

IMPROVING MENTAL HEALTH CARE SYSTEMS IN THE UNITED STATES

Policy Questions Arising from
a Case Study of Sheppard Pratt

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ABOUT THIS REPORT

Sheppard Pratt is one of the oldest providers of mental health care in the United States, founded as an inpatient psychiatric hospital in Baltimore in 1853. Beginning in the early 1990s, Sheppard Pratt made a transition into a community-based mental health specialty care system, combining its traditional inpatient services with an increasingly diverse array of community-based outpatient clinical, residential, and recovery-oriented services. Today, Sheppard Pratt comprises more than 160 programs at more than 380 sites across Maryland.⁶ To explore how Sheppard Pratt's experience can potentially inform national mental health policy, Sheppard Pratt engaged the RAND Corporation, a nonprofit, nonpartisan policy research organization. The RAND research team worked with senior staff at Sheppard Pratt to understand the distinctive characteristics of the organization, ways in which it addresses challenges that mental health policymakers face, and continuing challenges that it faces in reaching its own goals.

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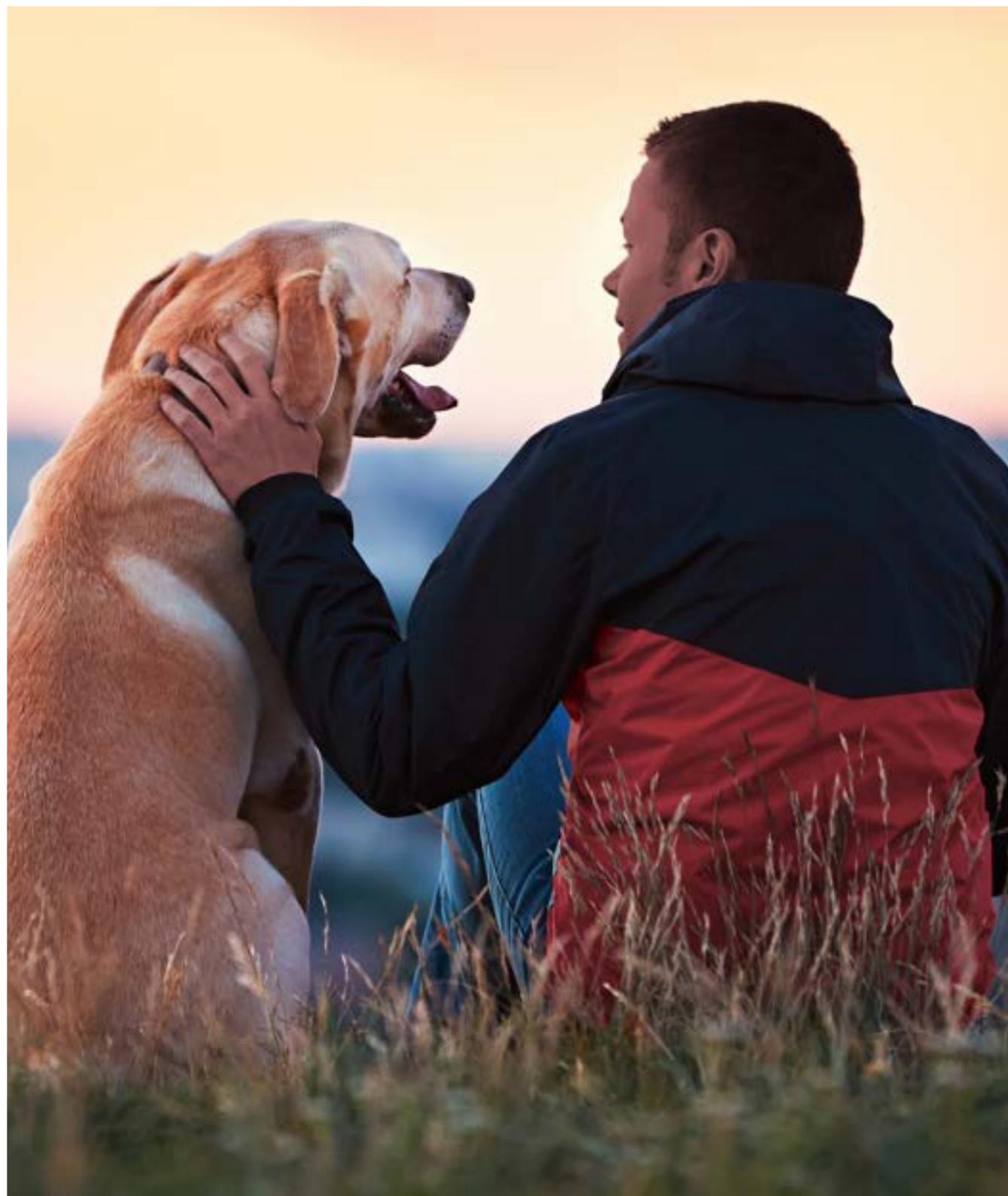
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INTRODUCTION

By many measures, mental health care in the United States falls short of equitably providing effective treatment and support for people living with mental illness in the community. Symptoms of systemic failures, summarized in **(Box 1)**, include the numbers of people with mental illness who are in prisons or jails, homeless, or unstably housed. Reflecting inadequate capacity to provide acute mental health treatment, patients in mental health crises are commonly “boarded” in emergency departments, held with minimal treatment for days or weeks until a therapeutic inpatient bed becomes available.¹ Many people with mental health conditions receive no treatment, and use of mental health services is highly inequitable across racial and ethnic groups; in 2019, the proportions of people with a serious mental illness who received any mental health treatment in the past year were 71 percent among non-Hispanic White people, 58 percent among non-Hispanic Black people, and 53 percent among Hispanic people.² Moreover, people with mental illness also suffer disproportionately high levels of chronic physical health conditions and have a life expectancy about ten years shorter than that of the general population.^{3,4}

Box 1



Falling Through the Cracks

- A survey conducted by the U.S. Department of Justice found that 15 percent of people in prison and 26 percent of people in jail experienced serious psychological distress, an indicator of a clinically significant mental health condition.¹²
- In 2015, 23 percent of single adults entering homeless shelters in the United States came from an institutional setting, such as a substance use treatment facility, psychiatric hospital, correctional facility or hospital.¹³
- Excess mortality among people with serious mental illness is largely due to preventable cardiovascular, respiratory, and infectious illnesses.⁴
- Emergency department boarding (being held while waiting for a treatment opening) is twice as common for psychiatric patients as for other patients.¹

For decades, the goal of mental health policymakers and advocates has been to create a robust continuum of mental health care—an organized and integrated system of services with the sufficient variety and volume of services to meet the needs of a population.⁵⁻⁸ Ideally, a continuum would include a full range of evidence-based psychiatric treatments, including outpatient and inpatient services, tailored as necessary to particular cultural groups, ages, genders,

and diagnoses. For people with serious mental illnesses, the continuum of care should also include a broad range of social supports and recovery-oriented services, including residential, vocational, and educational supports. The continuum of care should be more than the sum of its parts, providing coordinated services as needed to enable patients to thrive in their communities while minimizing the use of coercive measures. Such a continuum should be capable of

Understanding how continuums of mental health care can be constructed and sustained in the context of the U.S. health care and social services systems, and devising policies to support them, remain critical research priorities.

providing culturally competent care, tailored to individuals' needs, and responsive to change over phases of illness and across the life course. The system should serve all, equitably, recognizing the extreme challenges of living with a serious mental illness and actively addressing the legacy of racist systems of care.⁹

Although the concept of a continuum of care receives widespread endorsement, constructing systems of mental health services is an enormous challenge in practice. Much of the challenge stems from organization of community-based public and safety-net psychiatric and social services for people with serious mental illness. As the United States transitioned from hospital-based to community-based mental health care, the large psychiatric

hospitals that once dominated the field were replaced by myriad small-scale community-based providers, each offering a limited scope of services.¹⁰ In each locality across the country, local policymakers, often at the county level, work with these local provider agencies, along with state and federal agencies, to create and manage a viable continuum of care. The numbers of people who fall through the cracks reflect the systemic challenges they face, decades after deinstitutionalization. Understanding how continuums of mental health care can be constructed and sustained in the context of the U.S. health care and social services systems, and devising policies to support them, remain critical research priorities.¹¹



Origin of This Report

This report grew out of an interest expressed by researchers in RAND Health Care (a division of the RAND Corporation) and the leadership of Sheppard Pratt in contributing to national mental health policy discussions, from the perspective of their organization's unique history and current status as a comprehensive specialty mental health care system. Sheppard Pratt is one of the oldest providers of mental health care in the United States, having first opened as an inpatient psychiatric hospital in suburban Baltimore in 1891. Beginning in the early 1990s, a period when many private psychiatric hospitals were closing, Sheppard Pratt made a transition into a community-based mental health specialty care system, combining its traditional inpatient services with an increasingly diverse array of community-based outpatient clinical, residential, and recovery-oriented services. Today, Sheppard Pratt comprises more than 160 programs at more than 380 sites across Maryland.⁶ Given this historical trajectory, Sheppard Pratt leadership is interested in exploring whether its model has lessons for developing and sustaining integrated mental health services on a national level.

To explore how Sheppard Pratt's experience can potentially inform national mental health policy, Sheppard Pratt engaged the RAND Corporation, a nonprofit, nonpartisan policy research organization. RAND brings to this effort an independent perspective, a

commitment to using objective evidence to guide policy, and specific expertise in mental health policy. The RAND research team worked with senior staff at Sheppard Pratt to understand the distinctive characteristics of the organization, ways in which it addresses challenges that mental health policymakers face, and continuing challenges that it faces in reaching its own goals. In this report, we provide a description of Sheppard Pratt, focusing on how aspects of its organization and practice address issues of national mental health policy concern.

It is important to stress that this report is not an evaluation of Sheppard Pratt. The research team did not conduct systematic assessments of care quality or outcomes and did not attempt to directly compare Sheppard Pratt's performance with other providers or health care systems. Rather, the goal of the report is to explore Sheppard Pratt as a case study in how persistent mental health policy challenges are faced in the context of a distinctive provider organization. This case study can generate alternative visions for the future of mental health delivery and novel directions for exploration in policy research. This report is intended to pave the way for a series of more-focused reports that will examine how the experience of Sheppard Pratt bears on specific questions related to the national mental health policy discussion.

[T]he goal of the report is to explore Sheppard Pratt as a case study in how persistent mental health policy challenges are faced in the context of a distinctive provider organization ... [and] whether [the] model has lessons for developing and sustaining integrated mental health services on a national level.

The Continuum of Mental Health Care

Mental illnesses tend to begin early in life and continue throughout adulthood, with widely varying long-term trajectories.¹⁴ Many people with mental illness have long periods of relative stability and well-being interspersed with unpredictable episodes of acute illness when more-intensive services are called for. In addition to clinical services, those with serious mental illness often require ongoing social support to maintain stable housing, employment, and social functioning, though the level of support that is needed varies significantly—even for the same individuals at different times in their lives. Clinical conditions and social needs interact dynamically over time. For example, people with mental illness are at high risk for homelessness, but homelessness also has negative effects on mental health.¹⁵ Social disadvantages and mental illness interact: Social disadvantages early in life can increase risk for mental illness,¹⁶ while mental illness can increase risk for subsequent adverse life events.¹⁷ Those adverse life events can, in turn, worsen the long-term course of mental illness.¹⁸

The need for a continuum of care stems from these diverse and changing needs. As outlined in **(Figure 1)**, this includes acute mental health services provided in inpatient units and emergency departments, as well as community-based services with diverse programming that ranges from outpatient behavioral therapy to residential care. To address comorbid substance use and physical health conditions, integration with substance use and primary care providers is also critical. Finally, to address overall well-being and background social circumstances, there are requisite nonmedical services—for example, food, shelter, and support to pursue educational and vocational goals.

Two models of the mental health continuum of care, which were developed for different purposes, provide important reference points for understanding how Sheppard Pratt fits into the broader spectrum of health services. One is the Mental Health Intervention Spectrum (MHIS), developed initially in a report from the National Academy of Medicine and further developed by

the National Institute of Mental Health and the Substance Abuse and Mental Health Services Administration.^{19,20} The MHIS, based on a public health model, characterizes the variety of strategies available for addressing the burden of mental health conditions at the population level, ranging from universal prevention to identification and treatment of people with mental disorders to long-term rehabilitation and support for people with persistent conditions. A complete continuum within this model provides not only clinical treatment but also services that prevent onset of illness, improve the course of illness over time, and reduce the occurrence of adverse consequences of illness.²¹ While the MHIS characterizes the broad range of public health strategies for addressing mental disorders, it does not describe levels of care that are needed to address the variety of patients' needs.

The second important model of the continuum of care, known as the Level of Care Utilization System (LOCUS), was developed by the American Association of Community Psychiatrists.²² It aims to be a clinical tool for matching patients with the level of care and support appropriate for their condition. Whereas the MHIS is organized by the public health functions that a continuum should fill, the LOCUS characterizes specific types of services that should be included in a mental health system. The LOCUS defines six levels of care with varying intensity, ranging from recovery maintenance and health management at the lowest intensity to medically managed residential services at the highest intensity. The LOCUS has risen in prominence since a 2019 court decision—*Wit vs. United Behavioral Health*—that identified it as an authoritative statement of “generally accepted standards of care.” Although that decision was ultimately overturned, it nonetheless led to adoption of the LOCUS into state laws guiding mental health policy in New York and California.²³ The LOCUS is primarily a clinical decisionmaking tool, and it is also used for utilization review and for assessing network adequacy. The LOCUS does not provide policy guidance regarding core implementation issues about how a continuum can be built and maintained.

Figure 1. Complex Service Needs of People with Mental Illness



NOTE: ED = emergency department; SUD = substance use disorder.





A Case Study of a Continuum of Care: The Sheppard Pratt Experience

In the context of a search for policy strategies to strengthen mental health service systems, Sheppard Pratt, as a comprehensive specialty mental health care system, provides a useful case study in how a continuum of mental health care can be constructed and sustainably maintained. Whereas most specialty providers are small and focused on a narrow range of services, Sheppard Pratt provides a wide range of services at scale, all within a single organization. Moreover, Sheppard Pratt has developed into a large specialty care system while providing safety-net mental health services, regardless of patients' ability to pay, in a region with high rates of poverty. Baltimore, which is the core metropolitan area in which Sheppard Pratt operates, has a poverty rate above 20 percent. In addition, Sheppard Pratt serves a large African American population, a group that is dramatically underserved by mental health care, relative to non-Hispanic White people, across the country.²⁴ Lessons from Sheppard

Pratt thus address core issues related to health equity and public mental health services.

To learn more about how Sheppard Pratt's continuum of care could inform issues related to national mental health policy, we collected information from public documents and conducted interviews with organizational leadership. The interviews were designed to understand Sheppard Pratt as an organization and how Sheppard Pratt delivers care. The interviews covered the structure of the service system, leadership's perceptions of how the system functions, and challenges to meeting organizational goals. In addition, while this project did not aim to systematically assess patient perceptions of care, we conducted interviews with a small number of patients and family members of patients to provide illustrations of how Sheppard Pratt services are combined to address individual needs.

Each of the next three chapters explores a major topic of mental health policy interest, shedding light on three major questions through the experience of Sheppard Pratt:

1. What does a continuum of mental health care look like in a large specialty care provider?
2. How can services be integrated across such a continuum of care?
3. How can the continuum of care be scalably and sustainably *financed*?

For each question, we start by summarizing how Sheppard Pratt is organized and how it functions, as perceived by the organizational leadership. We then view Sheppard Pratt from a policy perspective, focusing on *drivers of success*, challenges, and policy questions. Drivers of success are historical and contextual factors that have contributed to Sheppard Pratt's development. In the "Challenges" section of each chapter, we describe ongoing barriers, drawn from interviews with Sheppard Pratt leadership and the policy literature, to Sheppard Pratt achieving its goals. Each chapter concludes by drawing out policy questions with national significance, based on the analysis of Sheppard Pratt. In our concluding chapter, we explore these policy questions in greater detail.





CONTINUUM OF CARE

Policy goal: To provide comprehensive services to meet the diverse and changing needs of everyone with mental illness throughout the community.

Sheppard Pratt is built around comprehensive specialty psychiatric care. Community-based behavioral health services in the United States tend to be provided by an array of relatively small provider agencies, each providing a relatively narrow scope of services in a small geographic area. These providers form a de facto network, with a variety of weak and strong ties to each other. Although some large health care systems provide mental health care, they focus primarily on general medical care, and mental health care is a small portion of their business. There are also large human services agencies that provide a range of community-based social, residential, and rehabilitative services for people with serious mental illnesses, but these agencies generally do not provide a full range of inpatient and outpatient medical treatment for mental disorders. In this context, what makes Sheppard Pratt an interesting case study is that it is a large specialty mental

health provider that directly covers a broad spectrum of the care continuum within a single organization. Our first goal was to understand the continuum of care as provided by Sheppard Pratt.

As shown in **(Figure 2)**, the Sheppard Pratt system includes a broad array of services across three major domains:

- **Core psychiatric services:** These are the most narrowly "medical" components of the system as a whole and are primarily focused on treatment for acute phases of illness and clinical elements of chronic disease management. These services include inpatient psychiatric hospitals, a variety of outpatient mental health treatment facilities, short-term crisis homes, school-based mental health services, and intake and crisis services that connect people with care.

Figure 2. The Continuum of Care



NOTE: CCBHC - Certified Community Behavioral Health Center; CMHC - Community Mental Health Center; MH - mental health.

- **Long-term recovery supports:**

The services within the Sheppard Pratt system extend from the core psychiatric services to include a broad range of services for clients who have ongoing needs for social support or sustained intensive clinical services. These services include residential and day treatment programs, as well as family and peer support programs.

- **Allied social services:**

Sheppard Pratt's services also include a broad range of social services that are not primarily focused on mental health treatment or people with mental illnesses. These services—which include housing programs for veterans, employment and job training programs, and special-education schools that serve students with autism spectrum disorders, behavioral disorders, and intellectual disabilities—provide potential connections to specialty care while addressing broader and more immediate social needs.

Sheppard Pratt provides integrated

programming. The integration of diverse services needed by individual patients is one of the core challenges that mental health care providers in the United States face.²⁵⁻²⁸ Having a continuum of care within a single agency has the potential to reduce fragmentation of care by facilitating connections across service types to meet the needs of patients. This linkage can work in two directions: bringing connections to primary care or social services into programs that are primarily

“The ‘secret sauce’ is that we have a confluence of services where we create niches where people can live, work, be in treatment, and thrive for years at a time. This leads to benefits to the individual and better outcomes. We have ecosystems of care, from psychosocial rehab, to supportive housing, to supportive employment, that plug together depending on patient need.”

– President and CEO, Sheppard Pratt

mental health treatment programs and bringing mental health programs into primary care or social services.²⁸

An example of the former is Sheppard Pratt's Chesapeake Connections program, which provides comprehensive care for people with severe and persistent mental illness who also have a history of very high levels of mental health service use. To meet the service use criteria, a person must have been admitted to a state hospital for six or more consecutive months, must have been admitted to an inpatient psychiatric unit four or more times in the past two years, or must have visited an emergency department for a mental health condition seven or more times in the past two years. Patients who meet these criteria and are approved for the program by the Baltimore City Health Department receive care from an interdisciplinary team that provides employment and housing support, recreational and social activities, and access to physical health care, in addition to psychiatric treatments,



such as medication monitoring and counseling. (For information on the financing of Chesapeake Connections, see the “Financing” chapter.)

Integrated care can also be designed to bring clinical mental health expertise into nonmedical settings. Two examples are illustrative here. First, Sheppard Pratt administers several school-based mental health programs that provide connections between school health programs and mental health clinicians. These programs include some schoolwide universal programs, such as trauma-informed training for teachers and staff, as well as access to treatment for students with identified mental health needs. Second, Sheppard Pratt provides access to mental health treatment through its veterans' services programs. These programs primarily focus on housing and employment but embed mental health expertise with the potential to integrate clinical treatment into program activities.

“Compared to places that I've worked before, in other parts of the country, you just have a much wider array of services available and the ability to create unique care experiences that most general hospitals don't have. They're piling three or four of those populations together in one general unit and then trying to sort it out as best [they] can. One of the advantages that you bring to the table is you know that when patients need more specialized care, it's available.”

– Vice President and Chief Operating Officer, Hospitals, Sheppard Pratt

Specialty Mental Health Care Connections in Social Services Settings

One of the features of Sheppard Pratt's broad scope of services is the potential to embed connections to mental health care within social services that are not explicitly targeted to mental health patients. The following case, described by one of our interviewees, illustrates an example of the potential benefits. A client entered through Sheppard Pratt's veteran services line with a history of homelessness and incarceration, a prior diagnosis of schizophrenia, and behavioral health issues that staff believed were interfering with his ability to find and keep a job. Veteran services hoped to connect him with supported employment, but the client was initially unwilling to see a mental health clinician, which is a requirement for the program. The Sheppard Pratt team engaged with this individual in the veterans' services program, building trust and developing a relationship with him but without providing any mental health care. After nine months of engagement, he ultimately agreed to go to therapy and receive clinical services. This veteran is continuing to work with the Sheppard Pratt team and is making progress, including continuing with treatment and living in stable housing.

Drivers of Success

1. Sheppard Pratt has been building its network of community-based providers since the 1990s.

The current continuum of care at Sheppard Pratt is the product of a strategy developed by the hospital administration in the early 1990s in response to changing patterns of care and pursued consistently over time.^{6,29,30} While many hospitals closed or became affiliated with larger health care systems, Sheppard Pratt pursued a different strategy, decreasing the size of its inpatient services while concurrently investing in development of community-based outpatient and residential services. Sheppard Pratt was able to make the transition from being a legacy private inpatient psychiatric hospital to a community-based specialty health system because its financial position at the time enabled it to make potentially risky investments in community-based services.

2. The continuum of care at Sheppard Pratt is built around specialty psychiatric care rather than general medical care or human services.

While there are large health systems and human services agencies that provide a wide variety of mental health services, very few, if any, health systems have been developed with a foundation in psychiatric care. For Sheppard Pratt, this foundation is in inpatient psychiatric care—i.e., the most acute and medically intensive psychiatric

services. Bringing this expertise into community-based service settings has given Sheppard Pratt a financial advantage in developing into a more comprehensive continuum of care because the more-intensive services are reimbursed at higher rates. Building community-based systems with foundations in clinical treatment may also have been a strategic advantage compared with social services agencies.

3. The size of Sheppard Pratt enables continued growth.

The size and diversification of services at Sheppard Pratt provides it with economic and clinical benefits that enable further growth. Covering a larger population enables the development and sustainability of highly specialized services. Sheppard Pratt is able to acquire existing agencies and potentially reduce operating costs by providing more-sophisticated staffing and administrative systems and increase volume by integrating referral patterns with its existing network of services. Later in this report, we will explore potential advantages and disadvantages of consolidation of behavioral health provider agencies.

Challenges

1. The continuum of care is not uniform across all the areas in which Sheppard Pratt works.

Sheppard Pratt has grown over time from its geographical base in the Baltimore metropolitan area, and its service system in that region includes the broadest range of

service types. However, the health system has expanded by moving into new geographic areas, usually through acquiring existing service provider agencies. This process of growth creates connections between the newly acquired agencies and the existing Sheppard Pratt system but does not immediately recreate the full continuum of services in the new area. This means that the degree to which Sheppard Pratt offers a full continuum of care varies across regions.

2. Clinical facilities are heterogeneous, and maintaining connections between them requires active coordination.

While the idea of a continuum of care implies that similar clinical facilities operate in the same way, this is not, in fact, the case at Sheppard Pratt. Among facilities that play the same role within the continuum, there can be substantial differences. For instance, there is a wide variety of facilities that provide outpatient mental health services, including some that are CCBHCs, which are advanced clinic models that provide an expanded range of services.^{31,32} Following Maryland Medicaid policy, health home services are provided in some psychiatric rehabilitation programs and opioid treatment programs. This heterogeneity makes the role of care coordination, discussed in more detail in the next chapter, more important and more challenging. Care coordinators need detailed and specific knowledge about the operations of each facility with which they work to effectively assist patients and providers.

3. Measuring quality of care and population health performance across the continuum remains a challenge.

Sheppard Pratt is held accountable for the quality of the care it provides through mechanisms tied to its diverse funding streams and service types. However, the reporting requirements vary across payers and, in most cases, are tied to individual providers rather than to the functioning of the system as a whole. Moreover, quality measures generally focus on care provided to individual patients, not on the extent to which services meet the needs of the population. Measures that allow assessment of the system are important because they enable Sheppard Pratt to engage in quality improvement, they enable researchers and policymakers to better understand the dynamics of health systems, and they enable funders and the public to ensure that resources are used as intended.

Assessing system performance at the population level is particularly important to the goal of assessing and monitoring disparities in access to care, care utilization, and quality of care across racial and ethnic groups and between rural and urban areas. Given the long history of disparities in mental health care between African American and White populations and the presence of a large African American population in the region in which Sheppard Pratt operates, efforts to assess system performance should include a strong focus on racial disparities.³³

Policy Questions

How Do We Know When a System of Care in a Community or Region Is Providing a Robust Continuum of Care?

The services provided by Sheppard Pratt extend beyond the scope of services described in the LOCUS by bringing mental health services into social service programs that are not focused on mental health. The services cover most of the range described in the MHIS, with the exception of universal prevention programming. However, checking these boxes on these two models of the continuum of care does not necessarily imply that Sheppard Pratt provides the full continuum of care in all areas in which it practices. The Sheppard Pratt experience points to the fact that we do not have metrics for assessing whether the capacity of the continuum of care matches population needs at each level, and this lack of metrics prevents systematic comparisons between systems or regions. Measures at the system level are needed to identify needs and monitor performance.

What Are the Advantages and Disadvantages of Provider Consolidation in Behavioral Health?

Sheppard Pratt stands out as a large provider organization in a nonprofit sector typified by small, loosely connected independent providers. Having a full continuum of care under one

roof offers some potential advantages with respect to integration of care and efficiency. However, studies in other areas of health care, notably focusing on large and often for-profit organizations, have found adverse effects of consolidation on prices and competition. Findings from other areas of health care may

not directly apply to behavioral health, where the current scale of organizations is much smaller. Yet little is known about the potential consequences of consolidation of behavioral health service providers, particularly in the safety net care sector.





INTEGRATION

Policy goal: To coordinate patient care across multiple service lines, to facilitate information sharing, and to monitor performance and ensure the quality of individual service lines and the system as a whole.

Coordinating patient care across the continuum.

The large number of programs that comprise the continuum of mental health care, as described in the previous chapter, can be overwhelming for patients to navigate. One way to ensure that patients receive the mix of services from which they would benefit is through care coordination services.³⁴ *Care coordination* has been defined by the Agency for Healthcare Research and Quality as “the deliberate organization of patient care activities between two or more participants to facilitate appropriate delivery of healthcare services.”³⁵⁻³⁷ In practice, care coordination involves active engagement with patients to assess service needs, facilitation and tracking of referrals to diverse services, provision of ongoing care management, and systems for tracking and sharing information.³⁸ Coordinating a patient’s care across multiple providers, services, and platforms is an important method for ensuring that the elements that make up the continuum of care function as an integrated system from the perspective of the patient.

At Sheppard Pratt, care coordination services are located within multiple service components, three of which are described in **(Figure 3)**. These are not necessarily novel models; what this figure illustrates is the fact that care coordination at Sheppard Pratt varies by service line. Care coordination is most common in inpatient settings, where handoff teams meet regularly to discuss transfers and where discharge planners connect directly with their counterparts in community-based settings. In CCBHCs, care coordination is one of the services that the clinics are required to provide as a condition of participating in the program. Veterans’ services use case managers to connect veterans to the employment program and available housing. Other service lines use slightly different coordination models. In intensive outpatient services, care coordination is directly supported by case management roles that are integrated into Assertive Community Treatment (ACT) teams. Patients in residential treatment centers receive care coordination from Psychiatric Rehabilitation Program counselors. Sheppard Pratt also employs

Figure 3. Three Care Coordination Models at Sheppard Pratt

Inpatient: Step-down and internal medicine coordination	Certified Community Behavioral Health Clinics (CCBHCs): Built-in coordination	Veterans Services: Case manager model
<p>Discharge planners and social work staff connect patients to services in the community, and the handoff team shares information to facilitate a smooth transition.</p> <p>Internal medicine providers are consulted on every admission and help develop a management plan for the patient.</p>	<p>The CCBHC model focuses on providing a comprehensive range of medical, behavioral, and supportive services through individualized treatment plans. Active care coordination is a fundamental part of facilitating this, and funding for care coordination is incorporated into grant funding.</p>	<p>Case managers connect veterans to the employment program and to available housing.</p> <p>The majority of veterans do not receive behavioral health services through Sheppard Pratt, though discharge counselors may refer veteran patients who need housing from inpatient care to veterans services.</p>

Care Connect, an innovative model of care coordination, when people make their initial contact with the system. Care Connect is described in **(Box 2)**.

Coordination of care with external physical care providers also occurs at multiple levels. Much like the care coordination that occurs within Sheppard Pratt components, coordination with *external* physical care providers plays a larger role in the care of higher-acuity patients and functions differently in each service line. Sheppard Pratt hospital patients receive an internal medicine consultation on admission, during which their provider helps develop a management plan. Some specialty outpatient mental health clinics embed coordination with primary care; CCBHCs are required to provide primary care referrals, and behavioral health homes have colocated primary care practitioners.

Information-sharing. A major challenge for integration of services across providers and agencies pertains to logistical difficulties and questions of confidentiality about sharing clinical information on patients. Electronic health record (EHR) systems used by different agencies are often incompatible, and health information collected from a patient in one setting is often inaccessible to providers treating the same patient in other settings. This also applies to health information exchanges (HIEs), which aim to share health data across institutions—including information on physical health needs that may be addressed outside Sheppard Pratt. Almost 70 percent of adults with

Coordinating a patient's care across multiple providers, services, and platforms is an important method for ensuring that the elements that comprise the continuum of care function as an integrated system, from the perspective of the patient.

behavioral health conditions have co-occurring physical health conditions. In particular, substance misuse confidentiality regulations—such as 42 U.S.C. § 290dd-2 and 42 CFR Part 2—limit the extent to which information can be freely exchanged on HIEs.

Barriers to information-sharing also place additional burdens on patients who must provide their information each time they see a new provider; they cannot trust that each provider will

have access to all their medical information. Moreover, historically, mental health has lagged the rest of health care in implementation of EHRs, HIEs, and other health information technology systems.^{39,40}

Information tracking and exchange is a key component of evidence-based integration frameworks,³⁴ and Sheppard Pratt benefits from the ability to implement compatible EHR systems across many of its provider agencies. When Sheppard Pratt establishes or acquires a new organization, it has the ability to link that organization through the EHR system to the existing continuum of care. However, maintaining consistency in EHR systems remains a challenge for Sheppard Pratt as it continues to grow because agencies that are brought into the system may use different systems, and changing EHR systems is a burdensome process. At present, Sheppard Pratt has consolidated records to two EHR systems: The hospital system uses the Sunrise platform, while all community-based services use myEvolv.

Measurement and accountability. Measuring and reporting are important pillars of integration because they guarantee consistent quality of care across service lines and hold each piece of the system accountable to system-level standards. Measures of quality are important within an organization like Sheppard Pratt for monitoring performance and guiding quality improvement efforts. Measures of quality are also important outside the organization for ensuring accountability of the agency to its funders, its payers, and the general public. Quality measurement takes on additional significance in the context of value-based payment models, in which payment for services is conditional on quality performance.⁴¹

Different programs and funders require Sheppard Pratt to track and report specific sets of indicators that are gathered from and live on different platforms. For example, the hospital tracks Inpatient Psychiatric Facility Quality Reporting (IPFQR) metrics and such indicators as restraint and seclusion rates, while the schools track indicators to stay in compliance with Maryland State Department

Box 2

Patient Centered Care Coordination through *Care Connect*

Behavioral health services are difficult to navigate, particularly for first-time users of a system. Someone interested in using Sheppard Pratt services will likely begin their journey with Care Connect, a newly developed call center that has the goal of helping people navigate the options and services in the Sheppard Pratt system. Care Connect is made up of mental health workers, social workers, and insurance verification experts tasked with speaking to callers and connecting them with the service that most directly meets their needs.

Care Connect also coordinates transitions for the roughly one-third of patients who enter the Sheppard Pratt system through psychiatric urgent care and are not hospitalized. They are tasked with finding appropriate outpatient clinics for the patient and coordinating patient handoff.

of Education (MSDE) requirements. Chesapeake Connections patients are assessed on a wide range of metrics, including employment, reduced incarceration, and clinical outcomes, while affiliated programs measure employment rates, homelessness, substance abuse relapse, and other domains of living measures.

These metrics are collected and housed on different interfaces, including those developed to respond to requirements, EHR systems, and a third system that collects patient-reported outcomes. Many of the programs themselves often have unique data (the schools, for example, have a database in which all of their metrics are aggregated); however, these systems are unable to speak to each other. This presents a major barrier to smooth integration because metrics that could be useful to one service line may exist in another but are not universally accessible.

Drivers of Success

1. Where colocation has been implemented, it allows for seamless transitions between some services.

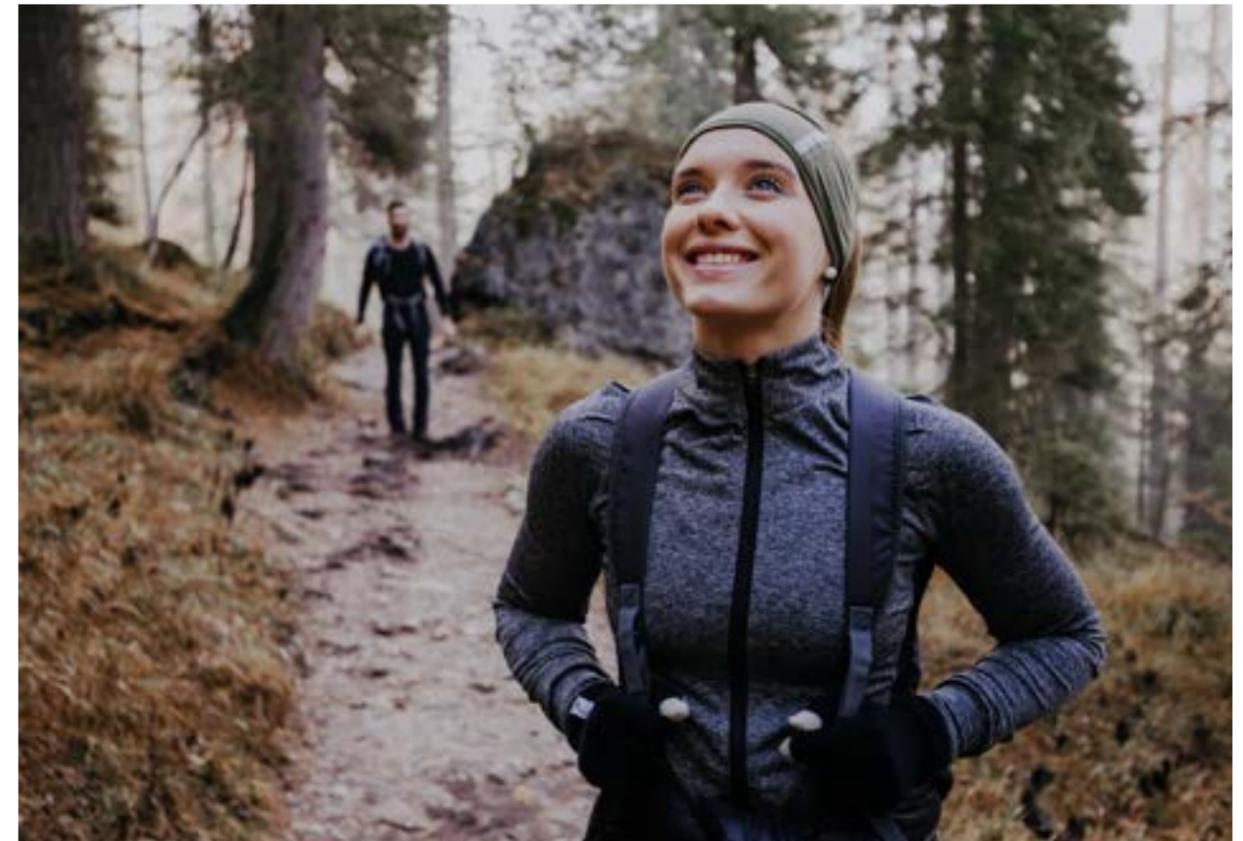
Sheppard Pratt's Towson campus allows patients to access multiple programs and services in a single setting, including urgent care, specialty inpatient units, day programs, school programs, and residential crisis beds. Although colocation is not a substitute for care integration, it does allow patients to transition from one level of care to the next with minimal friction. In conjunction with electronic communication systems, colocation allows support providers to convene in person more easily. While colocation is an asset to

“[With] low-income adults with serious mental illness, there's often resistance to transitions. Being on the campus, if a hospital patient is unsure or resistant, they can walk over and see the residential crisis program. And we also have a specialty program steps away where we have two 16-bed houses, and within those houses are 16 residential crisis beds and 16 residential rehabilitation program (RRP) beds, which is the longer-term option. So, we can even get that continuing step down from the residential crisis to the RRP.”

– Chief of Rehabilitation and Recovery Services, Sheppard Pratt

the Sheppard Pratt system, the opportunity for behavioral health systems to colocate services is highly context dependent and often infeasible.

In addition to the services colocated on the Towson campus, the health home services that Sheppard Pratt offers locate housing within walking distance of affiliated services, such as counseling, day programs, pharmacies, and supportive employment opportunities; in some cases, these are all located in the same building. This proximity allows patients who need additional support to live in the community. For users of services that do not include housing, such as ACT services, Sheppard Pratt offers transportation to day programs, counseling, and other affiliated services.



2. Taking full advantage of telehealth technology.

Sheppard Pratt quickly pivoted to a telehealth platform when the coronavirus pandemic began and regulations on virtual care were modified. Telehealth technology allows Sheppard Pratt to provide widespread access to behavioral health care and to optimize each provider to practice at the top of their license. It also removes physical barriers that silo patients in regional hubs of service or specific service lines. In addition to outpatient visits, Sheppard Pratt offered a virtual crisis clinic during the pandemic where patients were able to get crisis services immediately and be directed to the appropriate level of care without having to go through a medical emergency room. Telehealth augments inpatient services as well, because

a hospital patient or clinician can do a consult with a team in another part of the state without burdensome travel time for the consulting clinician or the patient.

3. The scale and reach of the Sheppard Pratt system allows for operational efficiency.

While this scale can introduce challenges, it also introduces efficiency and greater opportunity to meet community needs. Coordinating care for a patient who needs multiple services is more efficient, both financially and in terms of patient experience, when a patient is connected with services through a single organization. The scale of Sheppard Pratt allows case managers and directors in one service line to easily meet with those in

another to facilitate transitions and integrate care while also providing central access to patient records and limiting administrative burden. For example, when an interviewed patient's ACT team determined that she needed to be hospitalized, a member of the ACT team drove the patient to Sheppard Pratt, where they were able to facilitate a smooth transition to its inpatient services. On discharge, the ACT team drove the patient back

“First you need to know the very specific diagnostic and service codes that apply, and then you need to know if insurance will pay for this. To me, it's nice to talk about following up with people over time, but sometimes it's even more basic than that. It's knowing what they are and are not eligible for, and it's incredibly painful to focus on that.”

– Chief of Community Development, Sheppard Pratt

home and immediately reinitiated her community care. A system of this size, by nature, facilitates efficient care coordination while limiting friction for patients.

Challenges

1. The wide range of services, locations of services, and diverse program eligibility complicate care coordination.

While the breadth and diversity of services that Sheppard Pratt offers is an asset, it also presents navigational challenges. Coordinators need to have detailed local knowledge of the care options, availability of services, and eligibility criteria to link patients with appropriate care. It is also important to note that the heterogeneity in program types that creates challenges for coordinating care also applies to care coordination services themselves. These services are supported by a limited number of specific programs, such as the CCBHCs, and are designed from the perspective of that program rather than from the perspective of the continuum of care as a whole. For instance, care coordinators within inpatient units are primarily focused on coordinating a warm handoff with outpatient care, not with coordination of comprehensive services over time. In addition, the Veterans Health Administration has provided some funding for care coordination that is limited to veterans. In some cases, care coordination may be limited to services provided by Sheppard Pratt, which limits access to outside services. While these programs may function as intended, they may also represent a missed opportunity for care coordination to encompass the full continuum of services that Sheppard Pratt offers and to provide pathways to services outside of the Sheppard Pratt system.

“We can make a difference if we had more funding to coordinate care across systems, not just within Sheppard Pratt, but for those other kinds of things outside the system.”

– Chief of Community Treatment, Sheppard Pratt

2. The use of two EHR systems that do not speak to each other inhibits smooth care coordination.

While Sheppard Pratt has succeeded in reducing the number of different EHR systems used by providers in the organization, it has not yet succeeded in bringing all providers onto a single shared system. At present, Sheppard Pratt uses two EHR systems—one for hospital-based patients and residential treatment centers and another for all other programs. In practice, this means that if a patient is transferring between programs, the receiving program needs to be told to look at patient records in a different system than what they normally use. To further complicate this, the CRISP (Chesapeake Regional Information System for our Patients) system in Maryland, a health care exchange that hosts information on patient hospitalizations, is not interfaced with Sheppard Pratt's EHRs as of this writing (early 2023).

Recognizing that the fragmentation in the health record systems inhibits smooth care coordination and the ability to track quality or outcome metrics, Sheppard Pratt is in the



“We have separate records for outpatient and inpatient. We are in the middle of the process of identifying a single EHR to cover across the system. We’re down to three vendors. It’s a huge cost. That’s the struggle, can we afford it? It is one of the things that hampers us, because you don’t have that interoperability. So you don’t get that easy transfer of information.”

– Vice President and Chief Operating Officer, Hospitals, Sheppard Pratt

process of consolidating its health records into a single system. Our interviewees recognized that the ongoing challenge of technological integration limits the system’s ability to provide smooth care transitions, maintain consistency in following patients over time, and monitor its own quality to identify areas for improvement.

3. The scope of quality measurement is narrow.

Current systems for quality performance assessment and reporting, as well as other methods for demonstrating accountability, are not designed for a large specialty care system

like Sheppard Pratt. The result is fragmentation in reporting—i.e., responsibilities to meet reporting requirements established by multiple organizations that are not aligned with each other. Fragmentation may increase the administrative burden and cost of reporting while failing to achieve the goal of assessing how well Sheppard Pratt performs as a system. Moreover, each quality measure and each measurement system may focus on only a narrow scope of clinical or administrative processes or outcomes and could fail to capture features of care that reflect the function of the overall system. The limitation of the quality measurement tools is even more important for a large private provider, such as Sheppard Pratt, that does not have the same statutory responsibility for addressing population mental health needs as a publicly administered care system.

The limits of current quality measurements are not specific to Sheppard Pratt. The development of quality measurement in mental health care generally lags behind other areas of health care,⁴² and there are few measures specific to mental health that are used in standard reporting systems,⁴³ such as the Medicaid Core Set. However, these measures are generally designed to assess the performance of providers or agencies with a much narrower scope of services than Sheppard Pratt. Development of measures that assess the functioning of the system as a whole could reduce the administrative burden while improving the validity of the measures. Improving measurement to address population mental health needs broadly is particularly important for the development of value-based payment systems, where payment to providers is conditional on their quality measure performance.



Policy Questions

How Should Care Coordination Work at a System Level?

While connections between diverse service types may be easier to facilitate in a setting in which they are situated within the same organization, care coordination remains a challenge for Sheppard Pratt. Facilitating connections presents an even greater challenge when services are spread among multiple behavioral health care providers in geographically and socioeconomically diverse regions of a state. Although individual care coordination programs have been studied and often found effective, the best strategies for coordinating services across the continuum of care have not been studied.⁴⁴ This is especially salient at the state level when attempting to synthesize local priorities and needs to be reflected in state budgets and planning efforts.

How Can Quality Be Measured at a System Level?

The administrative and clinical information systems at Sheppard Pratt are considerably more sophisticated than those of typical mental health providers, yet the measurement of quality of care across the system remains challenging. This is both a failure to realize the potential for system-level quality measurement and the result of existing reporting requirements that do not cover the full range of services that the system provides or is responsible for. In addition, the lack of measures explicitly focused on equity represents a missed opportunity for monitoring and incentivizing improvements in health care disparities. Limitations of measurement create limitations in the ability of institutions to improve care and the ability of policymakers and the public to hold providers accountable. Measures and requirements that reflect system-level functioning could enable comparisons between such institutions as Sheppard Pratt and systems of care with different structures.



FINANCING

Policy goal: Ensuring that stable and sustainable funds are available to provide a comprehensive set of services that meets all patients' needs.

Theory and Practice

Braiding and blending. Most health systems in the United States rely on disparate funding streams, a reflection of the fact that funding from a single source is often insufficient to cover costs. "Braiding and blending" is therefore common practice—where braiding refers to the coordination of multiple funding streams that are traceable to their original sources, and blending refers to the merging of multiple funding streams into a single stream.⁴⁵ Braiding ensures sufficient diversity of revenue streams to protect against overdependence on any single funder while maintaining accountability for reporting outcomes. Blending provides increased flexibility to pursue service areas that might otherwise go overlooked because of narrow funder interests and reporting requirements.

Sheppard Pratt provides a case study of the types of braiding and blending that are required to make a continuum of care work financially. The system is characterized by remarkable diversity,

"If you were ever going to find a braided funding model, we are the prototypical example—we have federal, state, local agencies, donors and foundations, commercial and public funders: all of which come together to provide each person the care they need."

– President and CEO, Sheppard Pratt

weaving together funding from a wide array of public and private payers, both within and beyond the traditional health sector. For example, such community-based programs as Early Head Start and CommonGround combine grants from the federal, state, and city levels, as well as support from private foundations and individual philanthropic gifts.^{46,47}

The makeup of Sheppard Pratt's revenue streams is, roughly, 40 percent community-based services, 40 percent inpatient services, and 20 percent education and other sectors (**Figure 4**). Within each

Figure 4. Revenue Categories and Major Payers for Community-Based Services



NOTE: Three major revenue streams are inpatient clinical services, community-based clinical services, and education and non-clinical services—which includes social service programs focused on social determinants of health.

of these, public agencies in Maryland—in particular, Medicaid and MSDE—are the principal payers. For example, for outpatient services, about 70 percent of service reimbursement derives from Medicaid; 20 percent is from Medicare; and 10 percent is from commercial insurers and self-paying individuals. For inpatient services, Medicaid is still the largest contributor, representing about 40 percent of revenue.

Medicaid as a major player and payer. This composition is unusual and idiosyncratic to Sheppard Pratt's function within the state of Maryland, as well as the regulatory structure of payment for services. Maryland has a rate-setting agency (the Health Service Cost Review Commission [HSCRC]) that sets rates for inpatient services at hospitals.⁴⁸ Rates are based on a combination of provider cost and benchmarking from other providers, both statewide and nationally, and are adjusted for inflation. For psychiatric

hospitals, including those at Sheppard Pratt, commercial payers must pay HSCRC-regulated rates. Government payers do not pay these rates. Rather, Maryland's state Medicaid agency has agreed to pay 94 percent of charges for Sheppard Pratt and to other systems. This rate-setting agency also offers a straightforward vehicle for increasing reimbursement rates when costs escalate, as a function of both inflation and other factors that may affect costs. (For non-inpatient services, Medicaid reimbursements are based on a fee schedule.)

By contrast, Medicaid agencies in other states often do not provide cost-based reimbursements,^{49,50} and they seldom provide reimbursement close to the 94-percent level of charges received by Sheppard Pratt.⁵¹⁻⁵³ The political and economic feasibility of persuading other states to adopt Maryland's reimbursement framework is an important question, central for determining the generalizability of the Sheppard Pratt model.



Sheppard Pratt receives inpatient prospective payment for Medicare services, which equates to roughly 70 percent of HSCRC-regulated rates. Medicaid therefore offers one of the highest payment rates of any insurer with which Sheppard Pratt interfaces, though even this does not always cover costs. This is true for inpatient services, as described previously, and outpatient services. This is a remarkably different arrangement from other states, where Medicaid reimbursement would likely be lower. Furthermore, Maryland adopted Medicaid expansion in 2014,⁵⁴ meaning that households with incomes up to 138 percent of the federal poverty level qualify for Medicaid.⁵⁵ As a result, the pool of individuals who receive Medicaid—and for whom Sheppard Pratt can bill to Medicaid—has increased over the past eight years relative to years prior.

Maryland State Department of Education. Sheppard Pratt manages 12 special-education schools and a residential treatment center for approximately 525–650 children and adolescents (depending on the year) with mental health conditions and developmental disabilities. The chief payer, MSDE, compensates Sheppard Pratt on a per diem basis established at program inception and adjusted annually for inflation. MSDE caps administrative costs at 10 percent and the profit margin on these services at 10 percent. Depending on the case mix of students and required staffing ratios to support student needs, Sheppard Pratt assumes the risk that it may generate a loss at any given school in any given year. The expectation is that losses at a small number of schools will be offset by more-robust reimbursement at other schools. However, if structural market shifts occur (for example, the local school system attempts to retain students in public schools), census decreases

in special education schools managed by Sheppard Pratt may generate operating losses.

Sheppard Pratt also manages a residential school and treatment center for adolescents in Towson.⁵⁶ At an earlier point, Maryland was home to roughly a dozen similar child and adolescent facilities; however, the payment model for these services has not only impeded growth but has also led to a cascade of closures, including by Sheppard Pratt, with only the Towson location remaining. Historically, reimbursement has been pegged to health systems' most efficient year of operation, leading unusually efficient years to all but guarantee that health systems generate a loss in subsequent years of operation. This reimbursement model has only recently been modified.

Alternative sources of payment. Sheppard Pratt also leverages alternative payment for specific clinical services. As shown in **Table 1** (see next page), Sheppard Pratt's Chesapeake Connections program uses capitation to provide intensive wraparound services for approximately 150 patients with serious mental illness.⁵⁷ Recognizing that the state would otherwise bear a high cost to care for patients with these conditions, the state has opted to contract with Sheppard Pratt to provide specialized community-based services ranging from case management to vocational training. Sheppard Pratt's diverse portfolio of clinical services allows it to assume the risks associated with a capitation model by developing individualized treatment plans that meet patients' needs as they evolve.

Services offered at The Retreat, another program established by Sheppard Pratt, are financed through out-of-pocket payment: Individuals seek out and

self-pay for residential psychiatric rehabilitation.⁵⁸ This boutique service category, limited to about 22 patients, is a highly sought and individually tailored program that produces a stable stream of revenue to cover programmatic costs and yields a profit that helps offset unsupported costs of other mission-critical service areas of the organization.

Finally, a development team at Sheppard Pratt pursues additional opportunities for growth by identifying public- and private-sector grants, as well as engaging in individual philanthropy and fundraising efforts. This has been a particularly important revenue stream for supporting community-based population health needs that

might otherwise go unsupported, as well as prevention and early intervention (PEI) programs. For example, Sheppard Pratt manages Early Head Start (family-centered services for low-income families with very young children) and the Safe Passage Center (a supervised visitation and monitoring exchange program for families involved in the county court system).^{46,59} Such programs as these are not reimbursed under regular payment mechanisms and, therefore, need to be supported by grants and charitable contributions, illustrating the importance of braided funding supports, as described previously.

Table 1. Examples of Alternative Financing Structures for Specific Services

Chesapeake Connections		
PAYMENT MODEL Capitation	POPULATIONS SERVED 150 patients with severe and persistent mental illnesses, including schizophrenia, bipolar disorder, and major depressive disorder	LEVEL OF CARE Partial hospitalization, community residential treatment, and intensive outpatient services
PAYER Medicaid		
The Retreat		
PAYMENT MODEL Self-pay	POPULATIONS SERVED 22 patients with moderate to severe behavioral health conditions, including personality disorders and (often co-occurring) substance use disorders	LEVEL OF CARE Residential treatment, including intensive individual and/or group therapy
PAYER Individual clients		
GUYS Youth Mentoring Program		
PAYMENT MODEL Grant	POPULATIONS SERVED Male middle school students in Montgomery County, Maryland	LEVEL OF CARE Outpatient, community-based social service program to help build resilience and social skills while minimizing the influence of street gangs and bullying
PAYER Private foundation		

Drivers of Success

1. Medicaid is a strong payer in Maryland, which is a Medicaid expansion state.

Maryland's cost-based payment system through Medicaid, which reimburses approximately 94 percent of charges, helps Sheppard Pratt ensure that it will receive sufficient compensation for service quality: Sheppard Pratt does not need to cut corners to sustain its operations. Braiding and blending with other funding sources allows Sheppard Pratt to ensure financial sustainability.

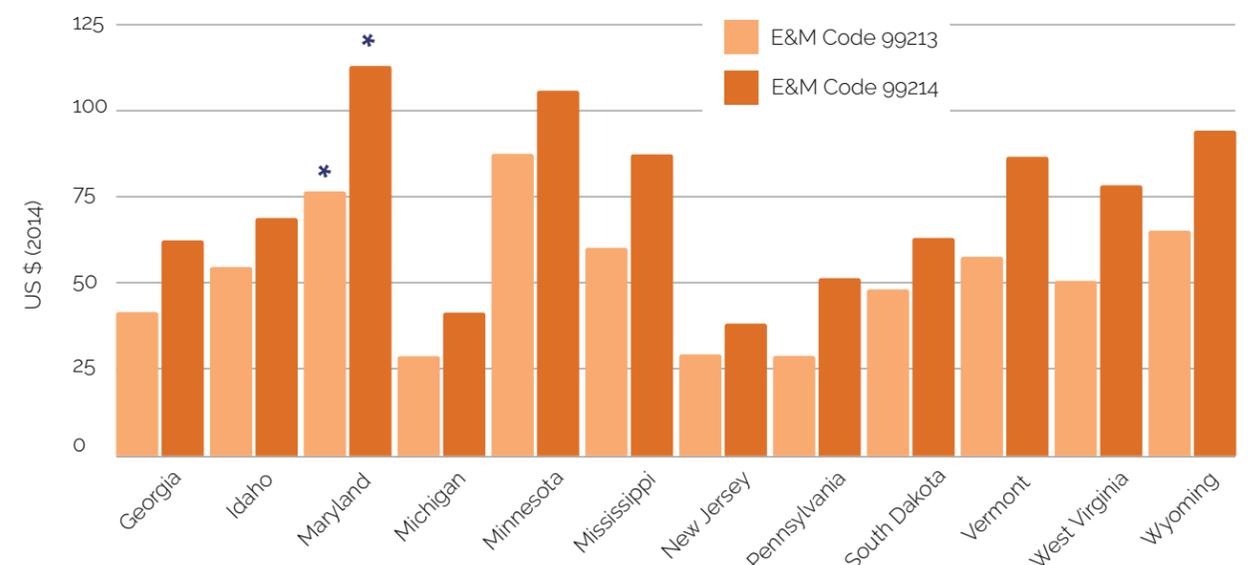
Moreover, because Medicaid is the largest health insurer of Sheppard Pratt's clientele, and individuals on Medicaid typically have complex needs,⁶⁰ Sheppard Pratt has been able to develop a diversified portfolio of specialized services. Once these services are established, they also have the potential to benefit non-Medicaid populations who qualify for them. By contrast, in states where Medicaid reimbursement is low, health systems may instead target clients with private insurance,^{61,62} who usually have fewer needs for specialized services. See **(Figure 5)** for a

“Sheppard Pratt serves as a statewide resource that serves all populations. There is wide variability in reimbursement by type of service and payer and requires extensive coordination to ensure that services are sustainable.”

— Chief Financial Officer, Sheppard Pratt

comparison of Medicaid reimbursement rates in Maryland with rates for 11 other states for a sample of commonly used outpatient psychiatric care visits.

Figure 5. Reimbursement Rates for Psychiatric Services^{53,63}



NOTE: * = Maryland reimbursement rates. Data are as reported in Mark et al., 2020.⁵³ Each bar represents the Medicaid reimbursement rate within a specific state for evaluation and management (E&M) code 99213 (outpatient psychiatric visit, 20–29 minutes) and E&M code 99214 (outpatient psychiatric visit, 30–39 minutes). As of 2014, Maryland provided the highest rate for the latter code and the second-highest rate for the former code, out of the 12 states inventoried.⁶³

2. Sheppard Pratt has longstanding relationships and continuous engagement with state public health leaders and legislators.

Though hard to quantify, Sheppard Pratt has enduring, deep relationships with Maryland’s legislators and public agency leaders, which may—at least in part—have shaped it as a system that is primarily supported by the public sector. From the vantage point of Sheppard Pratt leadership, these relationships are critical not just for the success of the organization but also for the state: It is in the mutual interest of public leaders and Sheppard Pratt to have an effective mental health system that meets population needs.⁶⁴

“I do a lot of balancing to make sure the finances flow and allow us to break even. My success is dependent on expanding access to get people the care they need. The hard part is the continual rebalancing to make sure the finances flow and allow us to break even.”

– President and CEO, Sheppard Pratt

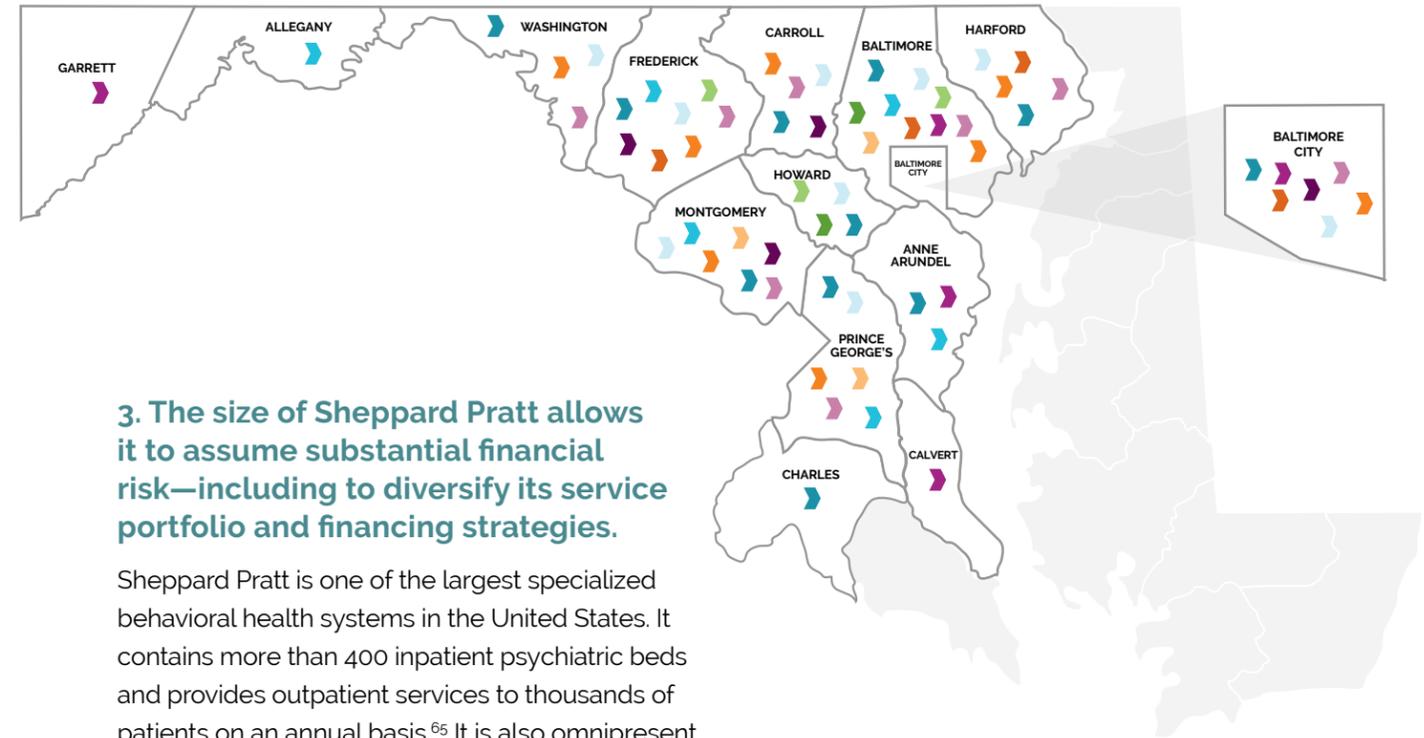
This relationship is also bidirectional: State leaders have viewed Sheppard Pratt as an institutional asset for helping to tackle thorny problems, including, most recently, establishing an emergency department (ED) boarding call center that has reduced psychiatric ED boarding by over 50 percent.

Sheppard Pratt Program Locations in Maryland



- Crisis & Admission
- Inpatient & Specialty Services
- Residential & Structured Day Services
- Schools & School-Based Services
- Therapy & Medication Management
- Community & Family Supports
- Housing & Homelessness Services
- Development Disability Services
- Employment & Job Training
- Care Coordination & In-Home Services
- Sheppard Pratt Solutions

(see map page 37)



3. The size of Sheppard Pratt allows it to assume substantial financial risk—including to diversify its service portfolio and financing strategies.

Sheppard Pratt is one of the largest specialized behavioral health systems in the United States. It contains more than 400 inpatient psychiatric beds and provides outpatient services to thousands of patients on an annual basis.⁶⁵ It is also omnipresent throughout the state of Maryland, with more than 160 programs across 12 Maryland counties.⁶⁵ Its size and breadth of services, coupled with the level of commitment by the state Medicaid agency, give it three strategic benefits. First, it is well positioned for expansion through acquisitions and mergers: Sheppard Pratt can draw from its experience with different models of clinical care to determine whether expansion into a new geography or clinical area is financially viable. Second, it has the flexibility to assume financial risk, including adopting value-based payment models, such as capitation, because it has a broad portfolio of services through which patients can be matched. Third, supportive services that are supported predominately through charitable donations and grants can be sustained—even when these revenue sources wane—by cross-subsidizing from other areas of the organization.

4. Financial incentives and Sheppard Pratt's infrastructure align to help patients receive treatment at appropriate levels of care.

As stated by Sheppard Pratt’s leadership, the organization does not have a strong financial motivation to channel patients towards a specific set of clinical services—for example, because they have more staffing and larger profit margins in certain parts of their system. Rather, Sheppard Pratt has stable profit margins across inpatient and outpatient care, and for certain service lines (e.g., Chesapeake Connections) they stand to earn the most by ensuring that patients are receiving appropriate care that keeps them healthy. As stated by Sheppard Pratt’s president and CEO: “I do a lot of balancing to make sure the finances flow and allow us to break even. My success is dependent on expanding access to get people the care they need.”

Challenges

1. Sheppard Pratt has struggled to finance residential mental health services for children and adolescents.

According to Sheppard Pratt leadership, closure of residential treatment facilities for children and adolescents has been influenced in the past by the payment structure within the state of Maryland: Reimbursement rates were set based on years in which health systems have been efficient. If these efficiencies were atypical for an average year, it meant that health systems had a high bar to clear for reimbursement rates to cover costs.

2. Sheppard Pratt has struggled to sustain fledgling community-based programs that support social determinants of health.

As noted previously, many community-based programs offered by Sheppard Pratt—ranging

from Dare to Be You (a ten-week substance use prevention education program)⁶⁶ to Together (a free couples counseling service)⁶⁷—are not billable services in the way that facility-based inpatient and outpatient care are. Rather, they constitute PEI services, designed to prevent, delay, or mitigate prospective health challenges. The grant-funded nature of these services introduces a certain amount of risk: If a funder decides that it will no longer support a community-based service, Sheppard Pratt is forced to identify a new funder, cross-subsidize from other clinical service lines, or cease to provide the service. Sheppard Pratt therefore has needed to carefully balance the mission of the organization with its profit margins to ensure that it does not run unsustainable long-term deficits. During the annual budget process, the financial health and prospects of each program are reviewed by the leadership team and approved by Sheppard Pratt's board of trustees.

Social Determinants of Health



Policy Questions

Does Higher Reimbursement Lead to Better Systems of Care?

Sheppard Pratt benefits financially from relatively high reimbursement for mental health services through Maryland's Medicaid system. However, policymakers should be concerned about whether higher payments to providers result not only in high-quality care but also in more-robust systems of care for Medicaid enrollees. Given the difficulties of collecting comparable data from states on reimbursement for and the quality of mental health care, little is known about whether and to what extent higher levels of funding for specific mental health services improve outcomes. In addition, there is the potential for increasing the role of commercial financing of mental health services in what has traditionally been a publicly funded area—particularly as a function of implementing the dependent care mandate and strengthening mental health parity. Policy levers for appropriately targeting these resources within existing systems of care should be considered.

How Can Integration of Financing Streams Be Simplified?

Despite the advantages of size and sophistication of financing programs at Sheppard Pratt relative to most behavioral health care providers, braiding and blending of funding sources remains challenging—particularly with respect to integrating services that address social determinants of health. Changes to financing within Medicaid and coordination between Medicaid and other federal, state, and local sources of financing are likely to be crucial to expanding services beyond narrow medical procedures; however, the systems for achieving integration are yet to be developed. Options for structuring Medicaid payment for mental health services, such as value-based payment models, remain understudied but promising for promoting integration and equity.^{41,68} Two models that Sheppard Pratt currently participates in, the Chesapeake Connections program and the CCBHC demonstration, employ innovative payment models that address these concerns but have not been rigorously evaluated for their impacts on system performance. Public-private partnerships that create governance structures for community-level administration of multiple funding sources are also being explored.⁶⁹





CONCLUSIONS

What to take away and how to move forward

OVERVIEW

In this report, we examined an integrated mental health care system from three vantage points, each of which highlights a major issue that mental health care delivery providers in the United States face. Sheppard Pratt is a unique institution, having evolved from a traditional retreat for long-term hospitalization to an expansive community-based behavioral health care system. The system maintains a core focus on medical treatment of mental illness but has expanded to include an extensive continuum of care that covers large areas of Maryland. Our goal in this report is not to evaluate Sheppard Pratt or compare its performance with other systems. Sheppard Pratt developed in circumstances that are unlikely to be replicated in other settings. Rather, the goal is to examine how Sheppard Pratt addresses the same challenges that mental health systems across the country face and identify lessons that Sheppard Pratt's experience may have for the future direction of integrated mental health care. In doing so, we focus on the potential advantages of a large consolidated mental health provider, like Sheppard Pratt, as well as the continuing challenges that Sheppard Pratt faces in making improvements.

We focus on three features of the Sheppard Pratt system that make it relevant to broader mental health policy discussions. First, its size and exclusive focus on behavioral health care, ranging from specialized inpatient programs to community-based social services, enable it to provide a *broad continuum of care* that has been remarkably challenging for other health systems to implement. Second, by bringing this full range of services under one roof, Sheppard Pratt has the potential to *integrate diverse elements of the continuum of care* in ways that have proven challenging in most other health care settings. Third, Sheppard Pratt has been able to *finance its continuum of care* by braiding funding from multiple private and public sources, including public-sector payers, such as Medicaid. In this chapter, we discuss each of these areas in turn, focusing on how Sheppard Pratt has addressed some key challenges and is still working to address others, and we highlight areas where research addressing these issues can inform policy development.



CARE CONTINUUM

The goal of a continuum of care has long been a central focus of mental health policy, the result of recognition that mental health services should be able to address the diverse treatment and recovery support needs that arise in each community. Not only are needs for mental health services complex; they also overlap with needs that we address through entirely different systems of care. There are needs for social services among people with mental health conditions and needs for mental health services among people receiving social services. Similarly, there are needs for primary health care among people with mental health conditions and needs for mental health care

among people treated in primary care. Evidence of the lack of robust systems of care is seen in unnecessary hospitalizations, high levels of boarding of mental health patients in emergency departments,^{1,70,71} and the large numbers of people with serious mental illness in the criminal justice system and coping with unstable housing.

Decisions made during the 1990s have set Sheppard Pratt on a distinct trajectory that has resulted in a unique system that brings a broad range of these services under a single roof. Human services agencies in many communities across the country provide a range of mental health services, but these tend to focus primarily

The goal of a continuum of care has long been a central focus of mental health policy, the result of recognition that mental health services should be able to address the diverse treatment and recovery support needs that arise in each community.

on recovery supports and rely on external providers for medical treatments and inpatient services. There are also health care systems that provide behavioral health care, including inpatient services, but these systems do not have depth of expertise in recovery services or mental health-informed approaches to social services. Consolidation of mental health services offers the potential for focusing clinical expertise while improving operational efficiency by decreasing overhead costs and centralizing back-office functions.

Future Research Directions

1. How do we know when a system of care in a community or region is providing a robust continuum of care?

In many places, policymakers can point to a variety of services that are available but lack an empirically grounded basis for understanding

the needed capacity or measuring the available capacity at each level of care. For instance, there have been efforts to estimate the need for inpatient psychiatric beds for a given jurisdiction or community.⁷² However, these efforts typically rely on expert opinion without strong research-based evidence.⁷³ Moreover, because services are interdependent, the capacity for each level of care may depend on the availability of other types of services. Inpatient beds are sometimes seen as the best way to increase system capacity, but the number of inpatient beds per capita needed to serve a community may be lower where capacity for community-based supports is stronger.⁷⁴

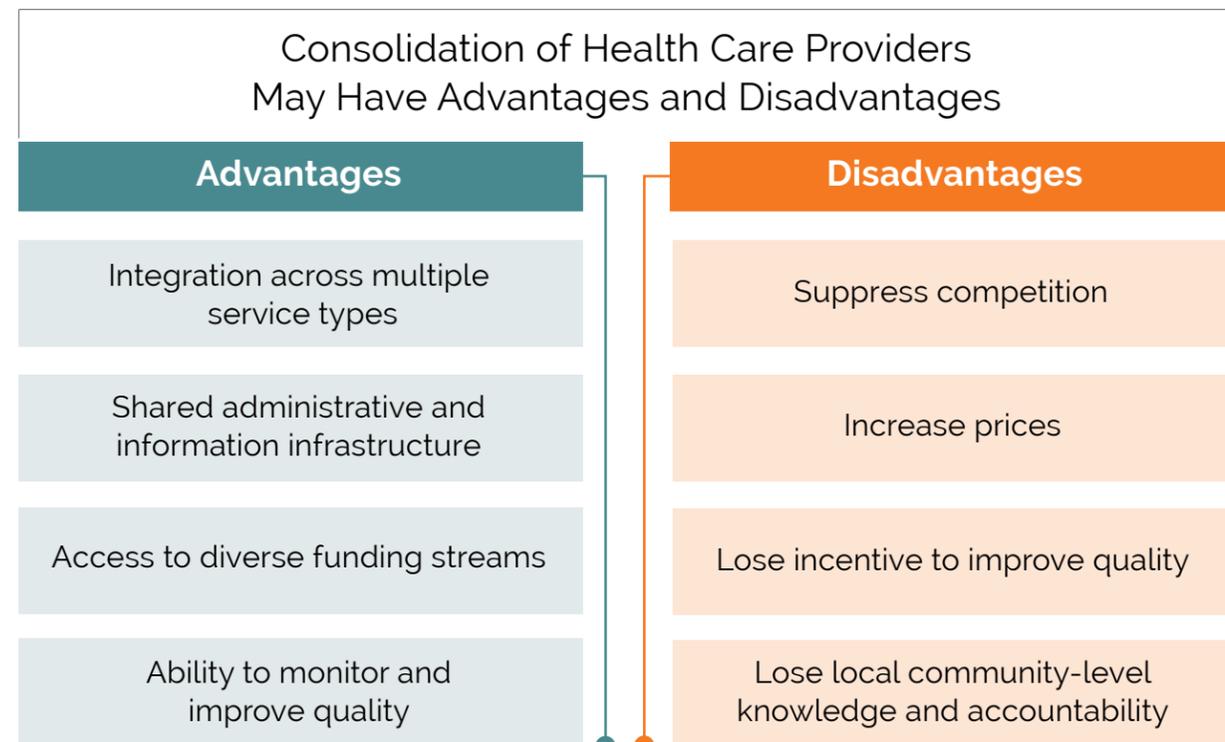
2. What are the advantages and disadvantages of provider consolidation in behavioral health?

Sheppard Pratt's ability to provide a continuum of care is enhanced by its size. (Figure 6) The

organization is well positioned to take on new services, either through acquiring existing provider agencies or developing new programs. These new services potentially benefit from a stronger connection to the existing organizational network; systems that are in place to provide care that cut across service lines, such as EHR and billing systems; and Sheppard Pratt's diverse funding streams. The benefits include integration with Sheppard Pratt's administrative and human resources systems that are critical for monitoring quality of care and maintaining a stable and well-trained workforce. The advantages of scale have clear potential to improve the quality and lower the cost of mental health care.

There are also potential downsides to consolidation, which have been discussed in the literature on consolidation in the general health care sector, that should be considered.⁷⁵ Larger provider organizations may be more difficult to monitor for quality of care and less accountable to local communities. Merging distinct organizations into a single organization can present challenges of its own. In the general medical literature, there is concern that consolidation suppresses competition among providers, increases prices, and reduces incentives to improve quality of care.⁷⁶ Yet there is little discussion about the potential advantages and disadvantages of consolidation in the behavioral health sector. The lessons from consolidation in general health care, where concerns are with mergers between large health care systems, may not apply to consolidation in the behavioral health sector, where provider organizations are much smaller and more specialized. One of the most commonly expressed concerns with consolidation is that it is a driver of higher prices.⁷⁷ However, in the context of mental health services, which are routinely reimbursed at levels below cost, higher prices may be an important ingredient for ensuring that appropriate services are available.

Figure 6. Consolidation of Health Care Providers Can Have Advantages and Disadvantages



INTEGRATION

Whether patients transition appropriately across the care continuum, whether they enter the continuum at the right point, and how well social determinants of health are addressed are predicated on effective service coordination. The literature highlights several best practices for service coordination, including implementing intensive case management for patients with severe mental illness, offering integrated care for persons with co-occurring mental health and substance abuse disorders, implementing multidisciplinary team-based psychiatric community care, providing elements of case management after discharge from inpatient treatment, integrating primary health care, and using digital technologies to link patients with providers.⁷⁸

Sheppard Pratt has employed many of these best practices and has invested in other successful integration strategies, such as the Care Connect system and service colocation. Despite the advantages of working within a single organization, challenges to integration of care remain, particularly with respect to health information-sharing. As in other states, barriers remain to integration of mental health care with statewide health information exchanges and integration between inpatient and community-based care. Barriers also remain within Sheppard Pratt, despite consolidation of information technology systems. Further integration of the two systems currently in use into a single system remains a high-priority goal for Sheppard Pratt's leadership. The wide range of services presents navigational challenges, and inadequate funding for care coordination has led to limited availability in several contexts. Furthermore, varying regulatory and funder accountability requirements, along with limited measurement tools, make it difficult to measure quality and track successes throughout the system.

Future Research Directions

Sheppard Pratt's scale is an asset for care coordination because the organization houses a full continuum of services. However, fully integrating 160 programs at more than 380 sites across 12 counties and Baltimore City presents challenges, particularly in service navigation, data-sharing, and quality measurement and accountability. Many other health systems face similar challenges, which motivate the questions for future research and evaluation outlined in the following section.

1. How should care coordination work at a system level?

The biggest barrier to care coordination, both within and across systems, may stem from financing. Dedicated financing for care coordination is limited and, when available, is often limited to specific programs, such as the Chesapeake Connections model, and is not focused on the system as a whole. This is a particularly salient issue for smaller providers, who do not have the time and funding to coordinate services. There have been attempts to promote care coordination through reimbursement codes, but uptake of these services has been very limited.⁷⁹ Another approach, being explored by the Agency for Healthcare Research and Quality, is the Pathways Community Care Hubs model. In this model, public-private partnerships are leveraged to create a governance structure through which multiple provider organizations can share information and coordinate care.⁸⁰

2. How can quality be measured at a system level?

As we have emphasized, quality measurement in behavioral health has lagged other areas of health care, both in the breadth of the

Sheppard Pratt provides an opportunity to study approaches to quality measurement that assess equity in mental health care delivery, because of the large and diverse population it serves.

measures that are available and in the health information technology required to collect and report them. Measurement is particularly limited at the system level. Most existing measures focus narrowly on individual-level treatment processes, such as adherence to medications. There are exceptions; some validated measures address multiprovider care, such as outpatient follow-up after hospitalization for a mental illness and monitoring of HbA1c (blood sugar levels) in patients on antipsychotic medication.⁶³ There are also measures, used more in research than in practice, that assess the frequency of emergency room visits and hospitalizations, which are considered potential failures of community-based support systems. However, there are no validated standards for these measures for use in practice. Moreover, existing measures are very limited with respect to their scope in that they do not address such recovery-related outcomes as educational achievement, employment, or housing tenure. Measures that capture aspects of the functioning of the system of care are needed to compare systems, to guide improvement, and to hold providers and policymakers accountable.

As a large-scale behavioral health system pursuing integration, Sheppard Pratt presents

the opportunity to develop and test an outcomes-based measurement system that assesses the functioning of the system as a whole while also streamlining reporting. One promising method is to use patient-reported outcome measures (PROMs) to assess system performance based on patient experience and well-being ratings.^{81,82} Sheppard Pratt already uses the National Institute of Health's Patient-Reported Outcomes Measurement Information System (PROMIS) metrics to track patient-reported outcomes for select services; exploring the use of PROMs to assess system-level outcomes is a promising next step.

Finally, Sheppard Pratt provides an opportunity to study approaches to quality measurement that assess equity in mental health care delivery, because of the large and diverse population it serves. Approaches to quality measurement that address health equity are being developed for Medicaid and other federal and state programs, but their application in mental health has yet to be examined in detail.^{83,84} The large African American and low-income populations in the areas where Sheppard Pratt operates make the organization particularly relevant for these approaches.

FINANCING

Whether any health system can implement and sustain an adequate portfolio of services depends, fundamentally, on its ability to cover the costs of those services. If services are reimbursed by insurance companies at inadequate rates, the only options are to cross-subsidize from other service lines or to shutter services. Financial sustainability is also predicated on an expectation that services are fulfilling a market need—if you build the services, clients will come.

Sheppard Pratt has successfully developed a broad continuum of community-based services that are financially sustainable, where other

systems have struggled. We identified several reasons for this. Throughout the United States, Medicaid is the largest insurer of patients with serious mental illness,⁸⁵ and Maryland's Medicaid program is no exception. Therefore, establishing adequate reimbursement for services that meet the intensive and diverse needs of Medicaid beneficiaries has been a staple of Sheppard Pratt's financing approach. Ongoing bidirectional lines of communication among Sheppard Pratt, Medicaid agency officials, and members of the state legislature have helped ensure this success. Sheppard Pratt's relative size in the state of Maryland has also been a boon to its

financial success: Sheppard Pratt is able to take on patients with higher and lower levels of need, with the surety that it has the relevant service lines to provide appropriate and timely care. Smaller systems may be comparatively ill-prepared to assume the risks presented by higher-needs patients or to enter into value-based financing arrangements like capitation.

Future Research Directions

While Sheppard Pratt has succeeded in financing a diverse portfolio of services, its experience raises questions about whether and to what extent other health systems could chart a similar course. We provide motivation for two questions, which could be pursued in subsequent investigations.

1. Does higher reimbursement lead to better systems of care?

Research consistently shows that mental health services are reimbursed at lower rates than those for physical health services.^{53,86} Low reimbursement rates are also commonly cited as a barrier that prevents health systems from scaling up behavioral health services.⁸⁷ In addition to curbing the development of service lines, this dynamic can limit the reach of the mental health workforce: Many individual providers, such as psychiatrists, are unwilling to accept Medicaid as a form of payment because payment is lower than would be received from other sources.^{88,89} Yet research exploring the empirical relationship between high reimbursement rates and quality and availability of behavioral health services

is limited—in part because of the challenges of linking cost and utilization data. Further examination of Sheppard Pratt's arrangement with the state of Maryland could address these questions and provide a novel case study for others to examine. They have agreed on higher reimbursement rates that cover the cost of services and—according to interviewees—have allowed Sheppard Pratt to pursue new service lines that meet client needs.

2. How can integration of financing streams be simplified?

Braiding and blending is a routine part of financing in health systems throughout the United States. Yet many health systems fail to achieve an adequate balance of payers that ensures that these systems are routinely yielding a profit margin rather than running a deficit. As noted by its CEO, Sheppard Pratt blends funding from federal, state, and local agencies; commercial and private funders; and individual donors. Its size supports this diversity: Smaller organizations may not have the capacity to investigate and pursue a wide range of funding options. This includes exploring value-based payment models, such as capitation and bundled payment, that shift risk from payers to providers. Looking to Sheppard Pratt for lessons learned, including from more-recent programs, such as Chesapeake Connections and the CCBHC demonstration that rely on alternative payment models, could provide insights for health systems seeking a healthier funding portfolio.



LIMITATIONS

We note two primary limitations associated with this report. First, our interpretations are drawn from a select set of interviews with leaders at Sheppard Pratt. The analysis was not intended to be an exhaustive inquiry into the strengths and limitations of Sheppard Pratt but rather to probe perspectives on *how* and *why* Sheppard Pratt has developed a broad continuum of care while other systems have not. Second, and related, Sheppard Pratt has evolved organically over more than 100 years; our analysis is limited to those who are currently affiliated with the

institution in some capacity. It is very likely that decisions made decades ago, or extraneous policy factors, have altered the trajectory of Sheppard Pratt in untold ways. Nevertheless, we feel that these discussions have illuminated aspects of Sheppard Pratt that are novel and are likely to contribute as drivers of its current manifestation as a large behavioral health system that offers a wide portfolio of services. Further in-depth queries (detailed in the next section) would be necessary to explore these nuances in more detail.



FUTURE RESEARCH

Inaugural Report

Sheppard Pratt presents us with an example of how mental health systems can broaden their continuums of care and become more fully integrated because Sheppard Pratt has transitioned from a psychiatric hospital into a community-based care system. Moreover, it appears to have done so by developing a large network of services, built around a core of psychiatric specialty services, that includes residential and recovery services for people with serious mental illness and social services commonly used by individuals with unmet mental health needs. As we have seen, this approach generates new ideas that reach into areas of mental health policy.

This research sets the stage for a future body of work exploring Sheppard Pratt's policies, programs, and operations. Independent analysis of Sheppard Pratt has the potential to offer useful insights for an ongoing national policy discussion about sustainably financing an integrated continuum of care. This inaugural report has laid the foundation for these inquiries by examining the unique characteristics of Sheppard Pratt, including key drivers of its success and ongoing challenges, based on interviews with its organizational leadership.

What's Next

In future research, we hope to explore the questions proposed in the "Future Research Directions" section in this chapter—pertaining to the continuum of care, service coordination, and financing. This research will also seek to address new and timely questions that arise in response to current affairs in the United States, such as the launch of 988, a three-digit national mental health emergency hotline number that went live in July 2022.

This research sets the stage for a future body of work exploring Sheppard Pratt's policies, programs, and operations. Independent analysis of Sheppard Pratt has the potential to offer useful insights for an ongoing national policy discussion about sustainably financing an integrated continuum of care.

By providing nuanced and thoughtful discussion on the major obstacles confronting mental health systems throughout the United States, RAND researchers will work with Sheppard Pratt to draw from the latter's experiences—both successes and failures—to demonstrate where policy can be improved to expedite better mental health outcomes for everyone in need of care.

APPENDIX: Methods Used in This Report

This report is based on qualitative interviews conducted with Sheppard Pratt leadership and a small group of patients and family members of patients who receive services from Sheppard Pratt. Twelve interviews were conducted with members of the Sheppard Pratt leadership team in December 2021. These interviews focused on understanding the scope of operations of the Sheppard Pratt health system, perceived advantages that Sheppard Pratt has in providing mental health services, and ongoing challenges to reaching institutional goals. Our interview protocol is provided below. Individual interviews were conducted on Microsoft Teams with two members of the RAND research team, one leading the interview and one taking notes. Interview notes were coded initially with an open coding system by at least two members of the team. Through group discussions of codes and emerging themes across interviews, the team developed a common coding structure that was then used to code all the interviews. The three major themes—continuum of care, integration, and financing—were used to structure this report's chapters. Additional themes are described with illustrative quotes from the interviews in each chapter.

Interview Protocol

Understanding How to Implement a Continuum of Behavioral Health Care in the U.S.

1. What is the range of services that Sheppard Pratt provides?

Probe for:

- What are the levels of care available?
- What is the capacity at each level?

2. If appropriate to respondent: How does Sheppard Pratt finance its system?

Probe for:

- Are there different funding streams for different levels of care?
- Are there different funding streams for clinical services/social services/care coordination services?
- Is this unique or similar to other systems?
- Does that lead to any benefits or disadvantages?

3. How are needs for new services identified?

4. What is the role of psychiatrists within the Sheppard Pratt system?

5. How are care coordination services structured?

6. How does Sheppard Pratt address the non-clinical social needs of patients?

Probe for:

- How are they integrated with psychiatric care?

7. How are relationships between psychiatric services and other institutions maintained for individual patients?

Probe for:

- Schools
- Housing programs
- Jails/Prisons
- Social Services

8. How is information shared across sites and services?

Probe for:

- Between medical and psychiatric care providers?
- Between acute care and outpatient care?
- Between Sheppard-provided care and services in the community?

9. How is quality of care measured throughout the system?

Probe for:

- What measures are used?
- What are the measurement and QI [quality improvement] strategies?

10. Who slips through the cracks and why?

Probe for:

- What area of need has Sheppard Pratt addressed?
- What are the barriers to addressing these needs?

11. From your perspective, what do you think have been the drivers that have allowed Sheppard Pratt to develop more services and an integrated system—where others have had less success?

12. Do you think there are any unique contextual factors that have benefited Sheppard Pratt that might not be replicable elsewhere? If so, what? (For example, MD's [Maryland's] all-payer hospital rate setting? Relationships with payers or folks in CMS [the Centers for Medicare & Medicaid Services]?)

13. What advice would you give to systems that are trying to replicate your model?

ABBREVIATIONS

ACT	Assertive Community Treatment
CCBHC	Certified Community Behavioral Health Center
CEO	chief executive officer
CRISP	Chesapeake Regional Information System for our Patients
E&M	evaluation and management
ED	emergency department
EHR	electronic health record
HIE	health information exchange
HSCRC	Health Service Cost Review Commission
IPFQR	Inpatient Psychiatric Facility Quality Reporting
LOCUS	Level of Care Utilization System
MHIS	Mental Health Intervention Spectrum
MSDE	Maryland State Department of Education
PEI	prevention and early intervention
PROM	patient-reported outcome measure
PROMIS	Patient-Reported Outcomes Measurement Information System
RRP	residential rehabilitation program

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