Middlesex County Restoration Center
Monday, November 19, 2018
Behavioral Health Network
417 Liberty St.
Springfield, MA

MINUTES

Attendees: Senator Cindy Friedman; Representative Kenneth Gordon; Scott Taberner, MassHealth; Vic DiGravio, Association for Behavioral Healthcare; Kati Mapa, National Alliance on Mental Illness; Mandy Gilman, Association for Behavioral Healthcare; Nancy Connolly, Psy. D., Department of Mental Health; David Ryan, Middlesex Sheriff's Office; Marisa Hebble, MA Trial Courts; Catia Sharp, Middlesex Sheriff's Office; Emilia Dunham, MassHealth; Steve Winn, Ph.D., Behavioral Health Network, Inc.; Justin Mehl, MSW, LCSW, BHN Crisis Services; Caroline Bays.

12:00 PM: INTRODUCTION

Senator Friedman called the meeting to order, noting that she was standing in for co-chairs Sheriff Koutoujian and Danna Mauch, who both needed to miss the meeting.

12:05 PM: LEGISLATIVE UPDATE

Senator Friedman stated that there were no new legislative items to discuss.

12:06 PM: QUESTIONS AND ANSWERS WITH BEHAVIORAL HEALTH NETWORK STAFF, DISCUSSION

Senator Friedman thanked Behavioral Health Network (BHN) staff members Steve Winn, Chief Operating Officer, and Justin Mehl, Director of Recovery and

Peer Support Services for a tour they had just completed with Commission members of:

- Community Crisis Stabilization (CCS), a 7-bed short-term (3-5 day) out-of-home placement to stabilize individuals in an emerging crisis situation. The program offers a home-like, safe, and supervised environment for psychiatric crisis, hospital diversion or step-down, medication evaluation and service coordination. CCS is a voluntary, unlocked, community-based treatment program funded primarily by MassHealth and private insurers. Adults may access CCS only through Emergency Service Provider Crisis Evaluation Teams.
- Department of Mental Health-funded Respite, 8 beds for slightly longer-term (14-30 day) out-of-home placement to stabilize individuals in an emerging crisis situation. These beds are only open to DMH clients, but are otherwise is very similar to CCS.
- The Living Room, an open, home-like environment where those coping with a behavioral health issue can meet with peer support workers and avoid the emergency room or hospitalization. The Living Room is fully staffed and available to walk-ins during the day between the hours of 7 am and 7 pm, and allows for overnight stays for those in need, with reduced staffing capacity. BHN relationships with local law enforcement have led to police transports of walk-in clients as well.
- The Hope Center, a Clinical Stabilization Services (CSS) program. The Hope Center is a 30-bed facility providing 14-30 days of stabilization for individuals with active addiction or substance use but who either don't need or who have already gone through detoxification and are not experiencing active withdrawal symptoms. Many individuals come to CSS as a step-down from Acute Treatment Services (ATS), or detoxification. The Hope Center also offers induction to extended release injectable naltrexone to individuals being treated at BHN's crisis services through the ERIN project, funded by the Department of Public Health's Bureau of Substance Abuse Services (BSAS).

Senator Friedman opened the floor to questions and discussion with staff members from BHN.

Catia Sharp asked BHN staff to talk about the programs provided by BHN that the tour did not cover.

Justin Mehl described a police education program in which BHN staff assist in providing Crisis Intervention Training (CIT) to local police officers, where they are able to teach officers about the crisis services available at the Living Room and CCS. He noted that police officers are making increasing use of these resources as an alternative to transport to hospital Emergency Rooms.

Justin also described the Emergency Services Provider (ESP) affiliated with BHN, which provides mobile behavioral health supports in the community.

Finally, Justin talked about a jail step-down program in Hampden County for individuals with behavioral health needs that BHN partners with.

Nancy Connolly commented that she believes individuals stay in crisis treatment more effectively at BHN than in traditional emergency rooms. While BHN crisis services are voluntary, they are more effective at engaging individuals and encouraging them to stay in stabilization services. Nancy noted that this is something police appreciate about BHN.

Marisa Hebble asked what the biggest challenge is with providing services at the Living Room.

Justin responded that his two largest challenges are that there is no shower on-site at the Living Room due to lack of necessary plumbing capacity, and not being able to provide longer stays for individuals who need more time to stabilize.

Steve Winn added that from his perspective, staff turnover is a large challenge, both at the Living Room and broadly at BHN. He attributed this to broader workforce issues in this field. He noted that the pay is not sufficient to attract workers into the field.

Mandy Gilman noted that ABH has been running focus groups among their member providers about workforce issues. They are hearing this concern more in the last two years, partly because of increases in funding from DMH and MassHealth for these types of programs (increased availability of funding for services has run into a longer time-horizon workforce pipeline issue). She also noted that BHN and providers like them are competing with providers that pay more, like hospitals.

Vic DiGravio added that in a salary survey of ABH members, they found pay to be 22% less than equivalent positions at private hospitals in Massachusetts. ABH believes this is mostly due to lower reimbursement rates for community-based providers.

Nancy Connolly added that the high cost of living in Massachusetts makes it difficult to recruit talented workforce from out of state as well.

Representative Gordon asked what the average tenure at BHN is, especially for peer support workers.
Steve Winn responded that there are two employment tracks they most commonly see at BHN. There is a two year minimum work requirement for social work and master's level licensure in behavioral health. The first track is individuals coming out of master's programs might do their two year supervised requirement at BHN and then leave to open a private practice or get better paying jobs at a hospital. The second track are career staffers who choose the mission of their work over better pay in alternative settings. Steve also noted that the staffing problems are exacerbated for individuals working with special populations, like individuals with limited English proficiency and individuals who are transgender.

Vic DiGravio added that it is not uncommon for ABH members to see 30% turnover rates.

Justin Mehl mentioned that the Living Room, which is staffed by peers, has higher turnover than other programs because the peers often struggle financially and have limited upward mobility due to additional levels of licensure that are required for the more clinical roles.

Marisa Hebble asked whether CCS and the ESP work together.

Steve Winn responded that they do work together, and added that a 30-bed forensic unit is also opening in Hampden County.

Scott Taberner noted that the acuity of mental health need is higher in ESP's and crisis services than in other residential programs. He said the MassHealth payment rate for addiction residential treatment beds is currently about $102 per day for a level of care equivalent to the ASAM level 3.1. Scott noted that this level is not able to effectively treat individuals with co-occurring substance use and mental health diagnoses. Therefore, MassHealth is creating a new level of care that will be enhanced co-occurring residential services to fill that gap. These new enhanced co-occurring residential treatment beds will be at a rate of $239 per day, with a length of stay up to 3 months or longer based on an individual's needs. This rate is more than double because the level

of staffing will be much higher than current residential treatment, and this enhanced treatment option will specifically be targeted at individuals with co-occurring mental illness and substance use disorder, which makes them more costly to treat effectively. MassHealth will be adding more than 450 enhanced residential treatment beds, in addition to the ~2700 existing residential treatment beds.

Senator Friedman asked which came first, the targeted level of care or the targeted payment rate.

Scott responded that the rate was set by first approaching ABH and other providers to ask how much it would cost to provide the right level of care to address the gap identified for more acute patients.

Vic DiGravio confirmed this process, adding that ABH and BHN, among others, provided initial feedback to MassHealth before MassHealth made the proposal available for public comment. ABH then submitted testimony on the proposal.

Marisa Hebble asked whether this is intended to be a post-CCS level of care.

Scott responded that ATS, which is a detoxification level of care on the substance abuse side, has a small number of programs for individuals with co-occurring disorders (citing Dual Diagnosis Acute Residential Treatment (D-DART) and Enhanced Acute Treatment Services (E-ATS)). However, there is a gap in elevated levels of care for individuals with co-occurring disorders that would be step-downs between acute care (ATS-level programs) and non-acute care (residential rehabilitation programs at the ASAM 3.1 level). MassHealth is accomplishing this through their 1115 waiver, and Massachusetts is among only 5 states in the country using the waiver in this way.

Senator Friedman noted that the Commission has been hearing a lot about MassHealth-funded services, but not about programs available to individuals with private insurance. She asked Catia Sharp to help the Commission address this question in the future.

Senator Friedman asked what the biggest barriers are to getting people into treatment and with having them follow treatment through, and what

complexities the state could address through legislation to alleviate these barriers.

Steve Winn responded that programs for individuals with co-occurring disorders are just starting to become available, and are very much needed. He also added that there is a great need to address the social determinants of health for this population – education, employment, and housing to name a few.

Justin Mehl added that there are times when the regulations don't fully align with the work. He said that ABH tries to be a voice on this issue. He cited recovery coaching as one example where regulations were recently promulgated, but weren't flexible enough to meet the need on the ground. He said that there are times where written regulations don't align with fidelity to the treatment model.

Marisa Hebble noted that the Living Room model is difficult to fit neatly into a regulatory box due to the individualized nature of the treatment to the individuals seeking stabilization services.

Vic DiGravio added that the more insurance-based the Restoration Center is, the more regulations there will be on how it is operated. He said that ABH is currently talking to MassHealth about regulatory relief to encourage innovation in member organizations. He thinks that providers are afraid that they won't be able to appropriately treat the level of acuity they are seeing in crisis stabilization services under the current regulatory environment. He also echoed Steve Winn on the need to address housing (a social determinant of health). He noted that people are sometimes staying longer than is clinically necessary in crisis stabilization and other residential treatment services while they wait for adequate housing placements.

Catia Sharp asked whether there are specific housing programs and funding sources that the Commission should be aware of when considering this particular social determinant of health.

Vic DiGravio noted Adult Community Clinical Services (ACCS), the DMH rental voucher program, and Executive Office of Housing and Economic Development-funded voucher and housing programs. He noted that providers are good at leveraging lots of different programs on behalf of clients.

Senator Friedman asked, in a perfect world, how much of each kind of program do we need? How much supportive housing? How many crisis

beds? She said that the Commission needs to build a better understanding of need vs capacity.

Scott Taberner agreed. For example, if MassHealth is adding 400-500 enhanced residential rehabilitation beds for individuals with co-occurring substance use disorder and mental illness on top of ~700 residential rehabilitation beds at the ASAM 3.1 level of care, that would be increasing bed space by 25% statewide. Is that the right amount of beds? He said that we are all trying to assess what the right continuum of care would be, how does it work cohesively, and does it support the needs of the community? No one has found the right answer to the right set of services at the right ratio.

Marisa Hebble noted, to the points made about the social determinants of health, that Portugal (a country which, she noted, is very different in substance abuse treatment than the US) decided to pay half of the pre-treatment salary of individuals leaving residential substance use treatment programs, which can help fund housing. She thinks that we ought to think about innovative ways to finance post-treatment housing.

Mandy Gilman noted that a legislatively-commissioned report recently looked at what the right level of inpatient psychiatric care would be in Massachusetts, but it is difficult to get specific numbers.

Senator Friedman asked where and why individuals drop out along the BHN continuum of care.

Steve Winn responded that this happens all along the continuum of care for a variety of reasons.

Nancy Connolly noted that the most promising models for keeping individuals engaged in treatment are those that engage people early on, like Wellness Recovery Action Plan (WRAP). If you engage the person at their entry point to service in their after-care planning, then the after-care will be more effective. Engagement should be across programs and needs to be aggressive in terms of outreach. There will always be dropouts, but it is easier to come back into treatment if the person has been engaged by the system before.

Senator Friedman asked if BHN is seeing people come back successfully.

Justin Mehl replied that peers see a lot of frustration from clients at the Living Room with long wait times for residential treatment, and individuals subsequently drop out of the pipeline. Peers try to build frustration tolerance, teaching clients how to navigate the system, how to be most effective at getting beds, and coping with frustration when beds are slow to open. He added that lots of clients are also banned from shelters, which is another source of frustration.

Nancy Connolly asked whether BHN bans people who have engaged in violence.

Justin Mehl said that they give people at the Living Room space to be aggressive verbally because it is a harm reduction model. He noted that they have only ever had to ban 2-3 people for life, and not because of physical violence, but because of emotional trauma those individuals had caused to other clients.

Dave Ryan asked about the security milieu at BHN.

Steve Winn responded that this is a challenge, especially in the last couple of years. BHN has good relationships with police, so they respond when called very quickly. He added that all staff, including peers at the Living Room, are trained in crisis de-escalation techniques. They also do a lot of outreach in the community and partner with health centers and primary care providers and the housing authority to bring in clients before they are in a full-blown crisis, as well as doing ride-alongs with police. He implied that this may minimize the need for crisis de-escalation.

Mandy Gilman added that DMH funds many of these programs for ride-alongs and police drop-off at crisis stabilization services.

Senator Friedman wanted to re-focus the group on why people leave crisis stabilization services. She asked if a person leaves voluntarily, what happens to them?

Steve Winn responded that, in a lot of cases, a person will leave and there is no follow up and they show up back in the system somewhere else. He cited the new MassHealth BHCP program that he thinks will begin to address this by creating more care management in behavioral health that will follow patients between care settings.

Vic DiGravio added that providers can offer any type of service that a funder will pay for. For example, providers, in partnership with MassHealth payer the Massachusetts Behavioral Health Partnership (MBHP), came up with the idea for the Community Support Program for People Experiencing Chronic Homelessness (CSPECH).

Marisa Hebble noted that people early in recovery are tricky to engage, and the Commission should make sure that staff of a Restoration Center are really well trained to do this engagement.

Justin Mehl agreed, noting that this is especially true when the individuals don't have stable addresses or telephones.

Marisa Hebble added that the Brigham hospital has begun doing a new social determinants of health screening that is an interesting idea.

Senator Friedman added Elliot Human Services were funded to study what people really needed, and they found that outreach really works.

Senator Friedman commented that the Commission seeks to address the real barriers to treatment rather than continuing to make the same mistakes in a new Restoration Center, and therefore is seeking honest assessments of those barriers in its information gathering phase. The Senator encouraged Commission members and others in the room to be honest about the challenges in the current system so that real solutions might be found.

Senator Friedman thanked the BHN team for the tour and their participation in the meeting.

Vic DiGravio suggested that the Commission look into the role of commercial insurance by inviting Blue Cross Blue Shield and/or the Massachusetts Association of Insurers to a meeting.

Senator Friedman suggested that a group of providers also be present at such a meeting to help address any discrepancies between the stated operating procedures and what happens on the ground.

Scott Taberner noted that as the Commission goes to Texas and looks at different models, it ought to remember that Massachusetts is different from many other places, not least because of the high rate of insurance.

Steve Winn noted in closing that in statewide data on hospital diversion produced by ESP's, western Massachusetts does better. He believes that

is due to a wider array of services from crisis to social determinants of health like CSPECH. This wide continuum allows care to be best tailored to individual's needs. He said that we need a big toolkit to meet the needs of all individuals. He said that right now, there is limited ability to say 'what does this individual need and how do we provide that' due to limited flexibility in state-funded programs. He suggested that we give people what they need rather than what we have.

1:25 PM CLOSING AND NEXT STEPS

Catia Sharp made some housekeeping announcements about upcoming Commission travel to Bexar County, Texas, subcommittee meetings on MassHealth and data sharing, and a convening of Middlesex County police-based jail diversion clinicians.

Senator Friedman adjourned the meeting.