The Value of Outpatient Redesign in Pennsylvania

The RCPA Outpatient Redesign work group addressed current challenges in the Pennsylvania outpatient service system to produce this paper. Members from urban, suburban, and rural communities gathered to examine the state of outpatient services and developed this series of recommendations to resolve the crisis. Participants identified the need to promote evidence-based practices, enact regulatory reform, create new funding alternatives, and embrace principles and practices of the person-centered home model as the basis for service delivery of outpatient care in Pennsylvania. The work group is committed to working closely with state leaders and decision makers to improve the outpatient model of care in Pennsylvania.

For nearly a half-century, publicly funded, community-based outpatient clinics have served a vital role in providing mental health and substance use disorder treatment to people in communities across Pennsylvania. Outpatient clinics have been the foundation of the public mental health and substance use service delivery systems. Outpatient clinics operate as a safety net for the Commonwealth’s most vulnerable populations. Hundreds of thousands of citizens use community-based outpatient clinics as their initial, primary, and often sole source of mental health and substance use disorder treatment. RCPA members have reported a significant increase in demand for outpatient services over the last several years. Outpatient-based evaluation, diagnosis, and core treatment services are the foundation for a wide range of other critical child, adolescent, adult, and family behavioral health services.

Today, these vital outpatient clinics face serious challenges that are threatening their very existence. These challenges occur at a time when the most clinically and cost-effective outcomes rely on early access, assessment, diagnosis, and treatment found in outpatient services. This fact has been evident in the national discourse ranging from reports from the Surgeon General to provisions in mental health parity and health insurance reform. It is in the interest of all stakeholders — individuals, family members, service providers, insurers, county systems, and state government — to come together to face these challenges and protect Pennsylvania’s mental health and substance use disorder outpatient service delivery system.

A strong body of literature exists to support the value of community integration and recovery and resiliency. People of every age with emotional disturbances, mental illnesses, and substance use disorders can lead fulfilling lives and participate in the greater community and contribute to society. But services and supports must be adequately funded, easily accessible, tailored to meet individual needs, and foster the principles of recovery, resiliency, and self-determination. A trained, competent, and adequately compensated workforce is needed to provide accessible, quality-driven services. These outpatient services and supports can be provided in the community at significant cost savings as compared to higher, more intensive, levels of care.

Access to community outpatient and psychiatric services is not only a cost-effective alternative to institutionalization, it can also produce improved outcomes for individuals with mental illness, including the population identified with severe mental illness (SMI). Community-based psychiatric outpatient clinics are a key component of the public mental health system, and should be accessible to all individuals to provide an array of cost-effective clinical services and supports. In recognition of the importance of mental well-being, the overall goal of the World Health Organization (WHO) Mental Health Action Plan 2013–2020 is to promote mental health, prevent mental disorders, provide access to care and enhance recovery, and reduce mortality, morbidity and disability for persons with mental disorders by providing comprehensive, integrated and responsive mental health services in community-based settings. WHO recommends the development of comprehensive community-based mental health services.
The most common types of treatment accessed are outpatient services and prescription medication according to the 2008 Substance Abuse Mental Health Services Administration (SAMHSA) survey data (SAMHSA Data Survey 2008, http://archive.samhsa.gov/data/NSDUH/2k8nsduh/2k8results.pdf). SAMHSA Administrator Pamela S. Hyde stated, “[a]lthough mental illness remains a serious public health issue, increasingly we know that people who experience it can be successfully treated and can live full and productive lives. Like other medical conditions, such as cardiovascular disease or diabetes, the key to recovery is identifying the problem and taking active measures to treat it as soon as possible.”

Community-based mental health service delivery should encompass a recovery-based approach that supports individuals with mental illness to achieve their own goals. The core services should include listening and responding to an individual’s needs, working with the individual as an equal partner, offering choices of treatment and therapies, and the use of peer support staff to support recovery, all of which can be provided by licensed outpatient psychiatric clinics in the community. Another key element of the WHO plan is to be responsive to the needs of vulnerable and marginalized individuals to ensure services are widely available. To recover, individuals need access to affordable, accessible and high-quality behavioral health care.

### Why Outpatient Services Are Critical?

- Most commonly the first place people seek care
- Least intrusive, least restrictive service thereby reducing/avoiding unnecessary inpatient/emergency room (ER) use and dollars
- Allows patients a choice when receiving care
- Helps manage the growing volume of people who need MH treatment
- Provides access to medication and ongoing monitoring
- Gives consumers the ability to manage their lives while living/working in the community/home, supporting a “normal” healthy life
- Offers timely assessments
- Offering expansion into integrated care settings will allow people to obtain services where they get their medical care and engage more comfortably, supporting the linkage of physical and behavioral health, lessening issues of stigma, and fostering access
- Outpatient clinics are the cornerstone of all mental health care

### Why Isn’t The Behavioral Health Outpatient Clinic Working Now?

- Outdated and costly regulations that restrict the ability to provide needed services (OMHSAS, DDAP, OMAP)
- Duplicated oversight including fraud, waste and abuse, quality, county monitoring, and BH-MCO audits consume too much time and take away from direct clinical service
- Staff are having to spend too much time on documentation which significantly decreases their time for direct clinical service, and subsequently their interest in the field and public, and community work – as a result, fewer and fewer qualified professionals want to work in the outpatient sector
- The inability or limiting of professionals to practice their trade to the full scope of their licenses such as not allowing non-medical licensed professionals to sign off on treatment plans which is within the scope of their licenses
- Lack of funds to support training and increased wages; rates have been stagnant, and have never covered true costs nor cost of living increases
- Lack of financial structures that support the use of evidence-based practices that are heavily encouraged and/or required
- Reluctance to utilize alternative payment models such as value-based purchasing and case rates
- The clinic ultimately holds the financial risk and liability of the provision of service
- Not enough time for triage and/or crisis management; payment systems need to cover cost of clinical consultation/triage
- The low pay and the lack of reward in the high volume mass production driven by the fee-for-service model have led to staffing shortages which result in waiting lists to enter outpatient care
Recruitment and retention of licensed staff is unattainable with current rates and low staff morale from the high volume fee-for-service driven outpatient model.

**What Outpatient Funding Should Cover?**

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) requires that health insurance coverage for mental health and substance use services have benefit limitations that are no more restrictive than the medical benefits offered by the plan. This will provide the same level of benefits to all eligible individuals by removing limits on the services or scope of covered services consistent with the approved State plan and the MHPAEA.

Funding should cover:

- The actual costs of operations including indirect services such as case management, quality monitoring, and competency development
- Staff training needs to be encouraged but fee-for-service requires all effort to be focused on productivity
- Evidence-Based Practices (EBP) implementation – most EBP models require extensive staff training, including multiple days and ongoing consultation which current rates do not cover
- Case management or service coordination that enhances outpatient treatment services for more acute needs
- The total costs for travel must be covered for mobile services
- Allowing for more than one service to be covered in the same day is essential for the convenience of the client as well as the efficiency of the provider. This is particularly significant when considering the advancement of “warm handoffs” which has been demonstrated to improve the engagement of clients
- The cost of clinical and administrative supervision is necessary to ensure and enhance practice and clinical outcomes
- Funding should include payment for:
  - Supervision
  - Team meeting
  - Discharge and aftercare planning
  - Technology needs EHR/EMR
  - Data entry/reporting
  - Complete coverage for employee costs (salary, benefits, tuition)
  - No-show reimbursement
- Funding for comprehensive assessment(s) that may require extended time

**Discussion Items For Redesigning Outpatient Services**

- Change funding systems that are based on meaningful outcomes developed with providers
  - Implement a value-based purchasing model
  - Case rates based on episodes of care
  - Team-based treatment model
  - Collaborative care model
  - Universal/Coordinated reporting requirements, (i.e., outcomes and financials)
- Transform regulatory oversight to maximize efficiencies
- Make it easier to create satellite sites in primary care to promote integration of care
- Convert the State Medicaid Plan from clinic option to rehab option, allowing greater flexibility without threatening the Behavioral Health Carve-Out
  - Licensed professionals should be allowed to practice within the scope of their license (rather than MDs), including the signing of treatment plans, which is a more meaningful review given that MDs are now approving hundreds of plans with no compensation to provide this oversight. Utilizing MDs in this role takes scarce psychiatric time away from direct clinical practice
Clinicians should be allowed to practice to the maximum scope of their credentials like LCSW, LPC, PhD.

- Decrease the amount of regulatory oversight and consolidate reviews of programs (i.e. one provider with three programs had 20 program audits during a six month timeframe. As a result, the provider incurred the cost of $150,000 for licensing and monitoring visits)
  - Move licensing visits to once every 2 – 3 years based on a positive review (to be defined) or based on national accreditation or certified clinic
  - Combine county and licensing visits whenever possible as well as combine licensing visits of similar programs
  - Combine managed care audits (including quality and compliance) across BH-MCOs

- Drug and Alcohol
  - Change the case load size from 1:35 to 1:50 or 60 to allow for no-shows, group, and infrequent sessions for some clients
  - Change group size cap from 10 to 12
  - Unify regulations across MH and D&A
  - Ease of opening satellite locations

- Require MCOs to use a sound and approved rate-setting process to adequately cover costs for services provided

- TeleHealth
  - Change approval processes for TeleHealth
    - Currently, there are as many as three to four levels of approval (County, MCO, MCO Oversight Corp, OMHSAS)
    - Move to an attestation process at the MCO, state, county, and oversight levels
    - Follow through on an attestation of TeleHealth at OMHSAS/OMAP

- Secure upfront funding for evidence-based practice and the required training to implement
- Remove School-Based Behavioral Health (SBBH) from outpatient regulations; it is too restrictive
- Improve confidentiality standards
  - Change mental health confidentiality so it aligns with HIPAA for mental health
  - Match drug and alcohol (D&A) confidentiality regulations so they don’t exceed the federal D&A confidentiality regulations
- Increase opportunities for integrated care (mental health/D&A; BH/PH)
- Freedom to offer services other than the approved clinic/site location on the PROMISE #-alternative care settings
- Increase the use of paid peer services and include them as part of team delivered service for higher acuity clients; current regulations encourage peer specialists to be separate from other services
- Reform/revise treatment planning process; what is on the forms, who has to sign it, how often, and how quickly
- Expand flexibility to offer service to the family when child/youth is in service and allow children to sign encounter forms — especially in the School-Based BH setting

### Alternative Payment Arrangements that Lead to Outpatient Redesign

Below are the reasons why alternative payment arrangements are necessary to improve the financial health of the outpatient clinics:

- Higher acuity and not enough flexibility
- Increase in children/families access in lieu of BHRS in-home services
- Need to address the needs of a diverse population including those re-entering from the Department of Corrections
- Poor access to qualified staff such as psychiatrists, LCSWs, CRNPs, LSWs, LMFTs, and PhD level clinicians
- Increasing complexity as a result of individuals and families impacted by the opioid crisis
- Increase in number of people experiencing trauma, especially subpopulations such as veterans, LGBTQIP, and youth in foster care
• An investment that supports rebranding and marketing of the behavioral health industry to help with recruitment and retention of qualified, experienced staff

How Will Outpatient Redesign Be Supported in Pennsylvania?

RCPA urges the Department of Human Services (DHS), the Office of Mental Health and Substance Abuse Services (OMHSAS), the Department of Drug and Alcohol Programs (DDAP), and the Office of Medical Assistance Programs (OMAP) to form a work group of which RCPA and other stakeholders are a part. The work group should review funding alternatives and regulatory reform.

Some final points to reinforce Pennsylvania’s need for outpatient redesign:

1. When utilized appropriately, outpatient treatment can save millions of dollars in unnecessary inpatient and emergency room costs.

2. As many state hospitals have closed and others are being considered for closure, a continued commitment must be made to community-based service structure and outpatient services, especially for people with severe and persistent mental illness. Community integration is key for these individuals transitioning back into “typical” communities.

3. Numerous studies over many years have shown that individuals who receive needed mental health and substance use disorder treatment experience significantly reduced physical health problems/costs.


5. The absence of community services and supports results in increased juvenile court placement of youth and incarceration of adults living with mental illnesses and substance use disorders. Incarceration is not the answer; it is ineffective, extremely costly, and traumatizing. The cost – both emotional and financial – to the entire system, including the police, probation, and courts is excessive.

6. The Drug Enforcement Administration announced in June 2017 that the state saw 4,642 drug related deaths in 2016, a 37% increase from the previous year — that is up from 3,377 in 2015, and 2,741 the year before. People with addiction need immediate access to treatment, and when it is not available, the addiction cycle just continues and contributes to additional overdose deaths.

7. The expansion of access to Mobile Mental Health Treatment (MMHT) for individuals with a broader array of diagnoses and for individuals under 21 years of age will broaden access to treatment services by allowing more individuals that would not be able to attend treatment at a traditional outpatient psychiatric clinic to receive services in alternative community settings. This will assist in engaging vulnerable individuals and reducing stigma.

RCPA proposes significant changes in the way the community outpatient service is paid for and modifying the regulations so they fit the reality of providing outpatient care in the managed care environment today. Moving from fee-for-service to value-based purchasing, including mechanisms with outcome based incentives, is necessary. The services must reflect the need of multiple levels of acuity with flexibility to provide clinically indicated services which help the client and family, not a one size fits all model. Outpatient clinic closures are already happening in Pennsylvania, adding additional pressure on the system. Failure to make these kinds of changes risks the collapse of the outpatient level of care that provides the highest volume and value of services in the Commonwealth.