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INSIGHT

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Renewed Optimism…

2020 is over.

With resolve, and renewed optimism we have moved into 2021.

While we carry many of the challenges of last year with us, we look forward to building upon all that we have accomplished with new lessons learned. Strategies have shifted and new opportunities are just over the horizon waiting for discovery.

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We often focus on the negatives. These are the things that bring risk and pain. Naturally, we would like to avoid these things that cause us pain, frustration, and loss. Negatives drive us to want to fix things… to make corrections and adjustments that remedy conditions that cause the negatives. We want to make things better for those we serve (and for ourselves and those around us).

But how often do we "catch ourselves" doing something right?

A small tid-bit of wisdom imparted during one of the many training sessions a professional in a county human services system attended was this simple concept in regard to management style – "How often do you catch your staff doing something right?" Brilliant, right? It is easy to find what someone does wrong (and accentuate it)… but what about those times when they do it right? Do we give this at least equal attention?

Now let's turn this concept upon ourselves. **How often do we catch ourselves "doing something right?"**

Pennsylvania Behavioral HealthChoices has been serving Pennsylvanians in recovery for several decades, and the service delivery system has grown and innovated with the healthcare needs of our citizens. Last year we may have faced our most challenging year yet, addressing and overcoming the operational challenges of providing services in the COVID-19 pandemic. There were so many negative things to focus on. Yet, there were also so many successes that we must not permit to go unrecognized.

In a recent RAND Corporation[1] report called How to Transform the U.S. Mental Health System – Evidence Based Recommendations the national mental healthcare system was evaluated and a number of "solutions" were offered as recommendations. **It was encouraging to learn that our system in Pennsylvania is already involved or has developed many (if not all) of the 72 recommendations listed. (See "72 Solutions" on page 5).** A national healthcare think-tank gives us evidence that we are doing something right.

[1] The RAND Corporation is a research organization that develops solutions to public policy challenges to help make communities throughout the world safer and more secure, healthier and more prosperous. RAND is nonprofit, nonpartisan, and committed to the public interest. www.rand.org

The United States, RAND writes, is at a time of promise for historic transformation in mental health care. For decades, systemic problems have persisted — including high levels of unmet need, underdevelopment of community-based supports, and inequities in access and quality of care. In 2019, only 45 percent of people with a mental illness received any mental health treatment. This translates to unmet need for more than 30 million Americans. Additionally, despite similar levels of mental health care need, racial/ethnic minorities in the United States are about half as likely to use mental health care as non-Hispanic Whites. There are also striking geographic variations in availability of mental health specialty care, with rural areas particularly underserved.

Yet recent years have seen positive signs of change. Congress has passed key legislation — such as the 2008 Mental Health Parity and Addictions Equity Act — with overwhelmingly bipartisan support, states have endorsed an expanded role of Medicaid in providing coverage for individuals with serious mental illness who are often lower income and struggling with employment, and researchers have identified new evidence-based treatment models that health systems can implement.

This report provides recommendations to promote transformational change to improve the lives of the millions of Americans living with mental illness. To identify these recommendations, the authors conducted a broad review of policy ideas related to goals for the mental health system. They conducted an extensive analysis of mental health systems processes, policies, and solutions supported by evidence and received input from experts around the country.

The analysis and findings are organized under three goals for mental health system transformation:

1. **Promote pathways to care.** Too often, people with mental health needs do not even make contact with mental health providers. This is partly attributable to a system in which individuals are unaware of available resources, fear the repercussions and stigma associated with mental illness, and fail to receive screenings and diagnoses. High-need populations, such as those with a pattern of homelessness or criminal justice involvement, may also require shepherding to services that best meet their needs.
2. **Improve access to care.** Once a patient is identified as needing care, several barriers may obstruct actual receipt of services. These include the cost to the consumer (affordability), the capacity of the system to provide adequate care in a timely manner (availability), the location of services (accessibility), and the suitability of services from the consumer's perspective (appropriateness). All four barriers must be removed for patients to use services.
3. **Establish an evidence-based continuum of care.** Once patients are inside the system, uncertainty remains. Will the care be evidence-based? Will it correspond to the patient's level of need? Will it be provided

in a timely and consistent manner? There is no guarantee that mental health systems can answer "yes" to these questions and, ultimately, improve patient outcomes. For this to happen, the internal mechanics of systems need to be recalibrated, and rewards need to be established to align services with patient needs.

RAND used literature review, interviews, and advisory panel input to develop 15 key recommendations that map onto our three overarching goals for improving the mental health landscape in the United States. The recommendations are[2]:

1. Promote systematic mental health education.
2. Integrate behavioral health expertise into general health care settings.
3. Link homeless individuals with mental illness to supportive housing.
4. Develop a mental health diversion strategy centered on community behavioral health.
5. Strengthen mental health parity regulation and enforcement.
6. Reimburse evidence-based behavioral health treatments at their true cost.
7. Establish an evidence-based mental health crisis response system.
8. Establish a national strategy to finance and disseminate evidence-based early interventions for serious mental illness.
9. Expand scholarships and loan repayment programs to stimulate workforce growth.
10. Improve the availability and quality of peer-support services.
11. Expand access to digital and telehealth services for mental health.
12. Include patient-important outcomes in treatment planning and assessments of care quality.
13. Define and institutionalize a continuum of care in states and communities.
14. Launch a national care-coordination initiative.
15. Form a learning collaborative for Medicaid behavioral health financing.

Excerpted from: McBain, Ryan K., Nicole K. Eberhart, Joshua Breslau, Lori Frank, M. Audrey Burnam, Vishnupriya Kareddy, and Molly M. Simmons, How to Transform the U.S. Mental Health System: Evidence-Based Recommendations. Santa Monica, CA: RAND Corporation, 2021. https://www.rand.org/pubs/research_reports/RRA889-1.html.

[2] See complete document at: https://www.rand.org/pubs/research_reports/RRA889-1.html

72 Solutions

RAND reports that more than 46 million Americans live with mental illness (1 in 7 Americans), yet only half of those Americans receive treatment. RAND provided a tool that helps research what mental health system problem you would want to solve (See Mental Health System Solutions Explorer)[3].

The interesting discovery is that the Pennsylvania Behavioral HealthChoices Program administered through County primary contractors is addressing now or planning for the future many of the 72 items listed below in innovative and meaningful ways in their respective local County settings.

It is true we have many challenges yet to resolve as we emerge together out of the COVID-19 pandemic conditions. But we have learned much, and solved problems we could not have imagined.

As you read through these 72 solutions, make a mental note of how your county or region is doing it right. Take a moment to recognize the system you have assembled in your County, working with your behavioral health managed care organization and community provider networks.

As we proceed, there is much to be optimistic about how we can continue to develop and refine our local healthcare systems to make them even better. But for now, take a moment to catch yourself doing it right.

1. Public service announcements and public campaigns – Messages in the public interest that are disseminated without charge to raise awareness about the importance of mental health and shift public attitudes and behaviors related to mental health stigma and treatment-seeking.
2. Target-population initiatives – Messages tailored to vulnerable or high-risk populations for mental health needs (e.g., refugees) to raise awareness about the importance of mental health and to shift attitudes and behaviors related to mental health stigma and treatment-seeking.
3. Exposure-based initiatives – Initiatives that teach about mental health, including by having someone who has experienced mental health issues share their experiences.
4. School-based curricula – Initiatives that teach children, adolescents, and young adults about the importance of mental health, treatment-seeking, and other issues in the context of school curricula.
5. Gatekeeper training – Training for individuals, often in leadership roles, to identify people who are at high risk of mental health problems and refer them for treatment.
6. Embed mental health champions within existing institutions – Professional advocates and point persons for advancing mental health care within institutions, including work settings.
7. Workplace engagement in mental health support – Programs and initiatives within the workplace, such as on-site employee assistance programs, that extend beyond wellness programs to provide employees with substantive tools, training, and resources for mental health supports.
8. Workplace-based therapy (e.g., cognitive behavioral therapy) – Provision of psychotherapy and other evidence-based practices within the workplace, with the inclusion of work-related goals for participants.
9. First responder training – Training for first responders, including police officers and emergency medical services technicians, to identify mental health symptoms and needs and how to intervene appropriately.

[3] Mental Health Systems Solutions Explorer; RAND Corporation; Mental Health Systems Solutions Explorer | RAND; 2021.

10. Housing and homeless services – Behavioral health outreach, screening, treatment and rehabilitation offered through housing and homeless services, often for individuals with serious mental illness.
11. Diversion programs in medical settings – Medical programs, often within emergency departments, that rapidly screen individuals with acute mental health needs and divert these individuals in a timely manner to an appropriate level of care (e.g., a 24/7 crisis center).
12. Post-arrest diversion programs in criminal justice settings – Criminal justice system programs in which offenders are connected with behavioral health services post-arrest (e.g., pretrial or instead of being booked for low-level offenses) to help remedy the behavior leading to the original arrest and/or conviction.
13. Prison-to-community transition programs – Interventions aimed at improving outcomes for individuals leaving prison who have mental health conditions, often by enrolling individuals in Medicaid and connecting them to mental health resources and supports at release.
14. Mental health assessment through child welfare services – Administration of mental health screeners and diagnostic tools for children receiving child welfare services.
15. Mental health screenings in primary care – Administration of mental health screeners, such as the Patient Health Questionnaire-9 (PHQ-9), in the context of individuals' primary care.
16. Community-based mental health screenings – Administration of mental health screeners, such as the PHQ-9, in nonmedical community-based settings, such as places of worship.
17. School-based mental health screenings – Administration of mental health screeners, such as the PHQ-9, in schools and universities.
18. Phone apps and internet-based screening and prevention – Availability of mental health screeners, such as the PHQ-9, for self-administration through phone apps or online.
19. Financial incentives for mental health screening – Programs that incentivize mental health screenings for vulnerable and underserved populations.
20. Population-based mental health screenings – Broad scale initiatives to identify individuals with mental health needs through biomarkers, health information exchange and data mining, and other techniques.
21. Federal legislation to cover more people – Legislation passed by U.S. Congress with the intention of expanding the number of beneficiaries on insurance that covers mental health services.
22. State legislation to cover more people – Legislation passed by states with the intention of expanding the number of beneficiaries on insurance that covers mental health services.
23. Federal legislation to enhance insurance benefits – Legislation passed by U.S. Congress with the intention of expanding the depth of mental health services coverage for existing beneficiaries.
24. Enhanced mental health coverage in Medicaid – Policymaking with the intention of expanding the depth of mental health services coverage for existing beneficiaries.
25. Limitations on out-of-pocket payments, deductibles, and copayments – Insurance regulations that limit the amount of financial risk and liabilities borne by patients.
26. Enforced network adequacy through regulation – Regulations that support mental health parity by ensuring that insurers have in-network coverage that is adequate and comparable to in-network coverage for physical health conditions.
27. Legal enforcement for noncompliance with existing statutes – Legal action, including injunctions issued by state and federal courts, mandating that public and private providers are in compliance with such statutes as the Mental Health Parity and Addiction Equity Act and Americans with Disabilities Act.

28. Oversight and monitoring of nonquantitative treatment limits – Investigations of, and associated responses to, nonquantitative treatment limits, which are criteria (e.g., prior authorization) that are posed by insurers and that curb patients' access to mental health services.
29. Improved accuracy of network directories – Mechanisms, such as legislation and regulation (in addition to private industry efforts), that aim to improve the accuracy of network directory information.
30. Charge-price-transparency regulation – Regulations that increase the transparency of medical service prices for consumers.
31. Increased negotiation of prices for medications – Improving competition by allowing insurers, providers and patients to negotiate the price of medicines with vendors.
32. Targeted or broad-based price regulation – Regulations that set a ceiling or establish stipulations on the prices that can be charged for goods and services.
33. Subsidized educational opportunities – Mechanisms, such as scholarships and loan forgiveness, that lower the cost of training for prospective mental health professionals.
34. Higher reimbursement rates – Elevated levels of compensation for provision of mental health services, particularly the services that generate the most value to patients.
35. Enhanced attractiveness of entry-level workforce posts – Reforms that make entry-level jobs—such as peer support counselors and home health aides—more attractive, including better wages, career ladders, and work schedule flexibility.
36. Expanded diversity of the behavioral health workforce – Efforts to enhance the diversity of the mental health workforce, including by increasing the representation of minorities, such as African Americans and Latinx Americans.
37. Increased institutional capacity for training – Support for institutions to train more prospective members of the mental health workforce and to provide more-comprehensive curricula to equip the entering workforce to meet the needs of patients.
38. Federal funding for high-need positions – Allocation of federal funds to aid local (often public) health systems with addressing understaffing in key positions, such as psychiatrists, psychologists, and social workers.
39. Redistribution to underserved areas and populations – Programs that recruit members of the mental health workforce to serve in underrepresented communities, including health provider shortage areas.
40. Specialist training to non-specialists – Learning models in which professionals with specialized competencies (e.g., psychiatrists) provide mentorship and education to those without this specialization (e.g., internists)
41. Expanded scope of practice for members of the entry-level mental health workforce – Expansion of the procedures, actions, and processes that a health care provider is permitted to undertake in accordance with their professional license or certification.
42. Mental health training for mental health–adjacent professions – Programs that equip individuals (such as college resident assistants and child welfare professionals) to identify signs and symptoms of psychological distress and respond appropriately.
43. Support for providers to function at the top of their license – Institutional arrangements that allow providers to serve at their highest capacity by strategically allocating certain roles and responsibilities among other personnel.
44. Standardization and reciprocal recognition of certification and licensing – Efforts to harmonize the competencies for the certification and licensing of providers at state and federal levels and to allow reciprocal arrangements for certification in one state to be deemed suitable in another state.

45. **Improved risk adjustment and risk-adjusted payment** – Advanced algorithms and weighting schemes that determine allotted payments according to the severity of an individual's underlying health status and the value of services for improving patient outcomes.
46. **Reforms to behavioral health system infrastructure** – Modernization of mental health system infrastructure, including the arrangement and distribution of facilities and beds, the composition of services provided, and digital health resources.
47. **Mental health treatment and wellness apps** – Smartphone applications that provide therapeutic benefits to those with mental health needs.
48. **Telehealth services** – Use of telecommunications technology by health care professionals to provide behavioral health care remotely.
49. **Training for digital health** – Training for current and future behavioral health providers in providing high-quality telehealth services.
50. **Expanded reimbursement for digital health** – Increased compensation for provision of remote care to incentivize providers to routinely offer this type of care as an alternative to in-person care.
51. **Increased use of medical wearables** – Electronic devices that consumers can wear, such as smart watches and biosensors, that provide real-time feedback about an individual's health status or that can deliver or assist treatment.
52. **School-based mental health services: K–12** – Provision of mental health education, screening and services in school-based settings for children and adolescents in kindergarten through 12th grade.
53. **School-based mental health services: colleges and universities** – Provision of mental health education, screening and services in school-based settings for adolescents and adults in colleges and universities.
54. **Behavioral health urgent care clinics** – Facilities that individuals experiencing a mental health crisis can turn to for services during hours when a typical health facility would be closed, such as on evenings and weekends.
55. **Behavioral health integration with primary care** – The integration of mental health services into primary care settings, either through colocation or collaborative agreements.
56. **Behavioral health integration with substance use treatment facilities** – The integration of mental health services into substance use treatment settings (and vice versa), either through colocation or collaborative agreements.
57. **Increased patient control of data** – Systems that permit patients to easily review their electronic medical records (as documented by providers) and to electronically transport this information among providers and health systems.
58. **Culturally and linguistically competent care** – The capacity of health systems to provide care that responds effectively to the cultural and linguistic needs of patients.
59. **Novel modes of provider-patient communication** – New venues through which providers and patients can engage one another, such as text messaging and patient portals.
60. **Interventions to support caregivers** – Ways that the health system can support caregivers who are providing for the needs of someone with a mental health condition.
61. **Shared decision-making** – A process in which patients and providers work together to make health decisions that support patient goals and preferences.
62. **Incentives for evidence-based practices that address gaps in care and social needs** – Financial and nonfinancial incentives that encourage providers to offer forms of care and supports that are evidence-based and underused within the care continuum.
63. **Quality reporting requirements for evidence-based practices that address gaps in care** – Requirements for providers to report the provision of forms of evidence-based practices.

64. Quality reporting requirements for patient-centered clinical practices – Requirements for providers to report compliance with patient-centered policies, such as developing individualized care plans and ensuring patient access to medical records.
65. Training for models of integrated care – Efforts that support the capacity of practices to establish integrated care and adequately train personnel to follow new workflows.
66. Government funding for models of integrated care – Federal or state funding to offset the capital costs of transitioning health systems to integrated care models or to support ongoing financial needs to make integrated care models economically viable.
67. Integrated funding and reimbursement for mental health and support services – Forms of braided and blended funding, in which funding is merged or coordinated from one or more funding streams, as well as bundled payments that cover an array of potential medical and social services needs of patients.
68. Reimbursement for care coordination – Specific billing codes under fee-for-service models of payment that can be charged for care coordination.
69. Health information exchanges for electronic health records and other forms of enhanced system interoperability – Arrangements that allow providers across health systems and service sectors to securely access and share patients' medical information for the purpose of care coordination.
70. Develop state mental health plans that operationalize a continuum of care – Strategic plans at the state level that bring together agencies and institutions to align funding, benchmarks, and goals for the mental health system.
71. Incentivized handoffs between different levels of care – Institutional arrangements and incentive structures that motivate providers to more effectively coordinate patients services between levels of care (e.g., transitional care between hospital discharge and outpatient services).
72. Merge and integrate systems of care – Reorganizing the makeup of institutions within and connected to the mental health system such that a consolidated or formal connection is established.

Source: McBain, R., et.al.; Mental Health System Solutions Explorer; RAND Corporation; *Mental Health Systems Solutions Explorer | RAND; 2021.*

Final Thought…Acquire Optimism

Accentuate the positives – Keep a journal. In each entry, underline the good things that have happened, as well as things you've enjoyed and concentrate on them. Consider how they came about and what you can do to keep them coming. Eliminate the negatives – If you find yourself ruminating on negative situations, do something to short-circuit that train of thought. Turn on your favorite music, reread a novel you love, or get in touch with a good friend. Act locally – Don't fret about your inability to influence global affairs. Instead, do something that can make a small positive change — like donating clothes to a relief organization, helping clean or replant a neighborhood park, or volunteering at an after-school program. Be easier on yourself – Self-compassion is a characteristic shared by most optimists. You can be kind to yourself by taking good care of your body, eating well, exercising, and getting enough sleep. Take stock of your assets and concentrate on them. Finally, try to forgive yourself for past transgressions (real or imagined) and move on. Learn mindfulness – Adopting the practice of purposely focusing your attention on the present moment and accepting it without judgment can go a long way in helping you deal with unpleasant events.

Excerpt: Merz, B., 5 Ways to Hold on to Optimism; Harvard Health Publishing; 1/20/2017.