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Behavioral Health Commission

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Distinguished members of the Behavioral Health Commission, thank you for the opportunity to share personal experiences and expertise that will allow us to collectively identify opportunities to improve care for Pennsylvanians. On behalf of my colleagues at UPMC Western Behavioral Health, we commend the legislature, and the administration for the funding to strengthen the Commonwealth's adult mental health delivery system. We all share the same goals: to save lives and improve the quality of those lives. Given that fundamental alignment, we can work together to identify the best ways to optimize strategies through legislation, regulation, and population health. It is critical that we address our state's troubling mental health and addiction trends through expanded access to evidenced-based treatments, supportive interventions, and follow up care. The need for a more robust mental health care system has never been more clear or pronounced. Treatment for mental health issues should be accessible – no matter who you are, where you live or your ability to pay. **Appropriate investment along the care continuum and for the mental health workforce can improve access to care and retention and recruitment of mental health professionals.** Mental health **is** health and should not be thought of or managed separate or apart from physical health in the ways it historically has been.

My testimony today will summarize my experience leading to recommendations, to achieve our goals. I am Dr. Noreen Fredrick, vice president of ambulatory and community behavioral health services with the Western Behavioral Health Service line of UPMC Western Psychiatric Hospital. I am a nurse with over 42 years of behavioral health experience in multiple care settings and leadership roles. My journey has broadened my perspective from inpatient acute care to outpatient and community-based care. I have had the opportunity to build, support, and expand innovative services. While building services, I have successfully established community relationships focused on the well-being of the vulnerable population we serve.

The UPMC Western Psychiatric Hospital-based ambulatory continuum offers a comprehensive array of outpatient, intensive outpatient, and partial programs, mobile and in-home services for each population served, including for children and adolescents, adults, geriatrics, addiction services, and those with psychosis or developmental disabilities. The hospital also operates residential services, intensive case management and peer services. Collectively, these programs treat over 7,600 individuals per month.

Outside of the hospital, UPMC Western Behavioral Health operates community-based, licensed mental health centers which offer outpatient, partial hospital, intensive outpatient, case management, home-based, and residential programs for a variety of acuity levels, and all mental health conditions. Collectively, these programs care for over 4,000 individuals per month. These community-based centers include: UPMC Behavioral Health at Mon Yough (McKeesport), UPMC Behavioral Health at Safe Harbor (Erie), UPMC Behavioral Health of the Alleghenies (Altoona), and UPMC Behavioral Health at Twin Lakes (Somerset).

Our task at hand is to make recommendations to the legislature to allocate $100 million in one-time funding to address adult behavioral health concerns.

Each topic area in Act 54 is equally important and my recommendations do not minimize that.

Workforce Development and Retention and Rates

Ramping up value-based models such as embedding mental health workforce into primary care practices and home and community-based services settings will fall flat without increased capacity of mental health workforce as part of a larger comprehensive public health pandemic strategy to address increased mental health demands. **Broadening how we think of our future workforce will require review and revision of current regulations that define worker requirements.**

The high cost of training and student loan debt may also create barriers for mental health practitioners to participate as Medicaid providers. Medicaid payments yield, on average, only 52% of private insurance (CCBHO pays us better than commercial) and providers must be able to cover their costs to remain viable.[1] Expanding the recruitment pipeline for mental health specialty workers, such as psychiatrists, psychologists, and social workers will help meet the needs of underserved areas. **Policies for doing this include expanding scholarship, fellowship, and loan forgiveness programs that attract more individuals, support more-diverse students, and require a commitment to practicing in high-need settings.** A decade ago, we were competing for staff with other mental health agencies. Today, we are competing with Costco, the Transit Authority, and gas stations because their pay rates have increased substantially while ours have not. The U.S. Bureau of Labor Statistics reports that the median salary for

[1] https://thinkbiggerdogood.org/enhancing-the-capacity-of-the-mental-health-and-addiction-workforce-a-framework/

social workers, which includes therapists, was $51,760 in 2020. As a result of these market forces, it could take families months to find appropriate mental health care, especially in ambulatory settings.

Recommendations:

- Loan repayment/forgiveness, scholarships, and fellowships specific to MH, D&A, IDD community-based workers, and/or in underserved areas of the Commonwealth should be considered. We are supportive of SB 94 – (Sen. Scavello R-Monroe/Northampton) – Loan Forgiveness Program (Guaranteed Stafford, or Consolidated Loan thru PHEAA) for graduates entering community-based MH, IDD, DA services.
- Provide funding that goes directly to the employees for the purposes of recruitment and retention with requirements for service commitment included**:**
    - Sign on bonus
    - Retention bonuses

- Decrease outdated regulations to reduce workload and burnout. **While regulatory reform is not the topic of this exercise, it must be expressed that regulatory and administrative burden have been cited by staff in all forums as the principal source of burnout and ultimately why they are leaving their positions.** This information was cited by the National Council for Mental Wellbeing and is playing out locally in Allegheny County and within UPMC.

Unless there is regulatory reform, the core issue driving individuals from our field will not be resolved.

- The Western Behavioral Health Service line operates under 17 different sets of regulations for mental health services alone. Each set of regulations comes with its own distinct set of requirements and definitions that are not consistent. Each program/regulation set comes with annual licensing visits, visits from MCO; visits from county officials, fraud/waste/abuse visits, and quality visits. Each set of regulations requires a distinct set of policy and procedures, tracking requirements, new hire employment requirements, staffing requirements, documentation, and operational requirements.

Integration of Care

We support integrated care in all capacities and levels of care. Today, I am going to speak specifically to integration of behavioral health and substance use disorder and integration of behavioral health and primary care.

The integration of behavioral health and substance use disorder treatment.

Provision of integrated mental health and substance use disorders services provides whole person, efficient, effective care. Points of service for substance use disorder happen across the continuum of care. Sometimes people show up in the emergency department, primary care office, acute care settings and post-acute settings. We believe the integration of behavioral health and substance use disorder care needs to occur at all these levels of intersection. For example, we are engaged in efforts to innovate and partner with regional authorities to **provide integrated behavioral and physical health services to meet the needs of patients with complex care needs in a skilled nursing facility**. There are a variety of patients who cannot receive concurrent care for their physical health conditions because of their underlying substance use disorder. We are supporting focused resource development and dissemination, training and technical assistance, and workforce development for staff in nursing facilities who serve individuals with Serious Mental Illness (SMI), Serious Emotional Disturbance (SED), Substance Use Disorders (SUD), or Co-occurring Disorder (COD). Its hallmark is 24-hour nursing and 24-hour physician availability, along with robust access to support services, therapy, and discharge planning. We expect that this program will help to: (1) strengthen and sustain effective behavioral health practices and achieve better outcomes for nursing home residents with SMI, SED, SUD, or COD; and (2) ensure the availability of evidence-based training and technical assistance addressing mental health disorder identification, treatment, and recovery support services. Training and technical assistance is needed to support facilities in improving care for this population. Integrated, whole-person care approaches are effective in connecting people to care but are underutilized. Some evidence suggests that integrated care can result in cost savings at the level of practices and payers, as well as statewide initiatives.[2] [3]

Recommendations:

- Provide start-up funding/capital funding for bricks and mortar/infrastructure for the maintenance/update of current facilities, repurposed facilities, and new facilities for the development of new programs supporting innovative approaches and services to care for individuals at different points of service across the care continuum.
- Ensure there are structures to support the transitions of care for individuals with substance use disorders to all the types of health care they deserve.

[2] Reiss-Brennan B, Brunisholz KD, Dredge C, et al.: Association of integrated team-based care with health care quality, utilization, and cost. JAMA 316:826–834, 2016. Available here: https://jamanetwork.com/journals/jama/fullarticle/2545685.
[3] Ross KM, Klein B, Ferro K, et al.: The cost effectiveness of embedding a behavioral health clinician into an existing primary care practice to facilitate the integration of care: a prospective, case-control program evaluation. J Clin Psychol Med Settings 26:59–67, 2019. Available here: https://link.springer.com/article/10.1007/s10880-018-9564-9.

Establishing an integrated care model that can deliver timely psychiatric care in a primary care setting.

Psychiatrists and addiction specialists remain in short supply. While the demand for care is rapidly growing, the number of mental health professionals is barely holding even. As reported by the Pennsylvania Legislative Budget and Finance Committee in February 2021, 66% of Pennsylvania Mental Health Administrators indicated that the lack of psychiatrists was contributing to delays in obtaining evaluations. **This underscores the need to integrate mental health and addiction treatment into primary care and ensure that those providers have the skills necessary to screen, assess need, and provide treatment or refer as needed.**[4] Current payment models do not adequately support the hiring, training, workflow changes, and start-up costs associated with introducing integrated mental health and addiction treatment into primary care. [5]

Recommendations:

- Fund infrastructure/start-up costs for teleconsultation equipment for provider-to-provider consultation.
- Fund financial feasibility studies for new care models.
- Fund technical assistance, education and training for new care models including but not limited to:
    - Collaborative Care Model (CoCM)
    - Project ECHO
    - Team Based Care
    - Screening and Brief Intervention and Referral to Treatment
- Funding for Evidenced-Based Practices (EBP). Most EBP models require extensive staff training, including multiple days and ongoing supervision.

4 Behavioral Health Workforce Projections. Rockville, MD, Health Resources and Services Administration, 2020. Available here: https://bhw.hrsa.gov/data-research/projecting-health-workforce-supply-demand/behavioral-health.

[5] Wallace NT, Cohen DJ, Gunn R, et al.: Start-up and ongoing practice expenses of behavioral health and primary care integration interventions in the Advancing Care Together (ACT) Program. J Am Board Fam Med 28(suppl 1):S86–S97, 2015. Available here: https://www.jabfm.org/content/28/Supplement_1/S86/tab-article-info.

Expansion of certified peer support specialist services and peer-run services.

Increase funds for community-based partnerships for peer-support specialists who are individuals who have experienced mental health or substance use problems and been trained to support those struggling with mental health conditions, psychological trauma, or SUD. Certified Peer Specialists have been proven highly effective in improving patient outcomes.[6] **Expanding access to training, credentialing, and reimbursement for peer support has the potential to improve sustainable access to high-quality peer-support care.**

UPMC Western has engaged/expanded the involvement of Peer Navigator and Certified Peers where possible for follow-up care after a hospitalization or as an extension of outpatient behavioral health or addiction services. With 51 employees across the organization, an affiliate peer program is under development to scale availability of peer-support services by leveraging the employees of other community-based organizations that share a common geography within the Western catchment area. These community organizations are not traditional behavioral health providers, but social service organizations, which share the common goal of improving engagement of people in need by making social services available to them.

Recommendations:

- Funding infrastructure development for community-based organizations including:
    a. Up front funding for training; certifications for peer services.
    b. Up front funding for development of EMR/documentation systems/partnership development.
- Fund the expansion of organizations with the ability to provide training and certification.

Delivery of services by telemedicine

According to The National Council for Mental Wellbeing, the major successes of tele-behavioral health included expanded access, maintained and, in some cases, improved quality of care. It created access to those who would have otherwise not received care. While the pandemic exposed vulnerabilities in our system related to technology, research findings indicate how telemedicine narrowed inequities for patients among the most disadvantaged areas as measured by the area deprivation index (ADI) and how

[6] https://www.chcs.org/resource/southwestern-pennsylvania-peers-help-people-with-substance-use-disorders-move-toward-recovery/

audio-only services paid in line with other modalities have been crucial, particularly in integrated care models.[7] [8]

Over the past 12 months, UPMC WBH tele-services remain at 38% of our overall service delivery.

Recommendations:

- Support funding for infrastructure/equipment to integrate clinical decision support, management-based care, screening, and funding for hardware.
- Fund equipment, training, and technical assistance for innovative programs that allow provider to provider consultation (for example, the UPMC Children's Hospital TIPS program and Project EHCO) supporting connections between primary care and mental health specialists.
- Provide grant funding to counties for the provision of technology tools and technical support for those without access to phone/iPad/computers.

It is often said that, in the context of mental-health service delivery, we really struggle with what we call the implementation gap - *the gap between what we know and what we do.* That is not the case here – and as we consider next steps, I have full confidence that our Commission will be guided by scientific evidence and the brain trust surrounding us today. I appreciate the opportunity to contribute to this process and look forward to continued collaboration. Thank you.

1"Caitlin Hicks on Telemedicine and Care Inequities", Health Affairs Podcast, May 17, 2022. DOI: 10.1377/hp20220502.193894
[8] BMC Dr Michelle Durham Senate Finance Committee hearing on mental health....pdf