Report on the Outpatient Civil Commitment Pilot Program

Health-General Article § 7.5–205.1(c)
FY 2022

TABLE OF CONTENTS

Table of Contents

I. Background

A. Establishing Outpatient Civil Commitment (OCC) in Maryland

In 2016, the Substance Abuse and Mental Health Services Administration (SAMHSA) selected Behavioral Health Systems Baltimore (BHSB) as the Assisted Outpatient Treatment (AOT) grant recipient of $2,835,978 to be spent over four federal fiscal years (FFY) commencing October 1, 2016.[1] To establish a pilot program, the Maryland General Assembly passed House Bill (HB) 1383 and Senate Bill (SB) 1042 to authorize the Behavioral Health Administration (BHA) to establish an OCC pilot program in Baltimore City for the release of an individual who is involuntarily admitted for inpatient mental health treatment under Health-General Article, Md. Code Ann. §10–632, which was signed into law on May 25, 2017, as Chapters 576 and 577. This legislation was codified as §7.5–205.1(c).

In 2016, a stakeholder workgroup was established to support work for the Assisted Outpatient Treatment program in Baltimore City. The workgroup[2] submitted proposed regulations to the Maryland Department of Health (MDH) on June 1, 2017. The proposed regulation packet was approved, signed by the Secretary, submitted to the Administrative, Executive, and Legislative Review (AELR) Committee, and printed in the Maryland Register on August 18, 2017.[3]

The 30-day regulation public comment period ended on September 18, 2017. During that time BHA received comments from two organizations, the National Alliance of Mental Illness (NAMI) Maryland and Parents for Care. They were forwarded to the workgroup for consideration and response. The workgroup determined that any changes to the regulations as published would change the nature of the operations of the program as designed by the workgroup and approved by SAMHSA. To that end, the regulations became effective on November 6, 2017.

On May 10, 2016, letters of interest were sent out to the Public Behavioral Health System's (PBHS) provider network for Baltimore City detailing the requirements of the grant. The workgroup selected Bon Secours Baltimore Health Systems, Inc. (currently known as Grace Medical). Grace Medical was selected because the organization has an understanding of the complex needs of some of Baltimore's most vulnerable residents and has a well-established record of experience working with people with serious and persistent mental illness (SPMI). Grace Medical is a well-established Baltimore City hospital provider located in West Baltimore and was selected to serve as the primary service provider to offer assertive outreach to individuals during their hospital stay. The goal was and remains to build a rapport with consumers prior to release to the community and to develop appropriate treatment plans for these individuals.
[1]

[1] [1] Substance Abuse and Mental Health Services Administration (SAMHSA), Funding Opportunity Announcement (FOA) Information (Apr. 18, 2016), online at https://www.samhsa.gov/grants/grant-announcements/sm-16-011 (all Internet materials as last visited Oct. 27, 2020)

[2] The workgroup consists of representatives from the Behavioral Health Administration (BHA), the Office of the Attorney General, the Mental Health Association of Maryland (MHAMD), Behavioral Health System Baltimore (BHSB), Disability Rights Maryland, and the National Alliance of Mental Illness Maryland (NAMI).

Grace Medical has a long history of integrating the use of peers—persons with lived experience—in its service delivery model as well as a commitment to utilizing a trauma-informed care approach. Its continuum of care includes assertive community treatment (ACT),[4] Targeted Case Management (TCM), dual-diagnosis programs, and a range of mental health and substance use disorder (SUD) outpatient and inpatient treatment services.

BHSB oversees the implementation of the services provided by Grace Medical, and ensures that the hospital system and providers are accountable to the OCC participants, is available to troubleshoot and provide technical assistance (TA) as they arise, and makes system-level recommendations to improve care. Specific processes include weekly meetings with Grace Medical Peer Recovery Specialists (PRS), monthly progress notes submitted by the PRS for each OCC participant, and ongoing follow-up with hospitals when a referral is received to ensure a connection with legal representation and the peer recovery specialist.

BHA provides oversight for the programmatic and fiscal implementation of the OCC program, provides guidance and support in the drafting of the proposed regulation by BHSB and other stakeholders, and is responsible for reporting program outcomes annually to external stakeholders. These activities are completed in partnership with community stakeholders to ensure that Marylanders who participate in the Public Behavioral Health System (PBHS) are receiving high-quality specialty behavioral health services in the most appropriate, culturally, and linguistically sensitive settings. To ensure this, BHSB receives monthly progress reports from Grace Medical and uses that data to complete the quarterly progress report that is submitted to the BHA. This quarterly report also highlights participants' treatment plan progress. Additionally, BHSB has weekly telephone calls with the Peer Specialist to get updates on the program's progress and enrollments.

B. Regulatory Changes

From SFY'20 to SFY'22, the stakeholder group, which consists of representatives from the Behavioral Health Administration (BHA), the Office of the Attorney General, the Mental Health Association of Maryland (MHAMD), Behavioral Health System Baltimore (BHSB), Disability Rights Maryland, and the National Alliance of Mental Illness Maryland (NAMI) discussed strategies to expand eligibility for the OCC project. The proposed regulation changes were formally submitted for review on August 3, 2021. The OCC regulations are currently pending and under the regulatory promulgation review process. The newly proposed regulation changes, if approved, will:

1. Expand residency requirements to include additional residents of Baltimore City living in contiguous zip codes;
2. Ensure a prior commitment to a state hospital does not preclude OCC eligibility;
3. Expand eligibility criteria to include emergency department (ED) visits, not just inpatient admissions; and

[3] BHA follows the regulatory process required under the Department. See MDH Office of Regulation and Policy Coordination, Procedure for Regulations Process, 02.10.01.P (April 7, 2016), online at https://health.maryland.gov/docs/p021001P1.pdf.

4. Remove the Administrative Law Judge (ALJ) hearing requirement for patients enrolling into the program voluntarily.

C. Key Implementation Activities in State Fiscal Year SFY'2022

BHSB facilitates monthly meetings to keep the workgroup informed of program developments. BHA participates in the monthly meeting and receives updates and quarterly progress reports from BHSB. The workgroup provides consultation to BHSB and BHA, and assistance related to program implementation and regulation changes, as well as evaluating and recommending program activities and changes as individuals are served.

Over the past fiscal year, several notable implementation activities were built upon and completed with the support of the workgroup. They included:

- The collaboration of new partnerships that included the convening of meetings with the Local Behavioral Health Authorities (LBHAs) from Anne Arundel and Baltimore County to discuss the proposed regulation changes, specifically the expanded residency requirement. BHSB also presented on the OCC program and its benefits to the Baltimore County Behavioral Health Advisory Council. This expansion will include contiguous zip codes around the city and will include parts of both counties.

- Continued partnership with nine (9) hospitals with inpatient psychiatric units. The OCC program provides consultation to these partners regarding the eligibility criteria and the referral process. When a referral is received, BHSB will coordinate with the Law Offices of Terri. D. Mason and connect them with the inpatient social worker for the hearing or settlement agreement process and the Office of Administrative Hearings (OAH) to ensure that individuals entering the program voluntarily have adequate representation to assist them in making an informed decision about their admission into the program. Additionally, BHSB works with Grace Medical and the referring hospital to connect the participant with the Peer Recovery Specialist (PRS) in order to facilitate a "warm hand off".

- Bi-weekly or monthly meetings with eight (8) Baltimore City area hospitals to discuss high inpatient utilizers and potential OCC referrals.

- Collection of data throughout SFY22 that measured various health outcomes during a reporting period. These health outcomes included the number of times consumers engaged with mental health treatment providers, how many consumers were connected to permanent or stable housing, linkage to primary healthcare services, and linkage to employment or educational services.

- Presentations on OCC during BHSB service line meetings for Outpatient Mental Health and Assertive Community Treatment (ACT) providers to educate these stakeholders on the program and encourage outreach if clinicians feel their clients who are hospitalized could benefit from the program.

- Monthly meetings with the Administrative Service Organization (ASO) to discuss high inpatient utilizers and potential OCC participants. The collaboration with the ASO staff assists in determining if an individual has had multiple hospitalizations and serves as a potential reminder to hospitals about the OCC program when they request authorization for the hospital stay.

- Outreach events with other community behavioral health agencies. August 2021 through September 2022, BHSB presented to several area hospitals and staff, the Baltimore County Behavioral Advisory Council, and the Maryland Hospital Association Behavioral Health Roundtable on the OCC program and benefits to potential referrals and to provide education on eligibility requirements and the referral process.

II. Reporting Requirements

Section 7.5–205.1(c) of the Maryland Code of Health requires MDH to submit a report to the Senate Finance Committee and the House Health and Government Operations Committee showing program results for each year that the pilot program is in existence.

- In accordance with paragraph (c)(1), there were five (5) consumers admitted into the pilot program from July 1, 2021 - June 30, 2022. One consumer was admitted before July 1, 2021, that continued to be served through fiscal year 2022; therefore, six (6) unduplicated individuals served during the fiscal year.

- In accordance with paragraph (c)(2), there were eight (8) applications for admission into the pilot program submitted from July 1, 2021 – June 30, 2022; of the eight applications, three (3) did not meet the admissions criteria due to not having a history of prior involuntary admission. These applications were for involuntary OCC enrollment.

- In accordance with paragraph (c)(3), the cost of administering the pilot program for the immediately preceding 12-month period was $494,827.

- Of the five (5) individuals that were admitted into the pilot program during FY22, four (4) were admitted voluntarily and one was admitted involuntarily.

- In accordance with subparagraph (c)(4)(i), 100% of the individuals agreed to meet with the peer recovery specialist throughout the six-month commitment.

- In accordance with subparagraph (c)(4)(ii), 100% of the individuals received mental health services during their six-month commitment; and

- In accordance with subparagraph (c)(4)(iii), three (3) of the five (5) individuals admitted into the pilot program were connected to somatic health care through their enrollment in the pilot program. The other two received somatic care during a lengthy psychiatric hospitalization.

The pilot program utilizes a person-centered approach to care, which means that each individual in the program developed a program plan that was tailored to meet their unique healthcare needs and goals. To support the participant's program plan goals and ensure adherence to the program, peer recovery specialists meet with each individual several times a week. Peer support services include consistent, assertive, and trauma-informed outreach, case management, supportive counseling, and linkage to community resources. All mental health services received by program participants were individualized and appropriate to the level of care required for that individual. These mental health services included ACT and Capitation.

During the fiscal year, the Mental Health Association (MHA) of Maryland conducted Consumer Quality Team (CQT) surveys with program participants to assess the quality of the program and get the consumer's feedback on program services. Below are statements from program participants as reflected in the CQT reports:

"I'm very pleased with [the peer specialist]. He's been there three days a week. He always sees my problems."
"[The peer specialist] is a nice guy. He talks to you in a way you can understand."
"Everything is excellent, cause [the peer specialist], he's the best."
"[The peer specialist] sees me twice a week. He helps me with my appointments and is helping me look for places to live. He comes to where I stay or where I am."
"[The peer specialist] helps me out…Anything I need, I don't need to ask twice. He goes out of his way and he's an excellent worker"

A. Program Funding and Administrative Cost

During the SFY21, BHA provided $494,827 in state funds. Funding supported the following:

- Legal services provided by the Law Offices of Terri D. Mason, P.C. Ms. Mason provides legal representation to each individual who is eligible for the OCC program and provides representation upon request to participants during a hearing or settlement agreement conference. She is also available for consultation prior to the hearing or settlement agreement;
- A part-time clinical supervisor located with the sub-vendor, Grace Medical Center, and one full-time PRS who is enabled to conduct assertive, flexible, and sustained outreach and engagement with individuals whether they are immediately amenable to consent for services or not; and
- The MHA CQT to support the monthly collection of feedback from individuals who have served in the program, regardless of their willingness to engage or consent with the service system. This feedback is conducted through a telephonic survey and the results are submitted to BHSB.

B. Challenges/Barriers

The OCC program has been beset by a series of systemic challenges that have prevented an expansion of program enrollment. These challenges include:

A delay in the promulgation of regulations developed specifically to increase

program enrollment. The OCC stakeholder group spent several months in early 2021 drafting regulations to remove barriers that prevent the program from serving a greater number of people with complex mental health needs. In sum, these regulations would:

1. Expand residency requirements to expand access beyond Baltimore City to those living in contiguous zip codes;
2. Ensure a prior commitment in a state hospital does not preclude OCC eligibility;
3. Expand eligibility criteria to include emergency department visits, not just inpatient admissions; and
4. Remove the Administrative Law Judge hearing requirement for voluntary enrollments to allow for an expedited enrollment process and lessen the administrative burden on hospital social workers.

Significant hospital hiring and retention challenges, particularly as relates to hospital social workers. Due to staffing challenges, social worker caseloads are much higher. Per hospital reporting, they are often not able to complete an OCC referral and adhere to the administrative requirements of the referral process or make other outpatient referrals for the patient. Additionally, there is high staff turnover and difficulty with training and onboarding new hires and getting them up to speed on the benefits and requirements of OCC.

ASO is unable to provide the data reports necessary to identify eligible patients. Since the transition to the new Administrative Services Organization (ASO) at the beginning of 2020, BHSB has not had access to frequent inpatient utilizer data. This data is critical in identifying potential OCC referrals and allows for more proactive outreach and engagement with hospitals. Efforts continue to be made to remove this barrier.

C. Lessons Learned

One of the primary lessons learned is that there are residents of Baltimore City who fit the target population for OCC, and they are either not being served or are underserved by the program or the overall behavioral health system of care. In response to this, regulation changes were submitted to expand residency requirements to include surrounding zip codes outside of Baltimore City, ensuring a prior commitment in a State Hospital does not prevent OCC eligibility, and including psychiatric emergency department visits within the past year as part of the eligibility criteria. Additionally, the stakeholder group collaborated with the Office of Administrative Hearings to propose a regulation to eliminate an Administrative Law Judge endorsement for individuals entering OCC voluntarily who are not retained at the hospital. This will allow for a more streamlined and expeditious process for that referral pathway.

The stakeholder group also recognized the need for ongoing outreach and education about the OCC program. This outreach should extend beyond social workers and also include hospital physicians and administrative staff who may be involved in the referral or enrollment process. It is critical not only to educate about the referral process and eligibility criteria but also about the values and principles of OCC. This is especially important to communicate to hospital physicians, who often play a key role in deciding to make an OCC referral. BHSB will consider

a physician advisor to complete peer-to-peer reviews with hospital physicians who are considering a referral and have questions or concerns about their patient's enrollment in the program. Additionally, BHSB will continue to offer presentations and updates about the program regulations for both inpatient psychiatric hospitals and community behavioral health providers.

Last, a lesson learned from the Consumer Quality Team interviews with OCC participants is that the approach the program utilizes is effective. Participants value the person-centered nature of the program and the dedication and support of the peer specialist, as evidenced in the interview feedback.

D. Next Steps

The Behavioral Health Administration will continue to fund the OCC pilot with state general funds in SFY23 and will work with the OCC team to enhance the program and increase enrollment by:

1. Continuing to explore national best practices in administering outpatient civil commitment and improving outcomes;
2. Implementing proposed regulation changes when they are approved and finalized; and
3. Continued collaboration with the current ASO during SFY23 to develop a daily high inpatient utilizer report that will allow for more targeted outreach to hospitals regarding potential OCC participants;
4. Working with the ASO on gaining current and up-to-minute access to the high inpatient utilizer data reports to effectively work with each local hospital to develop additional operational strategies for real-time communication and identifying potential referrals;
5. Continued engagement with outpatient providers who may track when their patients have been hospitalized and could benefit from the additional support that the OCC brings; and
6. Continued program education for family members and caregivers in an effort to help advocate with the hospital on behalf of or in collaboration with their loved one to be referred to the program if they meet eligibility criteria.

E. Partnerships

BHA and the OCC will collaborate with the current ASO to establish a plan to maintain and strengthen the current partnership. Working with the ASO is integral to the monitoring of services being provided by individuals who utilize Maryland's Public Behavioral Health System (PBHS).

While there are some efficient operational strategies already in place, individualizing these strategies with the local hospitals to include the development of additional strategies for real-time communication and identifying potential referrals will be explored to maximize enrollment and patient engagement. These strategies will be piloted with specific hospitals initially that are still TBD. BHSB will project to expand this approach across all hospitals that have the capacity to refer to the program. Additional partnerships and engagement with outpatient providers will be continued and expanded upon to assist in tracking efforts when their patients have been hospitalized. This process will also assist in the education of these providers

to help bridge the gap in understanding the benefit of the additional support that OCC brings.

Strong family support is critical for OCC. BHSB and the stakeholder group will continue to provide program education for family members and caregivers in an effort to help advocate with the hospitals on behalf of or in collaboration with their loved ones to be referred to the program if they meet eligibility criteria.

The BHSB and OCC stakeholders will revisit current engagement processes with community mental health providers and resources to follow up, restore, and fortify the importance of OCC. BHA will work with the OCC program to conduct a needs assessment after OCC program refinements have been made.

F. Program Sustainability

The stakeholder group continues to meet monthly to oversee the pilot and consider options for program sustainability. MDH and the project stakeholder group recognize that sustaining this service through grant funds is a significant strength of the project since services provided through the OCC are not Medicaid reimbursable and federal grants are time limited. This enables continuous services and support to participants regardless of other services they may be receiving, providing greater continuity of care, and reducing the risk of negative outcomes.