Alternative Services Plan for Upper Shore Community Mental Health Center

Department of Health and Mental Hygiene

November 17, 2009

John M. Colmers
Secretary
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I. Executive Summary

Due to the widespread economic downturn and resultant impact upon State revenues, the Department of Health and Mental Hygiene (DHMH) has been forced to make significant budgetary cuts to community providers, State facilities, research and services grants, and to DHMH programs. In concert with other State agencies, DHMH has made five rounds of budget cuts over the past 15 months totaling $328 million. This has proved particularly difficult given that 93% of the DHMH budget funds services for Maryland citizens.

With regard to State facilities, over the past two fiscal years, DHMH has reduced the number of beds at Springfield Hospital Center, RICA Baltimore, RICA Gildner, Spring Grove Hospital Center, and the Deer’s Head Hospital Center. DHMH has closed the Rosewood Center, RICA Southern Maryland and Walter P. Carter Center. Given the continued forecast and anticipated lag between economic recovery and recovery of the State’s budget, along with the end of American Reinvestment and Recovery Act (ARRA) stimulus funding, FY 2011 will present even greater challenges. It is against this backdrop that the Department has reviewed the services provided at Upper Shore Community Health Center (Upper Shore) and has recommended changes in service delivery as provided below.

While the recession and its impact upon the State’s budget brought DHMH to a decision about services at the Upper Shore, a proposed transition to community-based alternatives is consistent with long-standing policy and law that provide preference for services to be given to patients in the least restrictive setting. While DHMH commends the care provided by hard-working and dedicated staff at Upper Shore, many of the patients admitted to Upper Shore do not require extensive care in an inpatient psychiatric facility. Under federal and State law, individuals are entitled to receive care in the least restrictive environment, and many of Upper Shore’s clients would not be served in an institution if they were in any other part of our State. They would, instead, receive much of their treatment for substance abuse and mental health needs in structured community settings.

DHMH acknowledges that community services and local providers should be strengthened on the Shore—and Upper Shore’s transformation presents the opportunity to do just that. On September 26, 2009, the Governor directed that admissions to Upper Shore not cease for a period of 90 days. He asked that the Department circulate a plan for transformation of current Upper Shore services. This plan, which was circulated in draft form for review and written comment on October, 28, 2009, presents a four-part approach to the proposed transition, including:

1) For acute inpatient needs, compensation of private hospitals through the HSCRC rate setting system and purchase of care agreements for physician services;

2) Expansion of the A.F. Whitsitt Center’s substance abuse services on-site at Upper Shore;

3) Expansion of community behavioral health services; and

4) Assistance for Upper Shore employees.

Acknowledging that this change will be difficult to accept for some, including the dedicated employees of Upper Shore, DHMH will make every effort to work with them so that to the extent possible, they may lend their expertise to local hospitals and community providers, including a proposed expanded Whitsitt Center for substance abuse on site at Upper Shore.
This document begins with an analysis of current Upper Shore patients and existing inpatient and community services, and then presents a transition plan for inpatient and community services. Also discussed are Upper Shore employee supports and a fiscal analysis of the proposed transition. As will be described in this report and plan:

- There is sufficient inpatient psychiatric bed capacity in three Eastern Shore general hospitals and vacancies in Eastern Shore Hospital Center;
- Reimbursement to local hospitals through the HSCRC rate-setting system and through Purchase of Care agreements will divert emergency department visits and inpatient admissions;
- Enhancement of community services and 20 new beds for the Whitsitt Center will assure co-occurring services for the Eastern Shore; and
- Expanding community settings on the Shore is consistent with national and State law and policy and will allow services to reach the greatest number of patients.

For these reasons, this plan recommends taking steps to heighten community capacity so that admissions to Upper Shore may cease January 4, 2010. Such action will generate General Fund savings of $1.6 million in FY 2010 and $5 million on an annual basis.

II. Analysis of Current Upper Shore Patients, Admissions and Discharges

In preparation for transitioning services, DHMH has, with assistance of facility staff, prepared the following current patient profiles:

As of October 19, 2009, a total of 36 patients were served on two units at the Upper Shore. The Upper Shore is licensed for 64 beds, but is currently operating 40. The average daily population census for the facility is 36. Over the past two years, the vast majority of Upper Shore patients have lived in counties on the Shore (see Appendix). Seventy-one percent of the patients admitted in FY 09 had a diagnosis of co-occurring substance abuse and mental health. In FY 09, a majority of patients (69%) were discharged to their homes.1

Upper Shore has two distinct units. The Red Unit serves individuals with co-occurring mental health and substance abuse diagnoses, but with substance abuse as the primary diagnosis. These individuals are uninsured or have exhausted their insurance. Their admissions are defined as civil as they do not include court ordered patients or individuals on jail certificates. The Red Unit does admit individuals on conditional release and some of the patients have pending charges related to their substance abuse problem. The Red Unit does not include individuals who are court ordered for substance abuse treatment.

As of October 19, 2009, the current population on the Red Unit (20) includes: 18 persons transferred from private hospital emergency departments and psychiatric units. The individuals on Red Unit have milder psychiatric problems as compared with the Brown Unit; however, the Red Unit patients tend to have severe substance abuse problems. It appears that most of the current population on the Red Unit will be able to be

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1 In FY 09, 22% were discharged to residential rehabilitation and 5% to other hospitals.
discharged within 60-90 days. There are two persons on the Red Unit that will need additional community supports in order to transition to the community and one may need continued hospitalization. The focus of discharge planning for this population is substance abuse treatment.

The Brown Unit serves individuals with a primary mental health diagnosis. These individuals are uninsured or have exhausted their insurance. The status of this population on this unit is subject to change daily based admissions and discharges. Additionally, because of the nature of mental illness the clinical status of these patients fluctuates frequently as well.

As of November 13, 2009, there were 20 individuals receiving services on the Brown Unit. Seven are expected to be discharged before closure, four will need continued inpatient care and nine have the potential for community placement with intensive supports. The status of this population on this unit is subject to change between now and the time of closure due to admissions and discharges.

Inpatient Psychiatric Services on the Eastern Shore

Three Shore hospitals, Dorchester, Union and Peninsula Regional have reported to DHMH a combined physical capacity of 40 inpatient mental health beds. Hospitals’ behavioral health specialists have reported to DHMH that inpatient psychiatric occupancy is typically short of physical capacity, however they also report concerns about availability of skilled behavioral health staff.

III. Analysis of Current Community-based Psychiatric, Substance Abuse and Co-Occurring Services

Community-based co-occurring resources

There are currently five Core Service Agencies (CSAs) serving the Eastern Shore - Cecil, Wicomico, Somerset, Worcester and Mid-Shore (Kent, Queen Anne, Talbot, Dorchester and Caroline). The CSAs assist citizens seeking services from community mental health providers and with patients being discharged from hospitals to community services. Substance abuse services are provided through both the county health departments and through local community-based providers.

To assist consumers and providers, the local counties, with support from the Core Services Agencies and Local Health Departments, have prepared Resource Guides. The Guides list local behavioral health resources, including social workers, counseling and support services, and acute services. These may be accessed online.²

The A. F. Whitsitt Center is a 24-hour, seven-day-a-week residential treatment facility operated by the Kent County Local Health Department on the grounds of Upper Shore. The Whitsitt Center offers treatment to adults ages 18 and over suffering from chemical dependency. A professional treatment team comprised of nurses,

² Cecil: http://www.cecilcountyhealth.org/ccdhxx/ccdh200pbhsguide.htm
Mid-Shore (Kent, Queen Anne, Talbot, Dorchester and Caroline): http://caroline.md.networkofcare.org/mh/countycontent/caroline/Guide-Public-MH-Addictions-Treatment.cfm
addictions counselors and a staff physician combine their skills and experience to provide a complete program tailored to the needs of each client. The Whitsitt Center also offers a medically monitored Detoxification Unit for alcohol, opiate and/or benzodiazepine dependent individuals. About one-third of the individuals served by the Whitsitt Center also have co-occurring mild mental illness. They are psychiatrically stable upon entry, already seeing a mental health professional and on medication. The Red Unit serves individuals with a diagnosis of substance abuse who have mild to moderate mental illness and have been psychiatrically stabilized at the hospital emergency department.

There are a total of 2,143 beds/slots for substance abuse services on the Eastern Shore. Excluding Worcester and Wicomico counties, the number is 1,312. The majority of these services are standard outpatient substance abuse treatment (Level I). The 20 beds operated by the Whitsitt Center are the sole services at the level of intensive inpatient beds (Level III.7) on the upper shore, although there are an additional 10 long term residential beds (Level III.5) and 35 halfway houses (Level III.1)

Local providers and other stakeholders have reported that behavioral health resources could be augmented with expansion of the Whitsitt Center combined with the transformation from institutionally based to community based services. As further described below, expansion would include the addition of assertive mobile treatment teams in the community, as well as a full-time staff person to assist consumers and providers to navigate provider listings and locate the appropriate community service.

IV. Plan for Enhancing Mental Health and Co-Occurring Services

Inpatient Services and Purchase of Care

Overall, seventy to seventy-five percent of adult psychiatric admissions for Medicaid recipients are to one of the three acute general hospitals (Union, Peninsula Regional or Dorchester). All three hospitals have reported some capacity for additional admissions. Therefore, it is anticipated that the uninsured adults who had been admitted to the Upper Shore will go to one of the three Maryland hospitals. In addition, Rockford Center in Delaware is available as back up in the event that a local hospital cannot provide a bed or if Delaware is more convenient to the consumer. This is consistent with the way inpatient care is provided for individuals who are uninsured throughout the remainder of the State. All three hospitals have reported capacity for additional admissions; however, hospitals have also reported concerns about the availability of professional staff, presenting opportunity for former Upper Shore employees.

Plan for Enhanced Inpatient Psychiatric Services:

  - **Hospitals’ service costs.** It is anticipated that these patients will be treated at Maryland acute care inpatient psychiatric units. In this event, the cost of services provided to patients without insurance will be handled through the Health Services Cost Review Commission’s unique hospital uncompensated care financing mechanism. It is difficult to estimate prospectively the number of patients who would use inpatient services, but the State share of the Medicaid portion of reallocated costs (using current costs per case of the three Maryland hospitals) for 100 admissions is $44,675³.

³ One-hundred admissions is based upon past years’ experience, per Upper Shore.
Physician services costs will be paid for by MHA for individuals who are uninsured. Union Hospital of Cecil County, Dorchester General, Peninsula Regional and the Rockford Center (Delaware) have in place Purchase of Care (POC) agreements with MHA. The cost of professional fees to the State is for 100 admissions is estimated at between $42,500 and $60,000 per year.

The five CSAs serving the Eastern Shore will link patients being discharged from hospitals to community services.

While a primary goal of this plan is to ensure that no client remains in an institutional setting if he/she could be more appropriately served in a community setting, care has been taken to ensure that individuals who continue to need hospital level services will not lose this access.

Some individuals who are currently at Upper Shore and who have been in institutions for a long period of time may not currently be ready for community care. The majority of these individuals were transferred from Eastern Shore Hospital Center and will be returned there. After transfer, readiness for community services will be monitored for these individuals through normal facility procedures and planning initiated to enable transition to community services as circumstances for these individuals change over time.

The Department will develop comprehensive discharge or transfer plans for all consumers at Upper Shore. Additionally, through the Department's existing contract with the Maryland Consumer Quality Team, current Upper Shore residents will have the opportunity to share concerns, issues and aftercare goals with the trained consumers and family members who make up these teams. In addition to regularly scheduled meetings with and calls to residents, the CQT teams will be available by phone as needed to address resident concerns. Issues raised by residents will be shared with facility, Core Services Agency and MHA staff for resolution through regularly scheduled CQT feedback meetings that are already operational on the Shore. Finally, the Department has appointed a point person, a former facility director, to assist with wind down of Upper Shore and the building up community resources. That person will be an additional check point in assuring safe and appropriate transition to each individual.
Plan for Enhancing Community-Based Co-occurring Services

The following is a proposal that was prepared by stakeholders on the Eastern Shore. The group was convened by the Mid-Shore Mental Health System as a part of the System’s ongoing planning process. The Department has consulted with Mid-Shore and other stakeholders about the plan and about prioritizing elements of the plan. Any plan adopted, however, must be flexible to adapt to current experience and circumstances as they develop.

A Consensus Approach...

Mid-Shore Mental Health Systems, Inc. (MSMHS) is the local mental health authority for the five counties of Maryland’s Mid-Shore. The organization has convened a workgroup to plan new initiatives and enhancements of existing community programs to support the transition of those consumers who have traditionally relied on the Upper Shore Community Mental Health Center (USCMHC) for inpatient care. Key elements of our Community Alternatives Framework are presented below.

It is the consensus of this group of healthcare professionals, consumers and advocates that the closing of inpatient psych beds will put pressure on the Eastern Shore’s community capacity. Accordingly, the Mid-Shore report recommends that a meaningful percentage of the State’s projected “savings” from the closure be repurposed into the slate of evidenced-based behavioral health alternatives herein presented.

Each of us acknowledges the importance of pursuing an opportunity for those served in our public behavioral health system to be treated in the least restrictive setting possible throughout their recovery. While a small number of those at Upper Shore will need placement at other beds in the State system, we anticipate that this Plan maximizes the opportunity for successful community treatment.

...Based on Comprehensive Analysis

The basis for this Community Alternatives approach lies in the substantial amount of planning that has been the focus of Eastern Shore stakeholders over the last decade. Every two years, each Core Service Agency prepares a comprehensive needs assessment to identify gaps in the delivery of public mental health care within their jurisdiction and develops strategies to overcome them. Several other interested parties have also conducted discovery that, at least in part, reflects on the same issues identified in the MSMHS studies.

Our community mental health planning identifies a near-complete lack of crisis response throughout our region. This stands in sharp contrast to our Western Shore counterparts, where urban and suburban crisis response is the norm. The State has regularly pointed out that limited financial resources preclude the development of these programs, which provide a tremendous safety net for those who seek care from, or work within, the urgent care aspect of the behavioral health spectrum. However, we conclude that the opportunity to divert dollars previously used to fund USCMHC represents ideal approach to address the disparity.

Plan Priorities

The Plan framework places heavy emphasis on building a community safety net for those areas that will be affected by the facility closure. The components will lead to significant enhancement of community services in Kent, Queen Anne’s and other counties whose residents are most often admitted to USCMHC.

The framework requires a significant labor component, which we believe will create employment opportunity for those workers displaced by the personnel reductions. Since most new and enhanced services are aimed at the Upper Shore region, providers serving that area will be ideally positioned to expand staffing to deliver.
community alternatives. Undeniably, the rich experience of the licensed mental health professionals at USCMHC will make them ideal candidates.

Plan Vision
This framework addresses the expected impact on all nine (9) Eastern Shore counties as it relates to metrics of both admission and release patterns at Upper Shore. It focuses efforts in Kent, Cecil and Queen Anne’s counties where the bulk of affected citizen reside, but clearly strengthens community treatment options across the entire Shore, building on services that are already available and planning for the implementation for those which are not. Our regional approach offers significant economies of scale in the procurement of needed services. Anticipated costs are presented in two tiers, representing core and secondary priorities.

Plan Elements

A. Crisis / Urgent Care Response
   a. 24/7 Eastern Shore Operations Center
   b. Mobile Crisis Teams
   c. Assertive Community Treatment
   d. Crisis Beds
   e. Same-Day Appointment
   f. Chester River Hospital Emergency Department
   g. Community Hospital Acute Psychiatric Capacity

B. Residential Co-Occurring Unit
   a. Crisis Beds
   b. Detoxification Beds
   c. Residential Beds

C. Housing & Employment
   a. Housing First Flex Funds
   b. Residential Rehabilitation Bed Expansion
   c. Supported Employment

D. Pioneering Fresh Solutions
   a. Integrated Dual Disorders Treatment
   b. Aging in Place Programming
   c. Peer Support / Wellness & Recovery

CRISIS / URGENT CARE RESPONSE

24/7 Eastern Shore Operations Center (ESOC): As mentioned earlier, the Shore has no central point for behavioral health emergency calls and orchestrated response. This operations center would serve as a single point of access for Eastern Shore residents in crisis with supportive assistance and linkages to resources within the community.

The center would receive calls 24 hours a day, 7 days a week. Anchored by behavioral health professionals, the Crisis Response System Staff would coordinates calls with the police, fire and community agencies that are requesting information on crisis matters. The ESOC Staff would also provide urgent linkage to community resources through Mobile Crisis Teams, Crisis Beds, Homeless Outreach Services, Urgent Care Clinics, Sexual Assault Centers and Community Education. Transportation arrangements can be organized during the encounter. Non-emergency contacts will provide the caller with information, support and referrals.
This represents the foundation of the entire framework. It was similarly the bedrock of the plan to address community needs in Anne Arundel, Prince George’s and the three Southern Maryland counties when Crownsview State Hospital was closed in 2004. The architects of that plan report even today that it has been the key to minimizing the community impact in the aftermath of the closure of that facility.

**Mobile Crisis Teams:** Team members will intervene with callers who are experiencing a behavioral health emergency. A major function of the Mobile Crisis Team will be to assist the police in assessing the need for services. Mobile Crisis Team members will be licensed mental health professionals available from 10 a.m. to 12 a.m. (Sunday to Thursday) and 10 a.m. to 2:30 a.m. (Friday and Saturday). Two regional teams are proposed; one for the four lower shore counties and one to serve the counties north of that. Minimum staffing would be three (3) FTE Licensed Mental Health Professionals per team.

**Assertive Community Treatment (ACT):** Two teams that would parallel the proposed Mobile Crisis Team structure geographically. Funding is needed to support the development and launch of mobile treatment teams and bring them to Evidence-based Practice (EBP) fidelity. Each team would serve fifty (50) individuals. The cost of these teams would be sustainable through Public Mental Health Services (PMHS) fee for service reimbursement and the start-up funding could be shifted in future years to sustaining Housing First funds (presented below) utilized by this program.

**Crisis Beds:** Increase Wicomico County’s existing program from three (3) to four (4) beds and position four (4) new beds to serve the mid- and northern counties of the Eastern Shore. Four new beds will be located in the Whitsitt Center in Kent County.

**Urgent Care Clinics:** Grants to ensure same-day access to assessment by a licensed mental health professional in at least one Outpatient Mental Health Clinic per county. This represents an excellent, inexpensive alternative for many who present in our Emergency Departments.

**Chester River Hospital Emergency Department:** Provide one (1) FTE licensed mental health professionals (day & evening coverage) to the Emergency Department at Chester River Hospital Center, augmenting existing capacity from a .6 FTE to 1.6 FTE. Link CRHC E.D. to the 24/7 Operations Center by televideo equipment for those needs outside of the 1.6 FTE.

**Community Hospital Acute Psychiatric Capacity:** Work with existing providers to increase acute bed availability in their existing locations by executing Purchase of Care agreements to cover professional fees when additional capacity is needed.

**RESIDENTIAL CO-OCCURRING UNIT**

With the closure of the Red Unit of the Upper Shore Mental Health Center, local hospital emergency rooms and community behavioral health providers in Kent, Caroline, Queen Anne’s, Talbot, and Cecil Counties will no longer have access to a regional residential referral source for individuals with behavioral health issues that include co-occurring substance use disorders and mental illness.

The workgroup believes that this population could be treated in a Dual Diagnosis Enhanced treatment facility. These individuals are generally well accommodated in a medically monitored intensive inpatient treatment program.

The Kent County Health Department will expand its current Level III.7 residential substance abuse program to be able to provide this enhanced capacity and maintain this vital service within the community. The target
population would be similar to that of the Red Unit – those individuals who have severe substance use disorders and low or moderate severity mental involvement. The plan is to serve approximately 200 individuals per year.

This co-occurring disorders unit would provide mental health and substance abuse treatment in an integrated manner. It will offer 16 beds, to include both detox and residential treatment, along with 4 new behavioral health crisis beds. A part time psychiatrist and an additional medical doctor would be needed to provide psychiatric and detox services. The utilization of staff from the inpatient and outpatient units will maximize both cost effectiveness and efficiency.

Significant utilization by the uninsured and underinsured, as has been the case historically with the majority of the Red Unit population, will necessitate ongoing grant funding to ensure sustainability.

**HOUSING & EMPLOYMENT**

**Housing First Flex Funds:** Establish a fund that could be used to stabilize individuals through rapid re-housing in accordance with the Housing First model and philosophy. This initiative allocates funds toward housing and supportive services for the hardest-to-serve, chronically homeless population, a substantial number of whom are mentally ill. Because it addresses this population and its needs, the Housing First approach is enjoying unprecedented success in breaking the homelessness and inpatient cycles.

**Residential Rehabilitation Bed Expansion:** Add eight (8) intensive level beds within the Kent-Cecil-Queen Anne’s catchment area, plus four (4) more south of it, to pursue a model similar to Wicomico’s highly successful Peer Connection program.

**Supported Employment:** To date, no Eastern Shore provider of Supported Employment has qualified to provide those services at the highly-successful evidence-based practice level. The framework will provide “start-up” funds as incentive to pursue the Collaborative Learning Program (CLiP) offered by the Evidence-Based Practice Center, Department of Psychiatry, University of Maryland School of Medicine.

**PIONEERING FRESH SOLUTIONS**

**Integrated Dual Disorders Treatment (IDDT):** Coordination of collaborative planning and implementation of this model will address needs identified in the Mid-Shore Behavioral Health Access Study. Offered by the Evidence-Based Practice Center, Department of Psychiatry, University of Maryland School of Medicine University of Maryland, MSMHS will assume responsibility for the planning and implementation components.

**Aging in Place Programming:** MSMHS will collaborate to develop provider capacity in evidence-based disciplines which allow our rapidly-growing geriatric population with mental illness to “age in place.” These opportunities demonstrate substantial savings while increasing the satisfaction of those who are consumers of the services.

**Peer Support / Wellness & Recovery:** Allocate funding to institute an 8-week training program for peer support specialists at Lower Shore Friends, Chesapeake Voyagers, On Our Own of Cecil County, and the peer support specialist for the proposed ACT teams. The Assertive Community Treatment requires a peer support specialist component as a fidelity standard, thereby increasing the professional opportunities for consumers in recovery.

**Final Conclusions**
We firmly believe that this Plan maximizes the opportunity for the successful transition of Upper Shore patients. It allows the Kent & Queen Anne’s County area, and indeed, the Eastern Shore to comprehensively address crisis
needs with a robust range of alternatives. A further benefit is that the framework creates professional job opportunities.

**Timelines for Implementing Enhanced Community-based Co-occurring Services**

The plan for enhanced community-based co-occurring services as proposed by the Eastern Shore stakeholders has been approved for funding by the Department of Budget Management. It would be implemented using the following timeline:

**Estimated Timeline for implementation of community services proposal (from launch date)**

<table>
<thead>
<tr>
<th>Service</th>
<th>Timeline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Program Coordinator</td>
<td>One month</td>
</tr>
<tr>
<td>24/7 Eastern Shore Operations Center</td>
<td>Two and one half months</td>
</tr>
<tr>
<td>Mobile Crisis Teams - Upper Shore/Lower Shore</td>
<td>Three and one-half months</td>
</tr>
<tr>
<td>Assertive Community Treatment - Lower Shore Region</td>
<td>Three and one half months</td>
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<tr>
<td>Residential Rehab.Beds</td>
<td>Four and one half months</td>
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<td>Urgent Care Clinics</td>
<td>Five months</td>
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<td>Inpatient Expansion (SA/Crisis beds)</td>
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<td>Supported Employment</td>
<td>FY 2011</td>
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<tr>
<td>Peer Support / Wellness &amp; Recovery</td>
<td>FY 2011</td>
</tr>
</tbody>
</table>
IV. Assisting Upper Shore Employees

Efforts to Date and Future Plans

The numbers of employees that will be impacted through transition of the Upper Shore are as follows:

- 89 positions at Upper Shore on August 25, 2009
- 85 employees to be placed
- Four (4) permanent employees are not being terminated – two (2) maintenance and two (2) security staff will remain to maintain the building for tenants. Also, one (1) contractual housekeeper will remain for tenants

Actions taken and planned actions:

- MHA management was present for the meeting with employees – 8/25/09
- CEO has met with the Whitsitt Center and Kent County Outpatient Behavioral Health about openings and will also be meeting with the Department of Juvenile Services. If Upper Shore employees were hired into these programs, they would maintain their status as State employees.
- CEO discussed with the other state hospital CEOs any job possibilities. The Department will freeze any vacancies in affected classifications so that Upper Shore employees will be able to interview for any available positions for which they qualify.
- Employees will be able to move into vacancies at the Eastern Shore Hospital Center (ESHC). This includes existing vacancies as well as those that may become available in the future. Expected turnover at ESHC is 9-10 over a year. ESHC management is asking that any of their employees who have retirement plans for the next year to make themselves known as this will assist with planning. Three employees have self identified.
- A tracking document has been setup for hospital management to use to track every employee, date of entry, age, etc. to prioritize ESHC openings for senior employees nearing retirement
- DHMH made a request to DBM for blanket hiring freeze exemptions for agencies hiring employees affected by budgetary abolitions/closures. This was approved by DBM on 9/08/09.
- DBM Outplacement Services Meeting at the Upper Shore Center 09/22/09.
- The Office of Human Resources (OHR) met with 47 Upper Shore Employees for career counseling 10/06/09.
- DHMH OHR tracking position recruitments and referral of employees to DHMH hiring managers for interview. Forty-one (41) applications submitted by Upper Shore employees to OHR for placement on DBM eligible lists as pending lay-off/separations 10/09/09
- Additionally, the Department is coordinating its efforts with those of the Upper Shore Workforce Reinvestment Board. The Reinvestment Board has arranged for the “Mobile One-Stop Unit” to make
regular visits to Upper Shore to provide assistance in developing employment plans; coaching for interview skills and training for employment skills.

- Retirement Benefit counseling at Upper Shore
- Job Fair (date TBD)

V. Fiscal Analysis

The closure of Upper Shore will result in General Fund budget savings for the State of nearly $1.6 million in FY 2010 and $5 million on an annual basis. The FY 2010 savings are based on gross savings at the facility of $2.7 million offset by increased costs for community-based behavioral health services and expansion of the residential substance abuse unit (Whitsitt) of $1.1 million. For FY 2011, the gross savings at the facility total $8 million offset by increased costs for community-based behavioral health services and expansion of the residential substance abuse unit of $3 million.

Funding Projections (Includes Expanded Whitsitt Center)

<table>
<thead>
<tr>
<th>Grant Funded Plan Element</th>
<th>FY10</th>
<th>FY11</th>
<th>FY12</th>
<th>FY13</th>
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<tr>
<td><strong>Community Expansion</strong></td>
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<td>24/7 Eastern Shore Operations Center</td>
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<td><strong>Inpatient Expansion (Whitsitt)</strong></td>
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<td>16 Substance Abuse / 4 Crisis Beds</td>
<td>$389,650</td>
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<td>$1,477,382</td>
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<td><strong>Subtotal</strong></td>
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<td>$1,477,382</td>
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<td><strong>Fee for Service (State Portion)</strong></td>
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<tr>
<td>6 Intensive / 6 General Residential Rehab Beds</td>
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<td>$207,978</td>
<td>$207,978</td>
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<tr>
<td><strong>Subtotal</strong></td>
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VI. Tenants – Plans and Planning for the Future

Tenant Plans

The current tenants of the Upper Shore building (the Whitsitt Center and a DJS Program) have plans to remain in place. They will be assisted with services by former employees of the Upper Shore - two maintenance employees, two security guards and one housekeeper.

Tenants – future plans

As previously discussed, the Whitsitt Center Director is considering increasing the capacity of their program by expanding into space now occupied by the Upper Shore.

VII. Recommendations and Next Steps

The major obstacle to the closure of the Upper Shore is the need to expand behavioral health services for residents of the Eastern Shore – specifically, community-based behavioral health services. Our analysis of inpatient psychiatric bed capacity demonstrates that there is unused capacity at the three Maryland general hospitals and back up if needed at the Rockford Center in Delaware. Our analysis of community-based mental health and substance abuse services demonstrated that residents of the Shore would benefit from additional capacity.

All three types of admissions can be accommodated: (1) Those from emergency departments that are acute psychiatric admissions. These patients’ care will be covered through the HSCRC and through Purchase of Care
arrangements with Dorchester General, Union of Cecil, Peninsula Regional Hospitals and, if necessary, the Rockford Center. (2) Those from emergency departments who have co-occurring needs. These patients’ needs will be handled through additional residential co-occurring services in the community; and (3) those already being served in the general hospital psychiatric units.

While no plan is perfect, the current budget constraints and the recognized need to expand services in community makes this Alternative Services Plan the best plan moving forward. Our recommendation is to go forward in adapting the service delivery model on the Upper Shore, and begin to terminate admissions on January 4, 2010. The decision to delay ceasing admissions for at least 90 days was made by the Governor in conjunction with Eastern Shore legislators during a visit to the Upper Shore in September 2009. Therefore we have selected a date after the holidays, January 4, 2010. Changes in EMTALA as well as the plans discussed above for compensation of the hospitals will help assure availability of inpatient psychiatric services. Enhancement of the community services will help assure services for a greater number of residents of the Eastern Shore.

As previously discussed, there are patients on the Brown Unit who will not be ready for the community at the time the inpatient unit ceases operation. These individuals will be transferred to inpatient services at the Eastern Shore Hospital Center or other inpatient services. The Red Unit would close through attrition following the January 4th termination of admissions, which would coincide with expansion of the Whitsitt Center.

The transformation process will be carried out by the employees of the Upper Shore with oversight by the Eastern Shore Hospital Center and MHA Management. DHMH officials will meet regularly with those overseeing the process as well as with the community stakeholders. A specific point person, a former director of a State facility, has been selected to coordinate the transition, including building up shore resources. We have developed a tracking tool for actions to be taken regarding the closure and another to monitor discharges. We will be monitoring the closure process for the following:

- Quality of care for the patients
- Numbers of new admissions
- Changes in patterns of admission referrals
- Numbers of discharges
- Barriers to discharges
- Implementation of community-based co-occurring services plan
- Possible problems with the Purchase of Care agreements
- The need to terminate admissions to the ESHC to accommodate US discharges
- Job placements obtained by the employees
- The needs of the building tenants
# Appendix

## Data on Admissions by County of Residence

Total Admissions by County FY2008-2010

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Year to date as of 10/22/09