, youth, and family, partnering with families to facilitate family-driven treatment plans. By wrapping services and supports around the child, youth, and family, the system brings in resources that leverage the resiliency of children,youth, and their families to remain together in their communities, and is a significant shift in the approach to delivery of care. The County continues the momentum to address service limitations for children, youth, and families, and we support wholeheartedly the implementation planning and service delivery model.

Some family therapies are EBPs, and they are specific approaches such as Multisystem Therapy (MST), which was developed as a family-focused intervention program for youth with challenging behaviors and/or substance use disorder. It offers an approach to understand the multidimensional contexts of problems including social-ecological factors. The County will need to establish a process for determining the relevance, considering the number of youth they identify as needing the services, the provider community's ability to invest in the EBPs, and the associated reimbursement under Medicaid. Although payment should not dictate EBPs, it is a practical consideration, as the SOC implementation grant establishes its priorities and implementation plan.

Hospital services, including intensive outpatient and partial hospitalization programs, can be facilitators to an effective behavioral health system. Since the County is one of the sponsors of the Regional Hospital development and partnership with University of Maryland and Dimensions, it is critical that the County assert its position that planning for psychiatric and substance use disorder hospital-based services be made a priority. It is common for the planning efforts of large hospital systems to spend the

majority of the planning time identifying capacity and space for medical surgical and specialty services, rather than giving significant time and resources to behavioral health services, which receive lower reimbursement and do not hold as broad a draw for the communities. Partial hospitalization services could create a step-down approach to community transitions from inpatient care, which helps stabilize the individual and support avoidance of readmissions. Although there is a national trend toward limiting partial hospitalization services, the reduction is associated with the changes that many programs have made, decreasing their staffing levels and resulting in a lessened ability to accept individuals with high clinical acuity. Programs willing to serve individuals with acute psychiatric needs who can be diverted from an acute hospitalization, or stepped down after a short hospitalization, provide a very valuable service. Other intensive outpatient programs can work effectively when they include activities to stabilize housing, prevent inpatient admission, and are person-centered.

Continuums of care have broadened their scope from traditionally defined clinical services to include peer support and family partner services, a broad array of EBPs and Promising Practices, and recognition of the needs of the culturally diverse population they serve. Principles of recovery and resiliency, the role of hope, and appreciation of the variability of acuity in one's illness over time requires a renewed flexibility in offering services, and a person-centered approach that incorporates the individual's personal goals. Programs such as Thinking for Change, Men's Trauma Recovery and Empowerment Model, Targeted Case Management under Medicaid for homeless with behavioral health needs, long-term treatment programs, outpatient mental health with daycare, enhanced crisis programs, inpatient beds, telepsychiatry and telemedicine, mobile services, and co-occurring treatment offer examples of the range of potential services.

It will be important for the County to establish a process of prioritization of services within its continuum, reviewing geographic and population distribution. The process should also identify the addition of EBPs and Promising Practices to complement its expansion of services. In Table 7 Evidence Based Practices and Promising Practices and Services, we identified key EBPs and Promising Practices relevant to the County and its delivery system. Some of the existing services are EBPs and already in place, and the recommendation is for the County to expand some services and reduce other services.

***Table 7: Evidence-Based and Promising Practices and Services***

| Evidence-Based Practices | Core | Consideration for Addition |
|---|---|---|
| Assertive Community Treatment (ACT) – Adult Service | In place | • Review capacity and determine number of additional Teams<br>• Consider addition of smaller teams of ACT staff as another service, as a transition to a lower level of care or establish intensive outpatient services as a step down from ACT |
| Case Management—Mental Health – Adult and Child/Family Service | In place | • Medicaid-eligible service<br>• Expand through contract and/or County employees |

| Evidence-Based Practices | Core | Consideration for Addition |
|---|---|---|
| | | • Project unmet need and add services to support enhanced coordination and transition of care |
| Community Support (Individual, Group) – Adult Service and Child/Family Service | In place | • Expand to support employment and training opportunities, skill development and self-care, and community integration activities |
| Crisis Intervention Services and Mobile Outreach – Adult and Child/Family Service | In place | • Evaluate capacity for adults and children/youth and families including mobile capacity<br>• Enhance components where there are gaps |
| Dialectic Behavioral Health Treatment (DBT) – Adult and Adolescent Service | In place | • Evaluate its inclusion in all behavioral health settings and expand/target populations as needed |
| Psychiatric Rehabilitation Programs – Adult Service | In place | • Review interface with Community Support and determine alignment and/or need for more of less of either service, e.g. CS or PRP to encourage complementary services |
| Therapy/Counseling - Adult and Child/Family Service | In place | • Add EBPs within therapy, such as CBT/ shorter term therapy, Trauma informed care |
| Medication Assisted Treatment (MAT) – Adult and Adolescent/Young Adult Service | In place | • Convert to Medicaid-eligible service<br>• Review range of medications available and align as needed |
| Family Therapies – Adult and Child/Family Service | In place | • Expand to be included in mental health and substance use disorder provider services |
| Systems of Care/Wrap Around Community-based services | In place | • Incorporate SOC implementation grant into one integrated behavioral health system transformation |
| Trauma-Informed Care – Adult and Child/ Family Service | In place | • Implement County –wide as sensitivity to its prevalence underscores its relevance to all interactions with residents whether they be within the behavioral health system or other sister agency interactions |

Cultural and linguistic competency is basic to the provision of accessible, high quality, and responsive services within the behavioral health system. It must be viewed as a priority for the Health Department and its personnel, as well as for the provider system in the County. For individuals and families to access services comfortably, there must be racially and ethnically diverse staff members, with the linguistic capacity to communicate with non-English speaking individuals, and who hold an understanding of cultural practices and attitudes of diverse individuals and families living in the County.

### Action Steps:

- Encourage providers to meet the National Standards for Cultural and Linguistically Appropriate Services in Health Care. These standards apply to all care, not just behavioral health.
    - Track which providers voluntarily meet these standards and compare their patient/consumer engagement data from OMS to similarly situated providers.
- Identify organizations within the workgroup who can act as a "cultural brokers" to span the boundaries of the culture of health care and the cultures of the people they serve.[121]
    - Direct special emphasis on establishing cultural brokers for individuals who are recent arrivals from Mexico, and Central and South America in order to assuage the immigration concerns of newly arrived residents accessing care.
- Coordinate initiative with SOC planning and implementation.

**4. Increase Housing Placements and Subsidies for Individuals with Behavioral Health Needs**

Increasing the availability of short-term and long-term affordable housing options, and improving access through greater funding for housing subsidies for individuals with behavioral health needs are key recommendations. Such housing should be flexible to include residents in recovery, who are not yet fully clean and sober, and should provide onsite support services or linkages to community-based services.

Need for additional housing options is well-recognized, and effective housing programs should work cooperatively with landlords to ensure tenant rules are followed, and interventions occur immediately to prevent or respond to incidents among individuals with behavioral health needs. The scarcity of housing resources leads to favoring transitions of individuals with behavioral health issues from State facilities, which further restricts housing options of non-institutionalized individuals with behavioral health issues, including the homeless.

### Action Steps:

- Collect data across multiple agencies to identify homeless or housing insecure individuals with behavioral health needs. Are those individuals engaged in outpatient services? Homeless or at-risk individuals need connections to affordable, safe housing, and to housing supports. While Medicaid will not reimburse for housing itself, it will pay for support that encourages success in maintaining housing.
- Develop a plan to monitor the availability of HUD vouchers for individuals with behavioral health needs.

**5. Improve Transportation to Reduce Systems-Level Barrier for Individuals Accessing Behavioral Health Services**

The County will need to partner with the Department of Transportation and Medicaid to establish a comprehensive and joint plan to improve travel within the County and its capacity to support the

[121] Cultural Brokering. *Georgetown University, Center for Child and Human Development, National Center for Cultural Competence.* http://nccc.georgetown.edu/resources/brokering.html

behavioral health system redesign. We also recommend the County engage sister agencies in this discussion, as the adequacy of transportation is a larger issue for the population than accessing behavioral health services.

Few health and behavioral health organizations provide transportation assistance for individuals to travel from their home to the location of services. This lack of transportation services is significant in southern Maryland and outside of the southern tip, as individuals travel outside of Maryland. Providers, consumers, and families reported a lack of public train and bus service for travel of long distances, particularly in Bowie and Largo, as well as services outside of the County, e.g. Baltimore County, Charles County, Washington, DC, and Northern Virginia. Although we do not want to minimize the need, the County must establish a realistic plan, in partnership with relevant parties and inclusive of timeframes.

### Action Steps:

- Consider community benefit expenditures. In 2014, Prince George's County had a Community Benefits Expenditure Workgroup that explored the possibility of "developing a collaborative, countywide community benefits strategy across the hospitals that operate [in the County]."[122] Transportation is key to accessing services needed to control chronic conditions. The County should explore whether community benefit funds could be used to subsidize transportation on existing systems (e.g., WMATA and The Bus) or create new limited service routes.

**6. Maryland Finance Reform and the County's Transition to Medicaid Reimbursement**

The County needs to develop a structure to transition to Medicaid financing of all behavioral health services and within this fiscal year, specifically substance use services. This process should include a comprehensive assessment of services provided, with evaluation of their effectiveness and impact. The County also needs to ensure that credentialed and licensed individuals are delivering the services. Another element of the overall strategy is the development of a billing process including submission of claims and procedures, as well as the documentation that supports the federal Medicaid requirements, including their ability to withstand a federal audit. This needs to be completed very quickly (to position the County to implement and make the appropriate changes associated with the new process).

Prince George's County has an opportunity to conduct a comprehensive review of all of its funding streams for behavioral health services, as has been completed within the SOC planning for children and their families. The County needs to assess the service areas in which it leverages current Medicaid reimbursement, as well as potential substance use disorder services; receives grant support and for what services; County-funded support (type of services, how many, contracted or County staff delivered). The County should also identify opportunities for more collaboration with sister agencies, leveraging County, Medicaid, and other state and federal funds.

[122] Prince George's Primary Healthcare Strategic Plan: Final Recommendations from Hospital Community Benefits Programs Committee Workgroup. (2014). *Prince George's County Maryland, County Executive*. http://www.princegeorgescountymd.gov/sites/ExecutiveBranch/CommunityEngagement/RegionalMedCtr/Documents/Community%20Benefit%20Recommendations%20Final%2010.1.2014.pdf

Once that baseline inventory has been completed, the County needs to evaluate and prioritize opportunities that are aligned with the recommendations for the behavioral health system transformation. Consideration of pay-for-performance incentives could help align incentives to provide care for individuals at their own customized level of need, rather than fitting individuals into slots of programs, with no incentive to transition services to less intensive need levels, which are insufficiently responsive to the person's current needs.

The County contracts for some services and directly provides other services. All services should be evaluated to understand the costs and benefit of the services, e.g., what is provided, to what number of people, for what length of time, and the associated outcomes. Establishment of this baseline will be used as the County implements the plan for behavioral health services as a guide to making decisions. The findings of assessments of the costs and effectiveness of various services will aid in shifting funds as needed to different areas and allowing the County to make changes as it obtains more information about the County's population's needs and the service array offered.

The more complicated yet vital initiative is developing sister agency collaboration in a process of assessment, identifying common areas of interest within the behavioral health system and potential synergies of funding when braided together. This process does not change a sister agency's authority and responsibility. Rather, it is a joint exploration of shared services to meet the complex needs of each agency's population, and together identify the services provided, contracted, or directly delivered by the County, financing for the services, population need, and the potential for joint purchase and/or provision by the County employees. To be successful, the sister agencies would need to agree that the discussion of the potential opportunities for joint funding is a "neutral" discussion, not one in which there is a winner or loser. Whether this could be sponsored through the BHWG or some other mechanism will need to be considered.

### Action Steps:

- Redesign and leverage Medicaid financing to support a robust array of behavioral health services
- Partner with sister agenices and identify common behavioral health needs among priority populations, determine shared approaches to meeting those needs, and braid funding to support the delivery of the services.

## Acknowledgements

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Wright Doss

Collette M. Harris and the National Alliance on Mental Illness – Prince George's County

Brian Hepburn

Sharon Hunt

Anea A. Jordan

Hillary Lindeman and the Human Services Coalition of Prince George's County

Prince George's County Behavioral Health Work Group

Prince George's County Department of Corrections

Prince George's County Department of Family Services

Prince George's County Department of Social Services

Prince George's County Police Department

Prince George's County Sheriff's Department

Transforming Neighborhoods Initiative

## Appendix A: Interview List

### Prince George's County Health Department

1. Pam Creekmur, Health Officer
2. Elana Belon-Butler, Deputy Health Officer
3. Dr. Ernest Carter, Deputy Health Officer
4. Wright Doss, Behavioral Health Division
5. L. Christina Waddler, Core Services Agency
6. Sarah Rosenberg, Youth Services
7. Ronald Bates, Adult Services
8. Dr. Jaqueline Somerville, Community Screening Assessments
9. Gena Greenhood, Core Services Agency
10. Gaylee Jordan-Randolph, Deputy Secretary of Behavioral Health
11. Karen Burks, Behavioral Health Services Division

### Sister Agencies

12. Henry Stawinski, Deputy Chief, Prince George's County Police Department
13. Orlando Barnes, Assistant Sheriff, Prince George's County Sheriff's Office
14. Mary Lou McDonough, Director, Department of Corrections
15. Whitney Palin, Interim Director, TNI
16. Susan Ward, Director, Affiliated Santé
17. Gloria Brown, Department of Social Services
18. Renee Enser-Pope, Department of Social Services
19. Theresa Grant, Department of Family Services
20. Stephen Liggett-Creel, Chief of Staff, Department of Social Services

### Providers

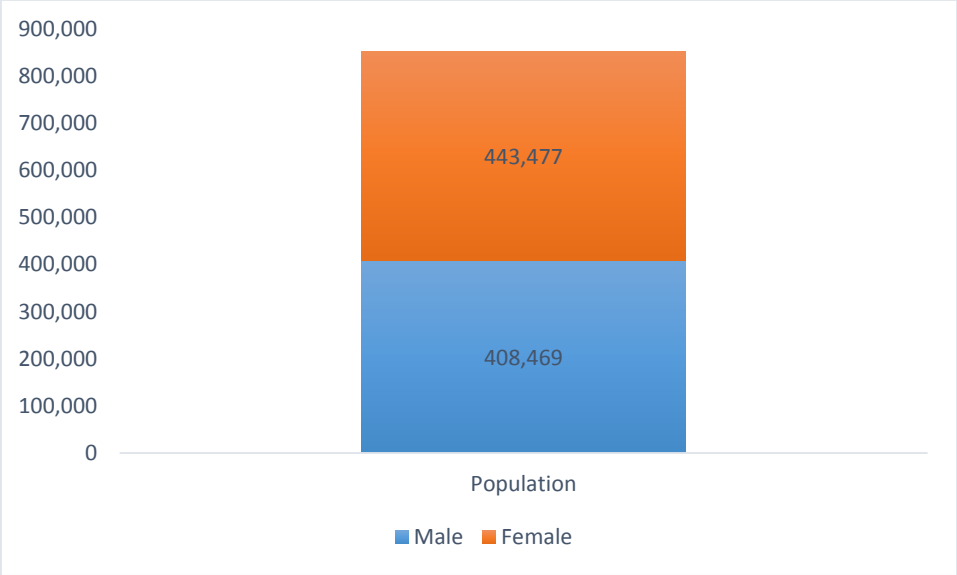
21. Valerie Stanfield, Director of Intake and Assessment, MedStar: Southern Maryland Hospital
22. Carrol Simmons, PHP Director, MedStar: Southern Maryland Hospital
23. Katherine Beach, Social Work Coordination, MedStar: Southern Maryland Hospital
24. Paul Grenaldo, Chief Operating Officer, Doctors Community Hospital
25. Singh Taneja, Chief Operating Officer, Prince George's Hospital Center
26. Candace Hanrahan, Chief Nursing Officer, Prince George's Hospital Center
27. Steven Twaddle, Executive Director, Dimensions Healthcare Associates
28. Colenthia Malloy, Chief Executive Officer, Greater Baden Medical Services Inc.
29. Steve Sharfstein, President and Chief Executive Officer, Sheppard Pratt Health System
30. Thom Harr, Chief Executive Officer, Sheppard Pratt Health System
31. Dimitrios Cavathas, Vice President of Integrated Care and Development, People Encouraging People
32. Scott Birdsong, Chief Program Officer, Family Services Inc.

### Other

33. Sharon Hunt, Project Director, Prince George's County Expansion Planning Grant; Principal Project Specialist, AIR
34. Collette Harris, President, National Alliance on Mental Illness
35. Pamela Preston, Principal, Suitland Elementary School
36. Jennifer Hawkins, Senior Manager, 311 Program
37. Shelia Lee, Faith Leader
38. Adrienne Ellis, Health Care Reform and Community Engagement, Mental Health Association of Maryland
39. The Hon. Patrice Lewis, Maryland Mental Health Courts
40. Christian Rhodes, Education Policy Advisor, Office of Prince George's County Executive
41. Brian Hepburn, Former Executive Director, Department of Health and Mental Hygiene – Behavioral Health Administration

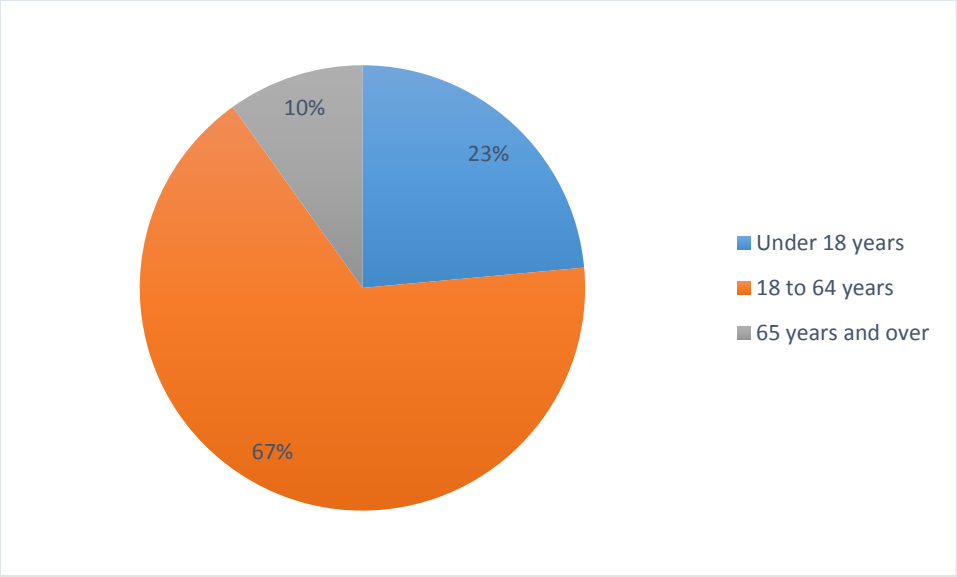
# Appendix B: Supplemental Demographics Data

***Figure 1: Gender breakdown of Prince George's County, MD***



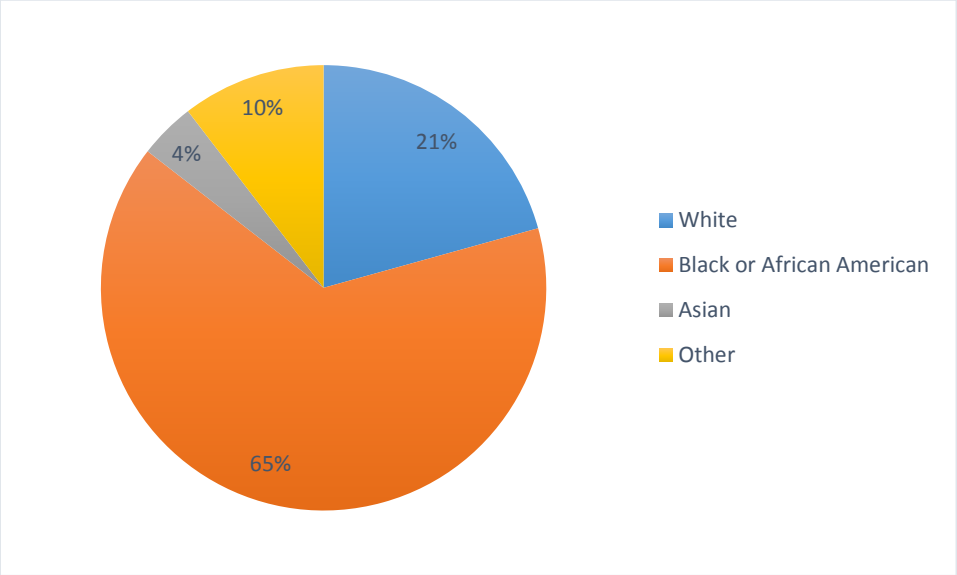

U.S. Department of Commerce, U.S. Census Bureau. (2013). People QuickFacts: Prince George's County.

***Figure 2: Age breakdown of Prince George's County, MD***



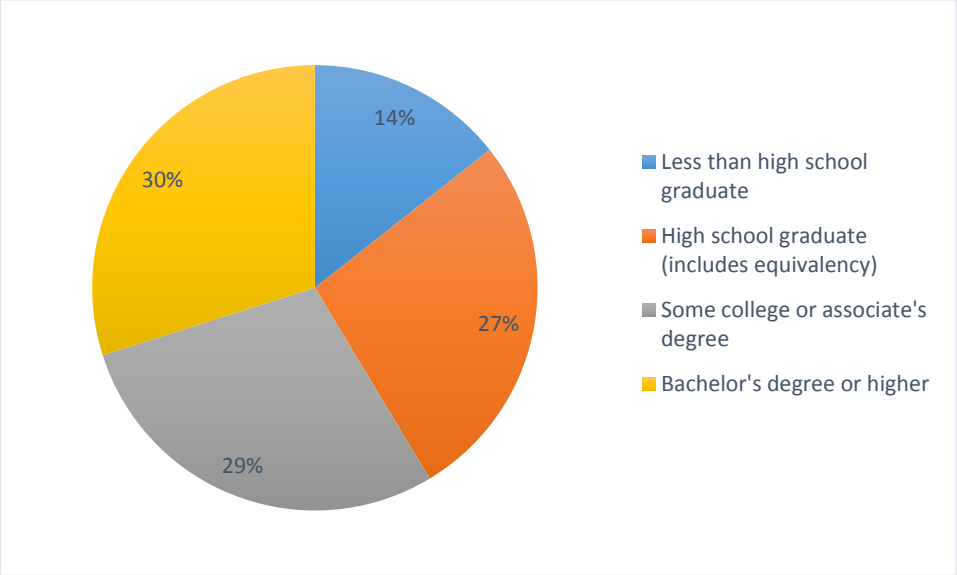

U.S. Department of Commerce, U.S. Census Bureau. (2013). People QuickFacts: Prince George's County.

***Figure 3: Race breakdown of Prince George's County, MD***



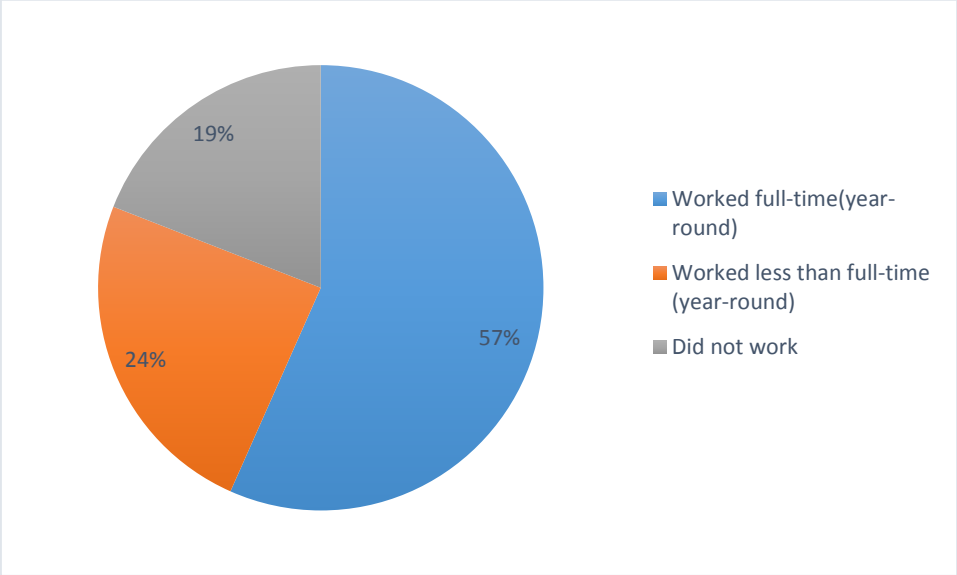

U.S. Department of Commerce, U.S. Census Bureau. (2013). People QuickFacts: Prince George's County.

***Figure 4: Educational attainment of individuals ages 25 years and older in Prince George's County, MD***



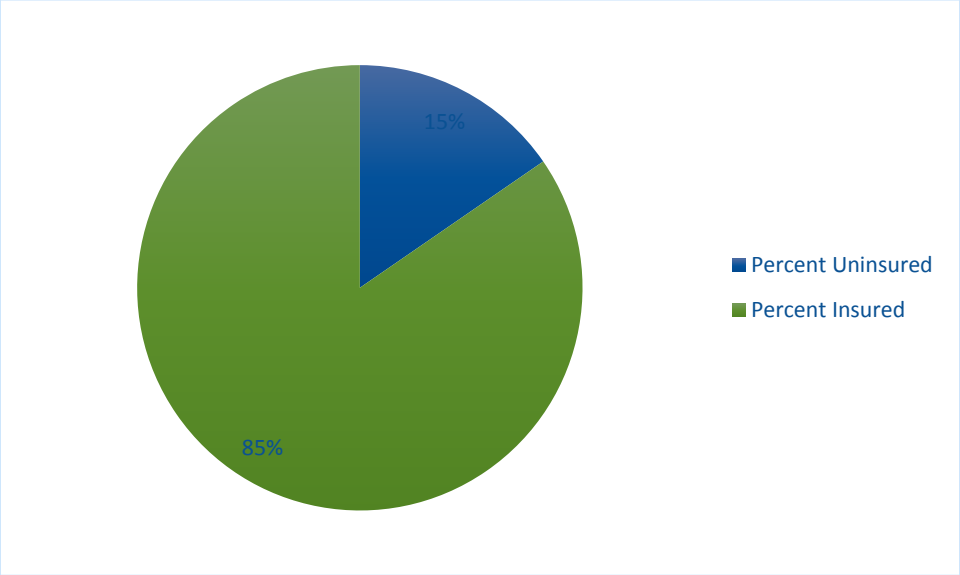

U.S. Department of Commerce, U.S. Census Bureau. (2013). American Factfinder: Education Level.

***Figure 5: Employment statistics of Prince George's County, MD***



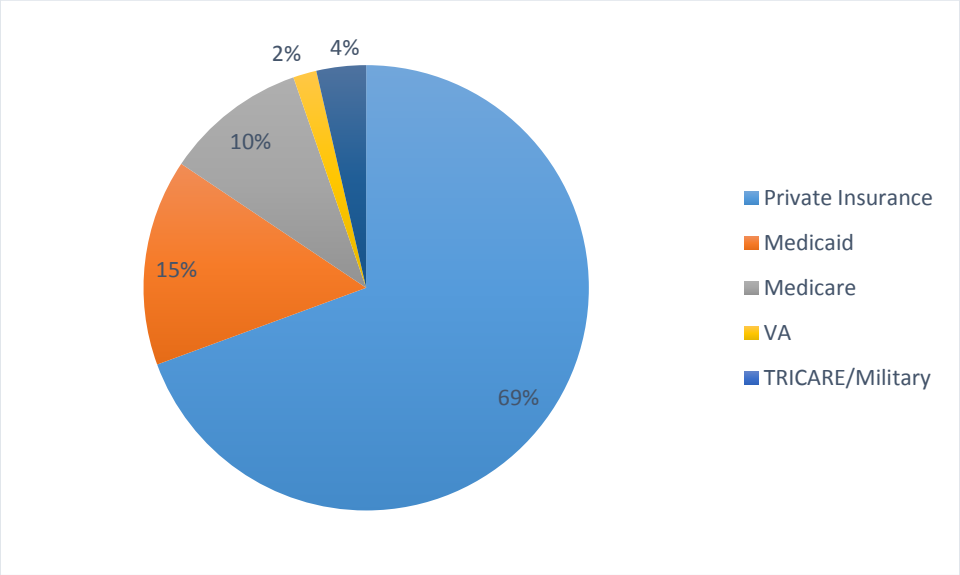

U.S. Census Bureau. (2013). Summary Statistics on Prince George's County: 5-Year American Community Survey.

***Figure 6: Breakdown of individuals with and without health insurance in Prince George's County, MD***




U.S. Department of Commerce, U.S. Census Bureau. (2013). American Factfinder: Health Coverage.

***Figure 7: Source of health insurance for individuals within Prince George's County, MD***




U.S. Department of Commerce, U.S. Census Bureau. (2013). American Factfinder: Health Coverage.

## Appendix C: Focus Group Participant Information Sheet

Instructions: Please provide answers, to the best of your ability, for questions 1-7 below. Note that for some questions you should select only one answer choice, and for others you may select all answer choices that apply. Please do not write your name on this participant information sheet.

1. Age: _____

2. Gender
   - ☐ Female
   - ☐ Male

3. Race/Ethnicity
   - ☐ White
   - ☐ African American
   - ☐ Hispanic/Latino
   - ☐ Asian
   - ☐ Other, please specify:_____

4. Which statement(s) best describe your interaction with the behavioral health system in Prince George's County? Please select all answer choices that apply.
   - ☐ I have used behavioral health services in Prince George's County.
   - ☐ My child(ren) have used behavioral health services in Prince George's County.
   - ☐ Other member(s) of my family (e.g., spouse, parent) have used behavioral health services in Prince George's County.

5. About how often do you and your family members use behavioral health services in Prince George's County? Please select one answer choice.
   - ☐ Rarely (0-1 times in the past 12 months)
   - ☐ Occasionally (2-6 times in the past 12 months)
   - ☐ Frequently (about once a month)
   - ☐ Very Frequently (more than once a month)

6. What types of behavioral health services have you and your family members used in Prince George's County? Please select all answer choices that apply.
   - ☐ Residential Services
   - ☐ Hospital/Emergency Room Services
   - ☐ Health Department/Clinic Services
   - ☐ Physician Services (e.g., primary care physician, psychiatrist)
   - ☐ Other Provider Services (e.g., counselor, therapist, psychologist, case manager)
   - ☐ Crisis Hotline/Crisis Intervention Services
   - ☐ Other, please specify: _____

7. Overall, how would you rate your experience(s) interacting with the behavioral health system in Prince George's County? Please select one answer choice.

- ☐ Excellent
- ☐ Good
- ☐ Fair
- ☐ Poor

# Appendix D: Sample Semi-Structured Interview Guides

**Prince George's County Health Department**
**Behavioral Health Needs Assessment**

**INTERVIEW GUIDE**

**Prince George's County Health Department Behavioral Health Division Program Chiefs**

**Overview of SOW (topic areas for interviews with PCs are in bold)**

- **Identify existing state and county BH services, plans/policies re adults and youth (0-18 years) with intensive BH needs**
- **Inventory and gap analysis of existing programs, services, resources, surveillance systems, policy / legislation, and current method of tracking utilization of BH services by clients- identify strengths and areas of improvement**
- Identify best practices for delivery of BH services
- **Determine opportunities for collaboration with key sister agencies**
- **Evaluate BH measures /demonstration of effectiveness and efficiency of services, goals, programs and objectives**
- Evaluate effectiveness and efficiency of Prince George's County BH advisory group
- Develop plan with defined action steps, recognizing the objective of launching changes to address gaps and create foundation for four to five year plan to transform BH system
- Conduct assessment of EBPs/promising approaches to BH prevention and treatment

**Interview Questions Prince George's County Health Department Behavioral Health Division Program Chiefs**
(Depending on person interviewed some questions more applicable than others; others may need to be added)

Overview of our study
Request interviewee introduce self

1. Before we get into the specifics and the various challenges you are facing, could you give us a brief overview of your vision for a system that would fully meet the behavioral health needs of the residents of the county?
2. What is your overall assessment of how the county is doing in ensuring access to BH services?
3. What County BH services and supports does your program provide? What populations receive the most attention?
    a. How well do you think the County is doing in meeting the objective of ensuring access?
4. Recognizing the diversity of populations in the County, their needs and how best to serve them with respect, and with cultural and linguistic sensitivity, what key information/data elements are critical to gather and review?

5. Please describe the existing BH surveillance systems in the County and the BH measures used to determine the effectiveness and efficiency of BH program services in meeting your goals.
    a. What is the current method of tracking utilization of BH services by clients? What are the strengths and weaknesses? What improvements are needed?
6. Who are the current vendor(s) with whom the County is contracting to provide BH services, and what types of services are being provided?
    a. How do you monitor vendor performance and services?
    b. How is the vendor currently performing?
    c. What are the vendor's strengths and weaknesses?
    d. How can the vendor and/or County improve access to and delivery of BH services to the target population(s)?
7. What are the gaps and/or weaknesses you have identified in County BH policies and legislation? What does the County need in terms of policies and legislation to best support the BH system, to deliver and expand access to BH services in the County, improve the County BH system, etc.
8. In light of your response, how would you go about prioritizing the issues you identified, understanding change and resource allocations may require the County to determine areas that are most critical and/or of higher or lower importance as it moves forward in its transformation?
9. How do you see your role in driving this transformation?
10. (Depending on response) Are there barriers and opportunities to being most effective in meeting your responsibilities with respect to your goals - within the County structure and with external partners?
11. Are there specific collaborations or opportunities for better service integration that would help you and your agency better serve clients and meet your mission? Are these within the County departments itself? Sister agencies (state/county)? Community partners (traditional health and BH care and faith-based/social services and supports)?
12. To what extent are you involved in setting goals for your programs (or agency) and are there established mechanisms to support accountability and/or demonstrate goals are met (for programs/agency) and /or are there goals for the entire County that cross different programs (and should there be)?
13. Are there particular people you think we should meet with to get a better sense of the effectiveness of the services provided or funded by the County?

**Prince George's County Health Department**
**Behavioral Health Needs Assessment**

**INTERVIEW GUIDE**

**Interview Questions for Hospital Executives**
(Depending on person interviewed some questions more applicable than others; others may need to be added)

Brief overview of our study

Request interviewee to introduce self

1. Before we get into the specifics and the various challenges you are facing, it would be most helpful if you could give us a brief overview of your hospital system, with a special emphasis on your behavioral health services.
2. What trends are you experiencing in inpatient admissions related to behavioral health problems? You may want to distinguish between those admitted for mental illnesses such as schizophrenia, bipolar disorder, and serious depression, versus people admitted for substance use conditions. Of course, we recognize that these two types of conditions frequently co-occur.
3. What can you tell us about emergency department visits related to both serious mental health problems and crises, as well as substance abuse ED use, particularly overdose situations? (perhaps probe more specifically about severe problems related to opioid misuse, heroin use, as these problems seem to be front and center concerns for a number of Maryland hospitals). Do you use 23-hour observation stays to address the needs of these patients?
4. Do you have adequate resources, both financial and human resources, to address these problems? What gaps, if any, in your ability to meet these needs are you experiencing, and what would it take to fill these gaps? What barriers do you face?
5. We wanted to ask you about efforts to divert people from ED use and to reduce admissions through better managing the care of people in the community. As you know, under the new All-Payer System with caps on the growth of total per capita hospital revenue, hospitals have an incentive to work with community partners such as FQHCs, other community health centers, and community-based organizations to manage the behavioral health conditions of patients in a way that controls their condition and reduces complications and crises that can lead to hospital use. Is your hospital participating in such efforts, or do you have specific plans to do so?
6. A specific follow-up: is your hospital actively participating in one of the Regional Partnerships that have recently received support from HSCRC to conduct regional planning in support of the goals of the All-Payer model?
7. Can you tell us about your work in improving discharge planning and follow-up for patients with behavioral health conditions? What are some particular strategies, including initiatives related to ensuring that the patient leaves with appropriate medications and advice on medication

management, home or telephonic check-ins, linkages to the patient's primary care provider and/or mental health provider?

8. Are you using your community benefit requirement in ways that address the behavioral health challenges in Prince George's County?
9. As a leader in the provider community, what is your overall assessment of how the county is doing in ensuring access to BH services? What gaps do you see in County provision of services? What could the County be doing, in your opinion, to help manage the needs of people in the community to reduce the incidence of crisis situations that you are seeing in your hospitals?
10. What initiatives are you involved with or have you started that recognize the diversity of populations in the County, their needs and how best to serve them with respect, and with cultural and linguistic sensitivity?
11. In light of your response, how would you go about prioritizing the issues you identified, understanding change and resource allocations may require the County to determine areas that are most critical and/or of higher or lower importance as it moves forward in its transformation?
12. How do you see your hospital's role in driving a transformation that emphasizes prevention, collaboration across sites and various agencies, medication management, and the integration of physical and behavioral health services?
13. Are there particular people you think we should meet with to get a better sense of the effectiveness of the services provided or funded by the County?

# Appendix E: Semi-Structured Focus Group Guide

**Focus Group Questions and Discussion Topics**

- How long have you been involved with the BH system in Prince George's County? (Directly as client/family member and/or as advocate)
- Please describe what those experiences have been like? Over what period of time?
- When you have needed assistance /access to BH services, were you able to find the help you expected or needed?
    - If not, what happened and/or describe how the issues you were facing were addressed?
    - Are there one or two things that you feel helped you get the assistance you needed and /or navigate the BH system?
        - Probe (Individuals)
            - friends/family
            - medical professionals
            - case managers/service coordinators
        - Probe (Organizations)
            - public health/social service organizations/agencies
            - advocacy organizations
            - insurer
        - Probe (Other)
            - web-based resources
    - Were there barriers or obstacles you faced? How did you get over those barriers?
        - Probes
            - availability of services/waitlists
            - affordability of services/insurance coverage
            - proximity of services/transportation
            - eligibility/restrictions on service use - set by insurer, set by provider/organization
- Have you ever received behavioral health services outside of Prince George's County (e.g., Montgomery County, Washington DC)? Please give some of the reasons you had to seek behavioral health services outside of the county? How did your experiences receiving these services outside of the county compare to receiving services inside the county?
- Do you have particular suggestions to the County that would make the system better? What would be your top two priorities? Do you have any further ideas that would make the suggestions actionable/realizable?

## Appendix F: Qualitative Analysis Coding Framework

| Primary Code<br>• Sub-code | Definition |
|---|---|
| **BEHAVIORAL HEALTH SYSTEM**<br>• **Public organizations**<br>• **Private organizations**<br>• **Laws and policies**<br>• **Accountability mechanisms**<br>• **Surveillance systems**<br>• **Collaborations**<br>• **Partnerships**<br>• **Leadership** | Descriptions of the current behavioral health system in the county, including:<br>• Roles and activities of public organizations (e.g., Health Department, FQHCs, community health centers), at all levels of government, and private organizations (e.g., hospitals, CBOs) that have some involvement with the behavioral health system.<br>• Laws and policies, at all levels of government, that establish, fund, direct, or otherwise influence one or more aspects of the behavioral health system.<br>• Mechanisms used to establish system level goals for accountability to those goals.<br>• Surveillance and tracking systems that capture data used for performance measurement or to otherwise evaluate one or more aspects of the behavioral health system.<br>• Collaborations between organizations for behavioral health purposes (e.g., advisory groups, Regional Partnerships).<br>• Formal (e.g., vendors/contractors, grantees, MOUs) and informal (e.g., as needed communications and/or referrals) partnerships between organizations for behavioral health purposes.<br>• Key stakeholders, leaders, decision makers, or other individuals of influence involved in some aspect(s) of the behavioral health system. |
| **BEHAVIORAL HEALTH SERVICES**<br>• **Types of services**<br>• **Modes of delivery**<br>• **Referrals**<br>• **Sites**<br>• **Providers**<br>• **Cultural competency** | Descriptions of behavioral health services currently provided in the county to the target patient population, including:<br>• Types of services (e.g., inpatient, outpatient, integrated care)<br>• Modes of service delivery (e.g., facility-based, mobile, tele-health)<br>• Patient referrals (e.g., within the county, from outside to inside the county, from inside to outside the county)<br>• Facilities and other locations where services are delivered (e.g., hospitals, clinics, schools)<br>• Types of providers who deliver services, in terms of training/discipline and (e.g., physicians, psychologists, case managers) affiliation (e.g., public, private)<br>• Culturally competent practices (e.g., formal training, translation services/multiple language print material) |
| **OTHER SERVICES**<br>• **Health services**<br>• **Family services**<br>• **Housing services**<br>• **Employment services**<br>• **Food programs** | Descriptions of non-behavioral health services currently provided in the county to the target patient population.<br>• Health services (e.g., screenings, primary care, specialty care)<br>• Family support services (e.g., domestic violence services)<br>• Housing services (e.g., shelters, affordable housing)<br>• Employment services (e.g., placement, training) |

| | |
|---|---|
| | • Food service programs (e.g., food stamps, WIC ) |
| **CHANGES** | Descriptions of planned/expected changes to the behavioral health system in the county that have not yet occurred. |
| **RESOURCES**<br>• **Financial**<br>• **Capital**<br>• **Human** | Descriptions of financial and non-financial resources currently leveraged in the county for behavioral health care, including:<br>• Financial resources (e.g., county funding, state funding, federal funding)<br>• Capital resources (e.g., buildings, equipment, mobile units)<br>• Human resources (e.g., administrative staff, providers) |
| **PATIENT POPULATION**<br>• **Demographics**<br>• **Socioeconomics**<br>• **Behavioral health conditions**<br>• **Physical health conditions**<br>• **Health services use** | Descriptions of the patient population that receives, or is in need of behavioral health in the county, including:<br>• Demographic characteristics (e.g. age, gender, race/ethnicity, nativity)<br>• Socioeconomic characteristics (e.g. poverty, income, employment, education)<br>• Common behavioral health conditions (e.g. schizophrenia, serious depression, substance use)<br>• Common physical health conditions (e.g. diabetes, obesity)<br>• Patterns of health services use (e.g., lack of primary care, non-emergency ED visits) |
| **GAPS**<br>• **High priority** | Descriptions of important features of a behavioral health system that do not currently exist in the county, including:<br>• Gaps in the behavioral health system that should be addressed with the greatest urgency/dedication of resources. |
| **BARRIERS**<br>• **High significance** | Descriptions of factors that diminish the effectiveness of the behavioral health system in the county.<br>• Barriers that most significantly diminish the effectiveness of the behavioral health system. |
| **SOLUTIONS**<br>• **High priority** | Descriptions of possible solutions to filling gaps or overcoming barriers that exist within the behavioral health system in the county.<br>• Solutions to filling gaps or overcoming barriers within the behavioral health system that should be pursued with the greatest urgency/dedication of resources. |
| **FACILITATORS**<br>• **High significance** | Descriptions of factors that improve the effectiveness of the behavioral health system in the county.<br>• Facilitating factors that most significantly improve the effectiveness of the behavioral health system. |
| **OVERALL ASSESSMENT**<br>• **Positive**<br>• **Negative** | Descriptions and ratings of the performance of the behavioral health system in fulfilling its purpose/mission in the county.<br>• Favorable ratings and characterizations of the behavioral health system.<br>• Unfavorable ratings and characterizations of the behavioral health system. |

# Appendix G: Full Results from Key Informant Interviews

## Gaps/Barriers

**Providers**

- Individual and Community Level
  - *Lack of family support*
    - Lack of family support hinders the ability of patients to identify and navigate services.
  - *Lack of access to insurance and benefits programs due to undocumented status*
  - *Overuse of hospital and emergency services*
    - Individuals have been slow to shift from seeking care through hospitals and emergency rooms to seeking care through their primary care provider and medical home.
- Organizational and Provider Level
  - *Long wait times for emergency room services*
    - Long wait times to be processed at intake and seen by providers in emergency rooms is a barrier to appropriate delivery care.
  - *Difficulty discharge planning for transition from hospital to community*
    - Hospital discharge planning, particularly from psychiatric inpatient admissions, is challenging given the limited availability of behavioral health services in the community, especially outpatient psychiatry and therapy.
  - *Lack of providers that deliver care to the uninsured*
  - *Restrictive policies affecting individuals with behavioral health needs*
    - Certain provider organization policies are restrictive toward individuals with behavioral health needs and detract from continuity of care. For example, some residential community based behavioral health service organizations require patient commitments to medication adherence to receive shelter. Additionally, nursing homes have refused to admit behavioral health patients with long term care needs transferring from hospital settings.
  - *Early stage development and implementation of integrated physical and behavioral health programs*.
- Behavioral Health Systems Level
  - *Shortage of behavioral health services and providers*
    - Lack of behavioral health services and provider shortages in the county limits referral capacity for the system, and is a particular problem for hospitals, which are frequently the point of entry into the system for individuals with behavioral health issues. Provider shortages include a lack of physician extenders, such as nurse practitioners. Additionally, it is a challenge to retain medical and social support staff members that provide services to behavioral health patients and there is a lack of efforts to attract behavioral health providers to work in the county. Behavioral health service shortages include residential and outpatient, especially for those with serious mental illness.
  - *Lack of transportation to care delivery sites*
    - Limited public and private transportation acts as a barrier to traveling to care sites, returns to the home or community, and for inter-facility transfers.
  - *Inter-organizational competition and resistance to partner*

        - Competition and resistance to partnership between organizations, particularly hospitals, impede collective efforts to improve system effectiveness.

**Health Department**

- Individual and Community Level
    - *Lack of access to care due to uninsured and undocumented status*
    - *Overuse of hospital and emergency services*
        - Individuals have been slow to shift from seeking care through hospitals and emergency rooms to seeking care through their primary care provider and medical home.
    - *Aging out of youth benefits programs and not enrolling in adult benefits programs.*
        - When youth transition to adulthood and no longer meet age eligibility requirements, they must enroll in disability and health insurance programs for adults. However, many youth age out of benefits and do not apply for adult coverage, particularly Medicaid.
- Organizational and Provider Level
    - *Lack of hospital capacity to provide behavioral health assessments and treatments to pediatric patients*.
    - *Lack of behavioral health training among school teachers and administrators*
        - The lack of training creates challenges within schools for correctly identifying behavioral health problems and connecting families to appropriate care, especially among very young children.
    - Shift from block grant to a fee-for-service payment system for addiction services.
        - Associated with loss of flexibility in block grant funding including covering indirect costs of care.
    - *Health department accepts Medicaid only*
        - The Health Department does not take Medicare, and has experienced bureaucratic barriers trying to receive approval for payment under Medicare. They only provide services to individuals with Medicaid. These services are provided on a sliding scale, which generates little revenue, given most individuals qualify for the lowest bracket on the scale.
    - *Lack of Health Department efforts/champions to seek resources not provided by the state for locally directed projects.*
    - *Lack of a Health Department system for patient outcomes tracking.*
        - There is a lack of patient tracking, particularly outcomes tracking among patients that complete treatment or discontinue treatment prior to completion. There is some measurement of utilization.
    - *Low cultural competency.*
        - The Health Department reports low multilingual capacity, cultural understanding of their racially/ethnically diverse patient population, and difficulty attracting bilingual health professionals.
    - *Low internal awareness of Health Department services.*
    - *Lack of community engagement activities and community awareness building of Health Department services.*
    - *Lack of oversight, monitoring, and accountability mechanisms to ensure Health Department vendors and partners are appropriately delivering services.*
    - *Lack of connections between services offered within the Health Department.*

- *Early stage development and integration of co-occurring mental health and substance use disorder services within the Health Department.*
- *Treatment services are roughly two to three weeks behind schedule.*

- Behavioral Health Systems Level
  - *Lack of funding from Maryland state government and low flexibility to use funding*
    - Resources that would otherwise be directed to Prince George's County Health Department are being directed to Baltimore County and Baltimore City to address heroin and PCP epidemics. Broader factors like the economic recession and state structural deficit also have negatively affected financial resources. Furthermore, the Health Department depends on funding that passes through the state and involves state-identified issues and priorities, which restricts flexibility of the Health Department to tailor funding to their own needs.
  - *Spillover demand from Washington DC*
    - Washington DC experiences greater poverty and social problems that spill over and put pressure on the Prince George's County system.
  - *Separation of mental health and substance abuse systems of care*
  - *Shortage of behavioral health services and providers, especially for uninsured*
    - There is a shortage of behavioral health services, particularly inpatient and residential services, as well as psychiatric services particularly for youth and adolescents. Also, there is a shortage of organizations that deliver care to the uninsured. As a result, there are long waiting lists for organizations that provide services to the uninsured within the county and referrals are frequently made to services for the uninsured outside of the county. The Health Department also lacks an organizational partnership with a medical training program that could help fill the need for behavioral health care providers.
  - *Lack of housing for individuals with behavioral health needs*

**Sister Agencies**

- Individual and Community Level
  - *Overuse of hospital and emergency services*
    - Individuals have been slow to shift from seeking care through hospitals and emergency rooms to seeking care through their primary care provider and medical home.
  - *Lack of enrollment into a medical home, especially among the homeless population.*
    - Although insurance enrollment has steadily increased as a result of the ACA, newly insured individuals are not always enrolled in a medical home, especially certain groups such as homeless individuals.
  - *Lack of awareness of services, especially among families.*
  - *Recidivism among individuals with behavioral health needs*
    - Individuals with behavioral health issues are frequently in and out of the corrections systems, often without spending enough time in the system to be properly evaluated and to determine appropriate medications and dosages.
- Organizational and Provider Level
  - *Low organizational focus on quality among services providers and overall low quality of care delivered*
  - *Lack of provider sensitivity/understanding of consumer and family needs*
  - *Core Services Agency has not fully integrated in the county Health Department*

        - This may be interfering with the ease of referral of individuals to mental health services.
    - *High attrition in the police force*
        - Police officers are retiring or otherwise leaving the force at a faster rate than new officers are joining the force. The Department reports a budget only for filling vacancies, rather than adding new positions that could be focused on addressing behavioral health issues.
    - *High burden on sheriff's office to serve court orders for transporting individuals with behavioral health issues to care*
        - The sheriff's office reports significant burden of time serving court orders from family petitions to transport individuals with behavioral health issues to care. A sheriff's deputy has temporary custody during the process and must remain with the individual in the emergency room, which takes roughly five hours to complete the hand off. This may be due to staff shortages, de-prioritizing these individuals, or both. Some of these individuals are repeatedly court ordered to care. Overall, the number of petitions is growing and nine to eleven staff members are at a hospital on any given day. The sheriff's office has not made progress to relieve this issue through working directly with the hospital.
- <u>Behavioral Health Systems Level</u>
    - *Lack of timely access to services, especially for Medicaid and uninsured individuals*
        - In cases where behavioral health services are available in the county, there are delays to receiving care for Medicaid and uninsured individuals due to lack of providers willing to treat them.
    - *Lack of behavioral health performance measures, quality assurance measures, and accountability mechanisms*
        - Specific mention was made to the lack of an ombudsperson or consumer affairs/protection office for consumers and family members to report and resolve issues with providers.
    - *Emphasis on behavioral health treatment more than wellness and recovery*
    - *Shortage of behavioral health services and providers*
        - Lack of behavioral health services, especially inpatient, outpatient, day programs and shelters, co-occurring programs, and generally, community-based programs. This leads to few resources for referrals for individuals released from jail and discharged from hospitals. Specific mention was given to insufficient service capacity to serve certain populations such as individuals with traumatic brain injury, the homeless, children and youth in schools, and those with a history of trauma. Lack of providers, especially psychiatrists and psychologists and especially in the southern part of the county. This poses long and often prohibitive distances for families and caregivers to travel to bring children and youth to services.
    - *Lack of transportation to and from home and behavioral health services sites.*
    - *Lack of provider visits to sites where individuals with behavioral health needs congregate, such as homeless shelters.*
    - *Lack of continuum of behavioral health services.*
        - For example, upon release from jail, many individuals do not get the follow-up needed for their behavioral health issues. It was noted that a sizable proportion repeat offend in order to return to the corrections system for behavioral health care. Additionally, family members often do not post bail out of the belief that the individual is safer and will receive better care in jail.

- *Lack of coordination and communication between providers, including disjointed medical and behavioral care and duplication/overlap in services.*
    - For example, the Department of Social Services reports there is no centralized mechanism, such as an alert system, for coordinating multiple agency efforts to help homeless individuals with behavioral health issues in a single day. This results in overlap and duplication of efforts.
- *Lack of coordinating funding streams for the justice system, child welfare, behavioral health treatment facilities, and the health care delivery system to optimize resources and reduce duplication of services and overlap.*
- *Housing shortage and resistance from landlords*
    - Shortage of funding for temporary and long-term housing assistance for individuals with behavioral health needs. Low resources leads to triaging such that those with behavioral health needs in expensive state facilities are placed in housing before those that are homeless. In some cases, landlords resist renting to individuals with behavioral health needs out of concern for unwanted incidents, eviction, etc.
- *Restrictions in state formulary*
    - In some cases, the state formulary does not allow for tailored combinations of prescriptions drugs that work best for a particular individual with mental health needs.
- *Lack of data sharing*
    - For example, the Police Department does not fully share individual data in order to protect privacy and the sensitive nature of the data, but this hinders collaborative efforts to detect youth in need of behavioral health services. Additional data-oriented barriers include separation of state and county level systems. For example, foster care and TANF data are state-owned, while school-based data and Health Department data are county-owned. This results in challenges to consolidate and cross-walk data on individuals for comprehensively understanding needs and coordinating care.

**Other Organizations**

- Individual and Community Level
    - *Lack of awareness of Prince George's County Constituent Services.*
        - Low levels of county resident awareness of constituent services.
        - Lack of integration of constituent services within the school system.
    - *Low service utilization among undocumented immigrants due to concern about being reported to authorities.*
- Organizational and Provider Level
    - *Difficulties effectively addressing behavioral health in the school system*.
        - Interviewees noted several limitations to effectively addressing behavioral health within the school system, including difficulty in-sourcing behavioral providers as evidenced by high provider to student ratios, lack of training and awareness for detecting early and warning signs of behavioral health issues, and protecting privacy while tracking the needs of students that return to school from behavioral health interventions.
        - Under the Transforming Neighborhood Initiatives (TNI) project reported barriers include integrating providers and services funded by the project into the Prince George's County Public School system, culture, and operations, especially without

duplicating existing roles/services. In some cases, school personnel were reportedly unaware or did not leverage TNI-funded providers and services.
    - *Lack of clear planning and coordination of TNI resources and activities.*
    - *Lack of a firewall between the provider and the oversight components of their county Health Department.*
    - *Slow procurement process for behavioral health services.*
        - One interviewee noted that the greatest limitation in the county is the procurement process, which was described as very slow (2-3 months) to authorize providers to deliver behavioral health care reimbursed by the county.
    - *Difficulty assessing the adequacy of the private behavioral health system.*
        - One interviewee indicated that one of the biggest challenges for the county will be identifying those individuals who received behavioral health services through commercial insurance in order to determine the adequacy of those provider networks.
- Behavioral Health Systems Level
    - *Lack of behavioral health services and providers.*
        - There was indication of a lack of behavioral health services and providers in the community (i.e., low infrastructure), especially those that serve Medicaid and the uninsured as well as in more rural areas of the southern region of the county.
        - Inpatient behavioral health services were indicated as being available for adults in the county but not for children.
        - Lack of residential beds in the county compounded the inability of the county to bill Medicaid for residential services because they are entirely state funded with no federal match.
    - *Lack of transportation services, especially for students that need behavioral health services but have working parents.*
    - *Lack of affordable housing.*
        - A county decision to forgo federal matching funds for affordable housing was noted as a key contributor to the lack of affordable housing in the county.
    - *Transition from block grant to fee-for-service payment system for substance use treatment services.*
        - The county transition to billing for substance use services, previously funded through flexible block grant dollars, was noted as a barrier, specifically due to the loss of funds for indirect costs.

## Facilitators

**Providers**

- Organizational and Provider Level
    - *Partial hospitalization services*
        - Partial hospitalization services follow a step-down approach to community transitions from inpatient care which help stabilize the patient and avoid readmissions.
    - *Financial incentives through innovative care delivery methods*
        - Financial incentives through value based payments and PCMH participation have facilitated effectiveness, mainly through enhanced payments for performance and the ability to bill for multiple health and behavioral health services delivered in the

same day. However, providers characterize these funds as small, useful for special projects or upgrades, and not a substantial funding source for their organization.
    - *Positive working relationships between organizations*
    - *Provider-sponsored transportation services*
        - Private transportation services offered by some providers helps ensure patients can get to care locations.
- Behavioral Health Systems Level
    - *Financial targets and penalties for quality measures*
        - Policies that penalize hospitals for readmissions and repeated emergency department visits, as well as financial targets to reduce Medicare spending, facilitate hospital attention to effectively address behavioral health issues to avoid costly patterns of hospital services use.
    - *ACA coverage expansion and generous eligibility thresholds for Medicaid*
        - State Medicaid eligibility thresholds are set high enough for individuals to access insurance and improve affordability of care. Some providers report substantial reductions in uninsured as a proportion of their payer mix, post-ACA.
    - *State progress encouraging/identifying evidence-based practices*

**Health Department**

- Organizational and Provider Level
    - *Intensive outpatient programs work effectively when they stabilize housing, prevent inpatient admission, and are patient-centered*
    - *Medicaid covers most behavioral health services*
    - *4E waivers through the Department of Social Services improve access to behavioral health services*
    - *Legal mandates and partnerships with the court system facilitate individuals accessing behavioral health care*
    - *Warm hand-off referrals to behavioral health services*
    - *Development/expansion of co-occurring services*
        - The  Health Department is increasing capacity to provide co-occurring services through staff training, and plan to increase co-occurring service options as they further integrate mental health and behavioral health internally.
    - *Adoption of new EHR system*
        - The  Health Department is transitioning to a new electronic health records system, Patagonia, which has greater functionality including connecting to state systems and integrating information from medical and non-medical sources, such as case management.
- Behavioral Health Systems Level
    - *Integration of systems for mental health and substance use disorder services*
        - County administrative services organization responsible for both mental health and substance use disorders. The two systems were previously divided.
    - *Maryland healthcare finance reform*
        - Global budgeting and readmissions penalties are facilitating coordination of care for patients with behavioral health issues. These have helped providers identify that unmet social needs, not necessarily unmet medical needs, such as housing, are key contributors to readmissions.
    - *ValueOptions working with county and state behavioral health authorities to develop strategies for meeting the needs of behavioral health patients in the county*

- *Diversity committee*
  - The  Health Department has a diversity committee that aims to address issues of cultural and linguistic competency of services.
- *Special projects and initiatives*
  - The  Health Department collaborates with roughly ten organizations in the county as well Montgomery County to coordinate with ACA navigators to help enroll eligible individuals in Medicaid and qualified health plans. Other initiatives that facilitate effectiveness of the behavioral health system include Transforming Neighborhoods Initiative and the Health Enterprise Zone.
- *Generous eligibility thresholds for Medicaid*
  - Eligibility thresholds for Medicaid are set high enough for children to access insurance coverage for behavioral health services

**Sister Agencies**

- Organizational and Provider Level
  - *Tracking individuals with mental health issues that frequently interact with the corrections system*
    - The department of corrections reports tracking of individuals with mental health issues and notifications to officers as they encounter these individuals.
  - *Police officer training and protocols for recognizing mental health issues and intervening appropriately*
    - Police officers receive training in identifying and responding appropriately to individuals with mental health issues. Officers can also request a psychological evaluation for an individual at any time. There is a departmental MOA specifying certain requirements/safeguards to follow when intervening with individuals with mental health issues.
- Behavioral Health Systems Level
  - *Integration of substance abuse and mental health within the county/public treatment system*
  - *Increase in insurance coverage under the ACA*
  - *Organizational representation/participation on the behavioral health workgroup*

**Other Organizations**

- Organizational and Provider Level
  - *Linking behavioral health care with academic success.*
    - An interviewee reported that emphasizing how improving access to behavioral health services would help improve academic success was a key facilitator for the school system to integrate behavioral health services. This is analogous to children struggling academically when they don't receive the proper nutrition.
  - *Effective features of school-based behavioral health intervention.*
    - Home visiting by school-based personnel to students and their families helps with understanding the issues that contribute to behavioral health.
    - Team-based approaches across elementary, middle, and high school help with continuity, collaboration, and resource sharing.
    - In-services for teachers improve staff capacity to understand behavioral health issues and appropriately intervene.
    - IEP meetings provide a mechanism for effectively addressing behavioral health.
  - *The behavioral health workgroup.*

        - The behavioral health workgroup was described as a helpful forum for behavioiral health information exhange and dissemination among participant organizations.
    - *Effectiveness of crisis intervention services.*
        - Crisis intervention services in the county were described as comprehensive and effective, including direct crisis services, partnerships with police, and access to crisis beds.
        - Crisis services are covered by Medicaid and privately insured individuals are referred outside the system.
- Behavioral Health Systems Level
    - *Activities funded under the Transforming Neighborhood Initative (TNI).*
        - The Transforming Neighborhood Initiative was described as a source of funding/resources and a broad context where behavioral health fits in as a component of improving crime, unemployment, educational acheivement and other issues in the county.
    - *Delay of transition from block grant to fee-for-service payment of susbtance use treatement services.*
        - Maryland has agreed to delay the transition from block grant funding to fee-for-service for substance use services (FY 2017 instead of FY 2016) in order to give the county more time to establish billing processes.
    - *Transition from block grant to fee-for-service payment of susbtance use treatement services.*
        - An interviewee reported that a fee-for-service payment system will create incentives to private providers to offer care, thereby creating greater access to care for residents.
    - *Generous Medicaid rates and rapid provider reimbursement for child/adolescent behavioral health services.*
        - Medicaid rates for child/adolscent behavioral health services were described as favorable/generous and the provider payment portal was described as streamlined so that authorized providers can be reimbursed for services within seven days.
    - *State 1115 waiver for Institutions of Mental Disease.*
        - Maryland has developed a 1115 Waiver for Institutions of Mental Disease that broadly includes pychiatric services, addiction services, and further behavioral health issues.

## Solutions/Recommendations

**Providers**

- Organizational and Provider Level
    - *Developing and expanding telepsychiatry and telemedicine, especially in hospital and emergency room settings*
    - *Increased behavioral health services, including inpatient beds, delivered at the new facility operated Dimensions Healthcare System*
    - *Hospital discharge and transition support services for patients enrolling in medical home, including at a new site on or near the campus of Doctors' Hospital*
    - *Extend facility hours into the late evening in order to improve access to behavioral health services*
    - *Adopt warm hand-off referral method between primary and behavioral health providers*

- Behavioral Health Systems Level
    - *Leverage Regional Partnerships for Health Systems Transformation planning grant to integrate behavioral health and primary care*
    - *Independent provider association with health centers and hospitals within the county*

**Health Department**

- Organizational and Provider Level
    - *Approval for payments under Medicare for Health Department services*
    - *Expand direct services and recruit additional service staff*
        - Additional service members should include licensed support staff member/case managers to identify and coordinate services to patients and families, possibly in-home delivered services. Additionally, coordination and linkages should focus on basic needs such as housing, access to primary care, and enrollment in benefits programs.
        - Also, wellness and education services delivered by a social worker or trained teachers/counselors/coaches in-schools to address behavioral and physical health issues, especially among undocumented youth. Services like these should be provided in Spanish, involve parents, and follow a one-stop shop or wraparound approach.
        - Other program services suggested included Thinking for Change, Men's Trauma Recovery and Empowerment Model, Targeted Case Management under Medicaid for homeless with behavioral health needs, long-term treatment programs, outpatient mental health with daycare, goal oriented and directed care, improved awareness of referral options with strong collaborative/coordinated relationships between organizations, and enhanced crisis programs.
    - *Improve referral services to include a clear plan with follow-up*
        - For referral services, it should no longer be acceptable to simply give patients a phone number. A referral should include a clear plan with follow-up.
    - *Develop monitoring, outcome measurement, and other data strategies*
        - Develop strategies that capture fidelity to evidence based programs, follow-up post-discharge and post-discontinuation of services, state metrics and measures of access and service use.
        - Modifying contractual language with providers/vendors to improve monitoring/reporting.
    - *Fully develop information sharing capabilities by leveraging health information technology infrastructure*
        - The Health Department should fully develop their health information sharing capabilities by leveraging current health information technology infrastructure, including the Health Department electronic health record system and the Chesapeake Regional Information Service Program. Given proper functionality and interoperability, the Health Department and other providers could document and share information on patient behavioral health through this information exchange, which could improve care coordination and provider communication.
    - *Design mobile services that transport individuals to the most appropriate service site, rather than only to the emergency room*
- Behavioral Health Systems Level
    - *"No wrong door" point of entry into the behavioral health system*

        - Structural changes with no wrong door point of entry and effective triage and referral processes for coordinating care.
    - *Increase capacity to effectively treat patients with co-occurring disorders*
    - *Incentives to attract clinics and providers to the county*
        - Fiscal reforms to attract clinics and providers to the county, especially those serving Medicaid and uninsured patients. Noted that companies like Seasons and Recovery Centers of America are establishing sites in the county, which would help to fill the gap of having no treatment centers.
    - *Inter-county agency collaboration for the effective design and targeting of services*
    - *Improve training for school teachers and administrators*
        - Increase training for school teachers and administrators to properly identify behavioral health problems and connect families to care.
    - *Increase outreach and enrollment of Medicaid eligibles through the state exchange using faith-based community support*
    - *Improve transportation services, especially for southern county residents*

**Sister Agencies**

- Organizational and Provider Level
    - *Dedicated hospital unit or observation room for expedited intake processing of individuals with behavioral health issues, especially those transported by corrections officials*
    - *Police department model shift from reacting to crisis calls to front-end prevention*
        - The police department suggested additional training, additional staff dedicated to behavioral health issues, and additional funding to pursue a model shift from reacting to police calls to front-end prevention strategies. These strategies would draw on community policing and include finding the source of repeat calls to police and others related for individuals with behavioral health issues, regular visits to high-risk locations to help reduce behavioral health related incidents, and coordination with the Health Department, social services, and other providers. Key elements of this model would be to perform a pilot project, perhaps with a control neighborhood, and analyze total cost savings to justify increased investment.
- Behavioral Health Systems Level
    - *Create a consumer affairs/protection office like those in surrounding counties to help with access and quality assurance of services*
    - *Legislation to make synthetic marijuana illegal, as well as the development of methods for street drug testing.*
    - *Involve the faith community in behavioral health systems*
    - *Align county with state behavioral health reform given that is the way money flows*
    - *Focus funds on direct services rather than evaluation*
    - *Increase housing subsidies for individuals with behavioral health needs*
    - *Inter-organizational care management and coordination models, for example, with homeless individuals who have behavioral health needs*
        - Develop a care management and coordination system in which a collaboration of agencies serving homeless individuals would alert a case manager when a homeless individual with behavioral health needs is encountered by law enforcement, homeless shelter, emergency room, child welfare or foster care office. The case manager could "huddle" various individuals across agencies to devise an appropriate plan of care to be stored and shared electronically. This would serve as a kind of integrated health and social services medical home. With regard to

prioritizing resources, they called for a cost-analysis to compare whether providing housing services for transitioning individuals from state facilities would be more cost-effective than transitioning individuals from homelessness.

**Other Organizations**

- Organizational and Provider Level
  - *Further develop behavioral health care in school settings.*
    - Develop and expand the school-based health delivery system to integrate behavioral health therapy and referrals to treatment of mental health and substance use disorders with traditional school-based health services (e.g., immunization, medication management).
    - Emphasize evidence-based practices and quality of care for school-based behavioral health services in order to help alleviate school system concerns about liability.
  - *Build out the constituent services hotline as part of the new Customer Relationship Management/Motorola system for the entire county.*
  - *Expand ValueOptions payment portal, currently for Medicaid only, to include the uninsured.*
- Behavioral Health Systems Level
  - *Increase payment for behavioral health services under Medicaid.*
    - Higher payment for Medicaid behavioral health services was suggested given higher enrollment under Medicaid expansion and the transition from block grant funding to fee-for-service payments.
  - *Increase behavioral health providers operating in the county.*
    - Specific suggestions were given to develop more FQHCs and/or create new incentives to lessen the financial risk to providers for operating in the county.
    - Leverage the new Dimensions regional hospital by emphasizing behavioral health care during the planning stage.

## Appendix H: List of Providers Referenced in Qualitative Sources

The following sections provide the names of behavioral healthcare providers, referenced by key informants and/or focus group participants, which deliver care to residents of Prince George's County. These providers are sorted by five provider types. Asterisks indicate providers that are not located in Prince George's County.

**Hospitals and Medical Centers**
MedStar Southern Maryland Hospital Center
Prince George's Hospital Center
Laurel Regional Hospital
Doctors' Community Hospital
Kaiser Permanente Largo Medical Center
Kaiser Permanente Prince George's Medical Center
Fort Washington Hospital
*MedStar Washington Hospital Center
*Washington Adventist Hospital
*Providence Hospital
*Suburban Hospital
*Holy Cross Hospital
*University of Maryland Medical Center
*Charles Regional Medical Center
*Shepherd Pratt Health System
*Johns Hopkins Hospital
*Adventist HealthCare Behavioral Health & Wellness Services (Rockville/Shady Grove)
*MedStar St. Mary's Hospital
*Sheppard Pratt Health System (Towson)
*George Washington University Hospital – Children's National Medical Center
*Dominion Hospital

**FQHCs**
Greater Baden Medical Services
Mary's Center for Maternal and Child Care
Community Clinic

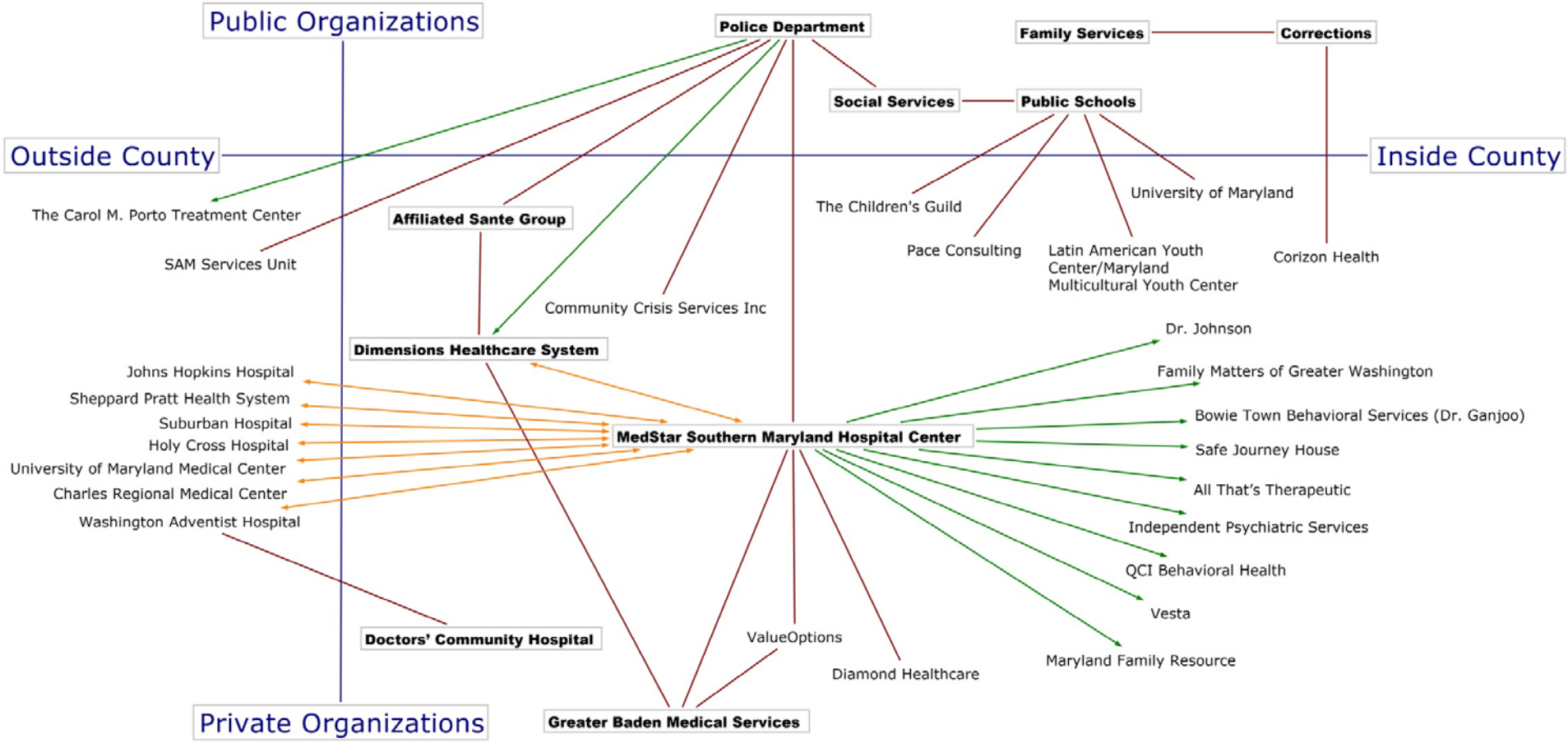
**CBOs**
Safe Journey House
Family Matters of Greater Washington
All That's Therapeutic
People Encouraging People
The Salvation Army Adult Rehabilitation Center
American Rescue Workers
The Children's Guild
Latin American Youth Center/Maryland Multicultural Youth Center
On our Own of Prince George's County
*Walden Sierra
*Hillcrest Children & Family Center

**Health Department Facility**
Adam's House Recovery Center
Addictions/Northern Region
Addictions/Southern Region

**Private Individual/Group Practices**
Independent Psychiatric Services
QCI Behavioral Health
Vesta
Maryland Family Resource
Bowie Town Behavioral Services (Dr. Ganjoo)
Axis Healthcare Group
Community Crisis Services
Corizon Health
Alek's House
University Psychological Center
Village Family Network
Affiliated Sante Group
Pace Consulting
*Another Way Inc.
*The Carol M. Porto Treatment Center

## Appendix I: Provider Organizational Network Described in Qualitative Sources

The following graphic provides a map of the organizational network of public and private providers of behavioral health and related services both inside and outside of Prince George's County. This organizational network was derived only using descriptions of partnerships given in qualitative sources. It is not intended to be a complete illustration of the true organizational network for behavioral health and related services. Instead, it depicts those connections between organizations explicitly described by key informants and focus group participants. Red connecting lines indicate formal partnerships to provide services (e.g., contractual agreements/paid services arrangements, memorandums of agreement). Green connecting lines indicate patient/consumer referrals between organizations. Orange connecting lines indicate patient transfers between medical care providers.



## Appendix J: List of Key Sources

Following is a table providing the key data sources used in the development of this report. (This is not an exhaustive list of sources used or referenced in the development of this report, but covers the most critical and highly utilized sources for our purposes.)

| Name | Unit of Analysis |
|---|---|
| **Providers of Behavioral and Mental Health Services in Prince George's County*** | County |
| **Prince George's County Department of Family Services, Mental Health and Disabilities Division<br>FY 2015 Program Monitor List*** | County |
| **Maryland Psychological Association<br>MPA Membership Directory*** | County |
| **Maryland Alcohol and Drug Abuse Administration<br>ATR Resource Directory*** | County |
| **Prince George's County Health Department<br>Providers of Behavior and Mental Health Services in Prince George's County*** | County |
| **Prince George's County Health Department<br>Prince George's County Core Services Agency<br>FY 2015 Funded Programs*** | County |
| **Prince George's County<br>'Network of Care' Service Directory*** | County |
| **Mental Hygiene Administration Public<br>Mental Health System<br>Total System Expenditures (MARF)** | County |
| **Maryland LAUNCH: Environmental Scan Report** | State<br>County |
| **Core Services Agency - Behavioral Health Services Monthly Report** | County |
| **Mental Hygiene Administration Office of Special Needs Populations<br>Services for Deaf and Hard of Hearing<br>Quarterly Reporting Form** | County |
| **Prince George's County Department of Corrections<br>Maryland Community Criminal Justice Treatment Program<br>Quarterly Report - November 2014** | County |
| **Mental Health Court<br>Fiscal Year 2015 Monthly Statistics** | County |
| **NAMI Prince George's Detailed Monthly Report<br>May 2015** | County |

| Name | Unit of Analysis |
|---|---|
| **Peer Support NAMI< Prince George's County FY 2015** | County |
| **Prince George's County Core Service Agency FY 2014 Annual Report** | County |
| **Evaluation of the HealthChoice Program**<br>**CY 2008 to CY 2012** | State |
| **HRSA Data Warehouse HPSA Map** | County |
| **Healthcare Cost and Utilization Project**<br>**State IP and ED Discharge Databases** | County<br>Hospital |
| **Prince George's County**<br>**Foster Care Data** | County<br>State |
| **Prince George's County**<br>**LMB Needs Assessment, School, Safety, Stability for Children** | County<br>State |
| **Census**<br>**Demographics , Industry codes for mental health facilities and professionals** | Zip Code<br>County<br>State |
| **Prince George's County health Rankings** | County |
| **FBI Crime Stats** | County |
| **Center for Disease Control and Prevention**<br>**Behavioral Risk Factor Surveillance System** | County<br>State<br>National |
| **Prince George's County Health Department**<br>**Prince George's County Data Zone** | County<br>Zip Code |
| **AHRF**<br>**Demographics, Workforce, Facilities, Utilization, Population** | County |
| **HSCRC**<br>**Regional Partnerships Data** | County |
| **Census**<br>**Disability; Earned Income - Household; Education Level; Food Stamps; Health Coverage; Immigration Status; Mortgage; Poverty Status; Rental Housing; Unemployment** | County<br>State<br>National |
| **Prince George's County Commission on Children, Youth and Families**<br>**2014 Needs Assessment, Evaluation of Resources, and Strategic Plan** | County |
| **HSCRC**<br>**CMS' Medicare Chronic Condition Data - Prevalence in Maryland Counties** | State<br>County |
| **ValueOptions**<br>**Outcome Measurement System** | State<br>County |

*= Data source was used in compiling the list of behavioral health providers within and around Prince George's County

## Appendix K: Prince George's County Core Service Agency (CSA) Programs

Following is a list of the Core Service Agency (CSA) Programs that were identified in the Prince George's County Health Department Behavioral Health Services Core Service Agency Fiscal Year 2014 Annual Report and Fiscal Year 2016 Annual Plan. Each of the programs listed below receive some form of financial backing from the Prince George's County CSA.

| Program | Program Description |
|---|---|
| **Domestic Violence Pilot Project** | The funding enhanced the existing Mobile Crisis Team (MCT) and allowed the MCT to respond with police to repeat intimate partner domestic violence calls in District IV (Oxon Hill area) in Prince George's County |
| **Dual Diagnosis Capability Training** | Three-day training entitled, "Introduction to Addictions for Mental Health Professionals", provided by the Office of Education and Training of Addiction Services (OETAS) and is designed to introduce mental health professionals to working with individuals with co-occurring to their mental illness and substance abuse disorders. |
| **Maryland Community Criminal Justice and Treatment Program (MCCJTP)** | MCCJTP offers Mental Health Assessments and treatment, follow up after discharge |
| **Trauma, Addiction, Mental Health and Recovery (T.A.M.A.R.)** | TAMAR program offers Trauma Informed Care approach to providing mental health treatment. |
| **Crisis Intervention Teams** | Crisis Intervention Teams are first responders who have received training on behavioral health and how to approach individuals with behavioral health issues |
| **Maryland Youth Crisis Hotline** | 24 hour phone line |
| **SafeTALK** | Training provided to school and community workers enabling them to recognize when a youth may be suicidal and when to refer a person for intervention. |
| **ASIST** | Training provided to school and community workers enabling them to recognize when a youth may be suicidal and when to refer a person for intervention. |
| ***The Crownsville Project*** | The Crownsville Project provides funds to subsidize housing costs for Prince George's County participants |
| **Assertive Community Treatment (ACT) People Serving People** | Team members provide frequent face-to-face contacts and assessments to provide individualized services to each consumer. The team serves the consumer wherever they are located and provides after-hour care when needed. |
| **In-Home Interaction for Children** | Program participants received crisis intervention and home-based support; families receive parent training and support services. |

| Program | Program Description |
|---|---|
| **Continuum of Care (COC)** | Formerly the Shelter Plus Care<br>Program to ensure linkage to supportive services to individuals recently released from detention or other court system involvement necessary for achieving and maintaining independent living |
| **Projects for Assistance in Transition from Homelessness (PATH)** | Program to collaborate with private landlord and/or apartment home complexes in effort to provide placement assistance to consumers with mental illness, who are homeless or at risk of becoming homeless |
| **Homeless Outreach** | Engage and evaluate homeless individuals for mental health services |
| **Homeless I.D. Project** | Provides funding for birth certificates and I.D. cards for homeless individuals |
| **Residential Rehabilitation Program** | Residential Rehabilitation Program (RRP) provides housing and supportive services to single individuals. The goal of residential rehabilitation is to provide services that will support an individual to transition to independent housing of their choice. Residential Rehabilitation Programs provide staff support around areas of personal needs such as medication monitoring, independent living skills, symptom management, stress management, relapse prevention planning with linkages to employment, education and/or vocational services, crisis prevention and other services that will help with the individual's recovery. |
| **Wellness and Recovery Action Plan (WRAP)** | The Wellness Recovery Action Plan (WRAP) is a group intervention for adults with mental illness. WRAP aims to teach participants how to implement the key concepts of recovery in their daily lives, identify and understand their wellness resources, create advance directives to guide family members or supporters when their involvement is required, and develop individualized post-crisis plans. The WRAP program includes lectures, discussions, and individual and group exercises. Two trained facilitators lead each WRAP group, which usually consists of 8 to 12 participants. A typical intervention takes place over 8 weeks of two-hour weekly sessions, although participants often choose to continue meeting after the formal 8-week period. |
| **Dual Diagnosis Capability Mental Health Treatment (DDMHT)** | Tool to providers in Prince George's County to self-assess their Dual Diagnosis Capable (DDC) and Dual Diagnosis Enhanced (DDE) capacity |
| **Co-morbidity Program Audit and Self Survey for Behavioral Health Services (COMPASS EZ)** | Tool to providers in Prince George's County to self-assess their Dual Diagnosis Capable (DDC) and Dual Diagnosis Enhanced (DDE) capacity |
| **Transition Age Youth with Families Program (TAY)** | Provide psychiatric rehabilitation services to include housing assistance, childcare, mentoring and linkage to services. |
| **Mobile Crisis Stabilization Program** | Respond to crisis issues in foster/kinship home where DSS has placed children, or for children who continue to reside with their families as a result of family team meeting intervention. |
| **SOAR** | Outreach program to expedite the receipt of SSI eligibility benefits for eligible mental health consumers |

| Program | Program Description |
|---|---|
| **Mental Health Court** | Mental Health Court is a specialized court docket established for defendants with mental illness that substitutes a problem-solving approach for the traditional adversarial criminal court processing. Participants are identified through mental health screening and assessments and voluntarily participate in a judicially supervised treatment plan developed jointly by a team of court staff and mental health professionals. (Justice Center, Bureau of Justice Assistance) The overarching goal of the Mental Health Court is to decrease the frequency of participant's contacts with the criminal justice system by providing participants with judicial leadership to improve the social functioning, employment linkage, housing needs, treatment, and support services of participants. |
| **Family to Family (F2F)** | A free, 12-week course for family members/caregivers of individuals with severe mental illness. This program includes discussions about the clinical treatment of these illnesses and teaches the knowledge and skills that family members need to cope more effectively. The weekly educational sessions are led by two family members who successfully completed NAMI training. |
| **Child Resource Center Early Childhood Health Consultations Program (ECMHC)** | Provides consultation services within the school classroom |

Prince George's County Health Department, Behavioral Health Services, Core Service Agency. (2015) Fiscal Year 2014 Annual Report & Fiscal Year 2016 Annual Plan.