Maryland Consortium on Coordinated Community Supports
45 Calvert Street, Room 336, Annapolis, MD 21401

Lawrence J. Hogan, Governor; Boyd K. Rutherford, Lt. Governor
David. D. Rudolph, Chair; Mark Luckner, Executive Director, CHRC

MARYLAND CONSORTIUM ON COORDINATED COMMUNITY SUPPORTS

ANNUAL REPORT

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and Joint Chairmen's Report, 2022 session

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I. Executive Summary

The Maryland Consortium on Coordinated Community Supports began its activities in August 2022.

The Maryland General Assembly Presiding Officers appointed former Delegate David Rudolph to serve as the Consortium's chair in July 2022. Under Chair Rudolph's leadership, the full Consortium met on August 17, September 22, October 18, November 15, and December 13. Meeting recordings and other meeting materials are posted on the Consortium's webpage.

In response to the legislation, four Subcommittees were created to organize the Consortium's work. These Subcommittees have been meeting regularly, and meetings are open to the public.

- The Framework, Design & RFP Subcommittee is developing recommendations for the overall program structure and the first Call for Proposals.
- The Data Collection/Analysis & Program Evaluation Subcommittee is developing standardized data measures and considering data platforms.
- The Outreach and Community Engagement Subcommittee worked to engage the public on the Consortium's public comment period.
- The Best Practices Subcommittee is evaluating best practices in the delivery of behavioral health services and supports for inclusion in the first Call for Proposals and developing recommendations to maximize Medicaid reimbursement for school-based behavioral health services.

The Consortium held a public comment period. Twelve questions were posed to the public. The Consortium accepted responses in writing as well as orally at a meeting of the Outreach Subcommittee. 81 individuals provided responses. A summary of public comments can be found in Appendix A.

Consortium Subcommittees are continuing to review public comments and consider key issues related to overall program design and the development of the first Coordinated Community Supports Partnerships Call for Proposals (RFP). The Consortium is expected to issue recommendations to the Maryland Community Health Resources Commission (CHRC) that will guide the issuance of the first RFP during CY 2023. As provided by statue, the CHRC will develop and release the RFP and will administer the Coordinated Community Supports Partnerships grant program.

The Consortium has been working closely with the National Center for School Mental Health, which was named in the implementing legislation as a technical assistance provider. National Center staff have consulted extensively with the Consortium on overall program structure and metrics, analyzing public comments, and supporting the work of all four Subcommittees. Going forward, the National Center will continue to advise on the program, support the development of the Call for Proposals, identify opportunities to maximize financial support through Medicaid, recommend best practices for the delivery of services and supports, and provide technical assistance to grantees.

II. Background and Mission

Under its authorizing statute, the Maryland Consortium on Coordinated Community Supports is a new state agency responsible for developing a statewide framework to expand access to comprehensive behavioral health services for all Maryland students.

The Consortium was created by the Maryland General Assembly as part of the Blueprint for Maryland's Future, Chapter 36 of 2021 (Kirwan education reform bill). SB 802 of 2022 (Ch. 713 of 2022) modified the Consortium's membership, increased funds available for Consortium grants, and clarified the role of the Maryland Community Health Resources Commission (CHRC).

The Consortium has three statutory purposes:

1. Support the development of coordinated community supports partnerships to meet student behavioral health needs and other related challenges in a holistic, nonstigmatized, and coordinated means.
2. Provide technical assistance to local school systems to support positive classroom environments and close achievement gaps.
3. Provide expertise in developing best practices in the delivery of behavioral health and wraparound services.

The Consortium also has nine statutory duties:

1. Develop a statewide framework for the creation of community supports partnerships.
2. Ensure supports and services are provided in a holistic and nonstigmatized manner and are coordinated with other youth-serving government agencies.
3. Develop a model for expanding available support services to all students in each local school system.
4. Provide guidance and support to the CHRC for the purpose of developing and implementing a grant program to award grants to coordinated community supports partnerships with funding necessary to deliver supports and services to meet holistic behavioral health needs.
5. Evaluate how a reimbursement system could be developed through the Maryland Department of Health or a private contractor to reimburse providers participating in a coordinated community supports partnership.
6. In consultation with the Maryland State Department of Education, shall develop best practices for the creation and implementation of a positive classroom environment for all students that recognizes the disproportionality of classroom management referrals.
7. Develop a geographically diverse plan to ensure each student can access services and supports that meet the student's behavioral health needs and related challenges within a 1-hour drive of their residence.
8. In consultation with the National Center on School Mental Health and in coordination with the Maryland Longitudinal Data System and the Blueprint Accountability and Implementation Board, shall develop metrics to determine whether grant-funded community supports partnership services are positively impacting students, their families, and their communities.
9. Use accountability metrics to develop best practices to be used by a coordinated community supports partnership to deliver supports and services and maximize federal, local, and private funding.

The Consortium will develop a statewide program to expand access to behavioral health and related services for Maryland students.

In consultation with the Consortium, the CHRC will administer the new Coordinated Community Supports Partnerships grant program. Grants will support local Partnerships throughout the state to coordinate the activities of a variety of community organizations to address student behavioral health and other needs. Funding levels are: $50 million for FY 2023; $85 million for FY 2024; $110 million for FY 2025; and $130 million for FY 2026 and each FY thereafter. Partnership grantees also will be required to maximize Medicaid billing and other funding sources.

The Consortium is beginning to investigate potential policy changes to facilitate Medicaid reimbursement for school-based behavioral health services. Recommendations for policy changes, Technical Assistance, and support to expand Medicaid reimbursement for school-based behavioral health services will be developed in 2023. Recommendation may address both community providers supported through Coordinated Community Supports Partnership grants as well as school-employed providers.

The CHRC is responsible for providing staff support for the Consortium, and the National Center on School Mental Health is providing Technical Assistance. The Consortium began its activities during the summer of 2022.

III. Consortium Membership, Appointment, and Selection process

The Consortium has 24 members and includes representatives from the state and local departments of education, health, human services, and juvenile services, members of the legislature, and other individuals representing the education and behavioral health communities. David D. Rudolph was appointed by the General Assembly leadership to serve as the Consortium's chair.

1. David D. Rudolph, Chair, Maryland Consortium on Coordinated Community Supports
2. Robin Rickard, Maryland Department of Health | Executive Director, Opioid Operational Command Center
3. Emily Bauer, Maryland Department of Human Services | Two-Generation Program Officer
4. Cory Fink, Department of Juvenile Services | Deputy Secretary for Community Operations
5. Mohammed Choudhury, Maryland Department of Education | State Superintendent
6. Edward Kasemeyer, Maryland Community Health Resources Commission | Chair
7. Mary Gable, Director of Community Schools | Assistant Superintendent, Division of Student Support, Academic Enrichment, & Educational Policy, Maryland State Department of Education
8. The Honorable Katie Fry Hester, Maryland Senate
9. The Honorable Eric Ebersole, Maryland House of Delegates
10. Christina Bartz, Council on Advancement of School-Based Health Centers | Director of Community Based Programs, Choptank Community Health Systems
11. Dr. Derek Simmons, Public School Superintendents Association of Maryland | Superintendent, Caroline County Public Schools

12. Tammy Fraley, Maryland Association of Boards of Education | Allegany County Board of Education
13. Russell Leone, Maryland State Education Association | President, Teacher's Association of Anne Arundel County
14. Gail Martin, Maryland Chapter of the National Association of Social Workers | former Baltimore County Public Schools Team Leader, School Social Work
15. D'Andrea Jacobs, PhD., Maryland School Psychologists Association | School Psychologist, Baltimore County Public Schools
16. Dr. John Campo, MD, Maryland Hospital Association | Director of Mental Health, Johns Hopkins Children's Center, Johns Hopkins University Hospital
17. Sadiya Muqueeth, DrPH, member, Maryland Community Health Resources Commission | Director of Community Health, National Programs, Trust for Public Lands
18. Linda Rittelmann, representative of the Maryland Medical Assistance Program | Senior Manager, Medicaid Behavioral Health ASO, Maryland Department of Health
19. Larry Epp, Ed.D., representative of the community behavioral health community with telehealth expertise | Director of Outcomes and Innovation, Families and Communities Service Line, Sheppard Pratt Health System
20. Gloria Brown Burnett, representative of local departments of social services | Director, Prince George's County Department of Social Services
21. Michael A. Trader, II, representative of local departments of health | Assistant Director of Behavioral Health, Worcester County Health Department
22. Kandice Taylor, Ed.D., individual with expertise in equity in education | School Safety Manager, Baltimore County Public Schools

The Consortium currently has two vacancies.

Appointment and Selection Process. By statute, some Consortium members are appointed by the Secretaries or Chairs of the government agencies they represent: state Departments of Health, Human Services, Juvenile Services, Education, the Community Health Resources Commission, and the Council on Advancement of School-Based Health Centers. Others are appointed by the membership organizations they represent, as provided by statute: Public Schools Superintendents Association of Maryland, Maryland Association of Boards of Education, Maryland State Education Association, Maryland Chapter of National Association of Social Workers, Maryland School Psychologists Association, and Maryland Hospital Association. The Governor has appointment authority for three slots: representative of the behavioral health community with expertise in telehealth, representative of local departments of social services, and representative of local departments of health. The General Assembly Presiding Officers appoint six members to the Consortium: an individual with expertise in creating a positive classroom environment, an individual with expertise in equity in education, two members of the public, a member of the Senate, and a member of the House of Delegates.

To help recruit Consortium members, CHRC staff, the Department of Health's Office of Appointments and Executive Nominations, and the State Department of Education's Division of Student Support, Academic Enrichment, and Educational Policy reached out to the various appointing authorities and provided a summary overview of the Consortium to interested parties.

IV. ACTIVITIES OF THE CONSORTIUM DURING CALENDAR YEAR 2022

The Consortium held its first meeting on August 17, 2022. Four other full Consortium meetings were held during CY 2022, on September 22, October 18, November 15, and December 13. All meetings were open to the public, recorded, and posted on the Consortium's website.

Chair Rudolph appointed four Subcommittees to organize the Consortium's work: Framework, Design & RFP; Data Collection/Analysis & Program Evaluation; Outreach and Community Engagement; and Best Practices. Subcommittees met regularly during the second half of calendar year 2022.

- The Framework, Design & RFP Subcommittee, co-chaired by Superintendent Mohammed Choudhury and Dr. Sadiya Muqueeth, met several times during 2022 to plan the overall framework of Community Supports Partnerships. The Subcommittee discussed the Collective Impact model, the role of schools in Community Support Partnerships, permissible grant-funded activities, and the structure of the grant program. The Subcommittee also developed eight questions for the public comment period and is reviewing the responses to these questions.

- The Data Collection/Analysis & Program Evaluation Subcommittee, chaired by Dr. Larry Epp, met several times during 2022 to discuss potential standardized data measures and platforms for Consortium grantees. The Subcommittee is working to develop a set of key quantifiable goals and indicators to measure overall program impact, grantee performance, and results at the individual student level. The Subcommittee also developed four questions for the public comment period and is reviewing the responses to these questions.

- The Outreach and Community Engagement Subcommittee, co-chaired by Tammy Fraley and Robin Rickard, was responsible for distributing the public comment questions to a wide audience. The Subcommittee also held a meeting to hear oral testimony on the questions. The Subcommittee is developing plans to do outreach to ensure local communities are aware of the future grant funding and opportunities to develop Partnerships.

- The Best Practices Subcommittee, co-chaired by Dr. John Campo and Dr. Derek Simmons, met several times to discuss best practices that align with each level of the Multi-Tiered System of Supports (MTSS – universal, targeted/brief/group, and intensive/individual/family) and correspond to each of the Consortium's goals. The Subcommittee is considering the degree to which interventions should be coordinated across the state versus providing local flexibility. In 2023, the Subcommittee will investigate and make recommendations on policy changes, Technical Assistance, and support to facilitate Medicaid reimbursement to school-based behavioral health providers.

The Consortium held a public comment period from October 26 – November 16. The Framework and Data Subcommittees each developed a series of questions on which to solicit public input. Twelve total questions were developed. Questions considered such topics as: permissible uses of grant funding, types of services to prioritize, ways to ensure funds are directed to areas of greatest need, addressing

workforce challenges, criteria for evaluating proposals if grants are awarded competitively, accountability measures, and support for future grantees. Members of the public could respond in writing to some or all of the 12 questions. They were also given an opportunity to testify orally at a meeting of the Outreach Subcommittee on November 10. The Outreach Subcommittee worked to distribute the questions to a wide range of stakeholders.

In total, the Consortium received responses from 81 individuals representing a wide range of behavioral health and educational interests from across the state. CHRC staff collated and summarized the responses. These responses were first shared with the Subcommittees and with the National Center for School Mental Health. Subcommittees discussed key topics raised in the public comments during their meetings.

Some overall themes from the public comments included:

- The grant program should fund interventions at all three tiers of the Multi-Tiered System of Supports (i.e., Tier 1: universal for all students, Tier 2: small group/short term for targeted students, and Tier 3: intensive individual supports for students with the greatest need).
- Tier 2 interventions for targeted students are often overlooked and should be strengthened. Medicaid billing reform may be required in order to reimburse for some Tier 2 activities.
- Families must be engaged, not just students.
- Transportation support is needed.
- Substance use disorder must be prioritized.
- Cultural and linguistic competency is critical.
- Funding should be focused on areas with the greatest socioeconomic needs and fewest behavioral health providers.
- Workforce challenges should be addressed through competitive wages and benefits, utilizing community providers, expanding the types of individuals able to provide services, developing behavioral health career pathways, and efficiently allocating limited staff by enhancing Tier 1 and Tier 2 supports.
- The Consortium/Maryland Community Health Resources Commission (CHRC) should provide key data to help with applications.
- Applicants/grantees would like training and Technical Assistance on how to collect and use data to demonstrate outcomes and inform treatment programs.
- Clinical data should be used to inform treatment programs at the individual level as well as the program level.

A summary of public comments, as well as a list of the questions asked and the individuals who submitted comments and/or testified on November 10, is included in Appendix A.

Consortium Subcommittees are continuing to review public comments and consider key issues related to overall program design and the development of the first Coordinated Community Supports Partnerships Call for Proposals (RFP). The Consortium is expected to issue recommendations to the Maryland Community Health Resources Commission (CHRC) that will guide the issuance of the first RFP

during CY 2023. As provided by statue, the CHRC will develop and release the RFP and will administer the Coordinated Community Supports Partnerships grant program.

The Consortium has collaborated closely with the National Center for School Mental Health as required by statute. A three-party Memorandum of Understanding is being developed and a contract is being finalized. The National Center is providing expertise on all aspects of the Consortium's work and planning efforts and will provide technical assistance to future grantees. The National Center has drawn on its national experience to consult on the design of the overall program framework and accountability measures, analyze public comments, and support the work of all four Subcommittees. The National Center will continue to advise on the program, support the development of the Call for Proposals, identify opportunities to maximize financial support through Medicaid, and recommend best practices for the delivery of services and supports.

V. Planned Efforts to Prioritize Concentration of Poverty Students

As required by statute, the Coordinated Community Supports Partnership program will be a statewide program offering holistic behavioral health and other related services and supports to all students in each local school system. While the program will be statewide, implementation and funding decisions will include equity considerations. As such, the Consortium will recommend that areas of greatest need receive priority for funding and support.

Schools that receive Concentration of Poverty Grants are, by definition, in areas of socioeconomic need. The Consortium is considering a competitive grant application process. To help grant applicants focus on these schools, the Call for Proposals will include a list of schools that receive Concentration of Poverty Grants. Receipt of Concentration of Poverty Grants will be one of several factors to be considered in awarding Coordinated Community Supports Partnership grants.

Public comments received during the Consortium's recent public comment period also stressed that priority should be given to areas of greatest need. While comments did not discuss Concentration of Poverty grants specifically, many comments recommended consideration of the percentages of students eligible for free and reduced meals (FARMs) as well as Community Schools. Both are closely related to Concentration of Poverty Grants. The number of children eligible for FARMs is used to determine a school's eligibility for Concentration of Poverty Grants, and schools that receive Concentration of Poverty Grants are required to become Community Schools.

VI. Creation of Coordinated Community Support Partnerships and Areas Served by Each

The Consortium is developing recommendations for the first Coordinated Community Supports Partnerships Call for Proposals. Once approved by the Consortium, these recommendations will be used

by the CHRC to issue the first Call for Proposals during the first part of 2023. According to statute, the CHRC serves as fiscal agent for the Consortium's grant program.

Funding under the first RFP is expected to include both service delivery and capacity building programs. The Consortium will include a list of Coordinated Community Supports Partnerships and the areas served by each in its July 2023 report.

The Consortium will prioritize areas of greatest need as it develops a statewide framework for Partnerships.

VII. Grants Awarded to Coordinated Community Support Partnerships

The Consortium is developing recommendations for the first Coordinated Community Supports Partnerships Call for Proposals. Once approved these recommendations will be used by the CHRC to issue the Call for Proposals during the first part of 2023. Funding under the first RFP is expected to include both service delivery and capacity building programs. The Consortium will include a list of grants awarded in a future report.

Appendix A.

Summary of Public Comments

Defining Behavioral Health Services: Comments reviewed two definitions for behavioral health services, one from the Blueprint bill and another from the Health-General Article of the Maryland Code. Most comments proposed modifications to the definitions. A proposed synthesized definition is below:

> Behavioral health services are trauma-informed prevention, screening and assessment, early intervention, treatment, medication management, recovery, support, wraparound, navigation, rehabilitation, and mental health promotion services to address mental health and substance use challenges and support the social-emotional, psychological, and behavioral health and wellbeing of all students.

Kinds of services that should be provided by Consortium grants: Overall, comments recommended supporting all three tiers of the Multi-Tiered System of Supports (Tier 1: universal services for all students, Tier 2: targeted/small group services for selected students with greater needs, and Tier 3: intensive/one-on-one services for only students with the greatest needs. Some comments recommended just one tier, but those comments were split nearly evenly among the three tiers. Others recommended equal priority for all three tiers in an integrated manner.

Many comments stressed the importance of preventative programming, early identification and interventions, as well as trauma-informed universal supports. Comments recommended expanded screenings with an emphasis on middle schoolers, attention to children with four or more Adverse Childhood Experiences (ACEs), training school staff to identify and connect students to care, and classroom management support for educators. A few comments recommended population level strategies with a public health approach, and said reducing systemic distress would be the first step to helping children with more serious challenges. Recommended Tier 1 (universal) services include: guest speakers; mental health assemblies; executive function and brain fitness programs; restorative justice; the Good Behavior Game; mindfulness programs; and programs addressing conflict resolution, truancy, bullying, violence, and suicide.

Comments also recommended a number of Tier 2 (targeted/brief/small group) services, including group therapy and support groups during and after school. They also recommended brief individual psychosocial services lasting approximately four weeks for children with emerging behavioral health issues. Support groups and group therapies could include: anxiety, social skills, communication, anger management, grief, social media, and LGBTQ supports. Medicaid reform may be required to bill for some Tier 2 interventions. Expanding Tier 2 efforts could help with workforce constraints by ensuring that Tier 3 supports are reserved for students with the greatest needs.

For Tier 3 (intensive/individual/family) services, comments stressed recovery, not just treatment. Comments recommended community based intensive out-patient services, individual and family therapy, stress/anxiety reduction, medication management, school-based wellness centers, support for trauma including domestic violence, and Occupational Therapy. Comments urged priority for students who are uninsured, underinsured, at risk of juvenile justice system involvement, and/or with active mental health diagnoses. Students with behavioral health concerns that significantly impair functioning should be identified and comprehensive wraparound services should be developed for each child's needs. Telehealth should be used to expand access to therapy and psychiatry but may not be the best approach for every student. Funding should support in-school telehealth suites as well as trained counselors to support students after telehealth sessions. Comments urged expansion of school-based substance use disorder programs, including individual and family recovery supports, harm reduction programs, certified peer recovery specialists, and transportation assistance for youth and families to access recovery supports.

Comments stressed the need to work with families in addition to students. Grants funds should be used to address behavioral health stigma among parents and should address cultural factors. Parents should be educated to spot the early signs of a behavioral health problem, provide daily care and guidance, decide which clinician to work with, monitor the results, and make changes. Family counseling, parenting classes, training in appropriate disciplinary techniques, and transportation assistance should be offered. Grant funds should support community health workers and social workers to provide students and families with case management, care coordination, and navigation to other providers and resources. Commercially insured children may not have coverage for case management.

Numerous comments recommended that interventions and priorities be flexible and respond to the local context. They said preference should be given to community-based organizations, smaller non-profit local community treatment providers, and linguistically competent providers. Involving trusted grassroots organizations can help to engage reluctant parents. Programs should be run by a board with the minority opinion considered when voting. They should be coordinated with, developed with, and supported by local educational and behavioral health authorities. The Consortium should encourage innovative ideas and programs. Programs should be available year-round and should be available after school as well as during the school day.

In addition, comments supported flexible wraparound case management services to connect students and their families to basic needs. Services (direct or through referral) could include: food security/food pantries, hygiene pantries, housing assistance, legal services, access to health care, domestic violence supports, care coordination/navigation, respite services, transportation supports, financial education, daycare, and job training. Older students should be taught independent living skills.

Comments recommended funds be available for school building renovations, including the creation of calming spaces, therapy rooms, mindfulness rooms, and outdoor spaces. School staff support and training was emphasized, including wellness incentives, incentives for teachers to implement new approaches, and training on clear protocols for crisis situations and behavioral threats. Comments recommended grant funds be available for truancy reduction programs, school safety and security measures, mentoring programs, and incentive prizes. Access to expressive activities (arts, equine therapy, outdoor activities) that support social emotional wellbeing was also recommended.

Funds should support administrative costs including: salaries and fringe benefits; staff recruitment/retention; staff training and a learning collaborative; office space and furnishings; IT systems; other infrastructure and staffing for data collection and analysis; program materials and supplies including therapeutic supplies, sensory corners, and Positive Behavioral Interventions and Supports (PBIS) incentives; program advertising and marketing; events for students and families; and virtual communication technologies. Some comments stressed using grant funds for planning and outreach activities, travel, and materials (including refreshments) for community planning meetings.

While questions did not address third party billing directly, several comments urged that funds be available for services not currently covered by Medicaid, including: certain Tier 2 interventions, participation in IEP meetings and teacher consultations, measurement-based care, and services for low-income individuals not covered by Medicaid including uninsured (often undocumented) students and students with high deductible plans.

The Consortium will continue to discuss other public comments related to: somatic health, academic and vocational supports, extra-curricular activities, the role of schools, crisis services, in-patient beds, specialized schools, and flexible emergency funds for families.

Ensuring priority for areas of greatest need: Overall, comments recommended a focus on areas with behavioral health provider shortages, greater socioeconomic need, high crime, populations lacking health insurance, populations with a higher number of limited English-speaking students, Community Schools, and schools with higher academic needs. Comments said rural Maryland lacks inpatient beds, behavioral health crisis services, and behavioral health providers.

Publicly available data that could be used to demonstrate need could include: local health department behavioral health needs assessments; Community Health Needs Assessments; mental health professional shortage area (HPSA) designations; Youth Risk Behavior Surveillance System (YRBS) data; Asset Limited, Income Constrained, Employed (ALICE) reports; percentages of students with Free and Reduced Meals; median income measures ; graduation rates; average wait times for services; and ratios of school counselors, psychologists, and social workers to students.

The Consortium will continue to discuss additional data that could be provided to help applicants design programs and develop applications, such as: number of students seen in Emergency Departments for overdoses and mental health incidents; Social Determinants of Health (SDOH) indicators; rate of change year on year in specific diagnoses among students including anxiety, depression, ADHD, and substance use by county; number of justice-involved students with a behavioral health diagnosis; Early Learning Assessment data; student homelessness counts; Kindergarten Readiness Assessment data; Department of Social Services data; Department of Juvenile Services data; mapping of service gaps; number of clinicians in each school; mobile crisis response data; and 211 or 911 call data.

Workforce challenges: Comments recommended more Tier 1 and Tier 2 services, and some shorter Tier 3 interventions, to help ensure that the limited workforce is allocated efficiently. Many comments focused on competitive wages and benefits, as well as wage disparities between behavioral health and somatic health providers. Some comments recommended benefits including paid time off for mental health days and mandatory respite days, as well as incentives to prevent burnout. Staff will be more likely to accept and stay in long-term positions than those which are dependent upon a short-term grant. Comments recommended hiring individuals from within the communities they serve, diversity in hiring, and housing relocation assistance. A supportive work environment, including supervision and consultation on complex cases, may help with retention.

Comments encouraged staffing plans to be broadened to include: graduate level licensed professionals, part time staff, volunteers, community health workers, and experienced parents. Some recommended working with colleges, universities, and faculty sponsors to develop behavioral health career pathways.

Comments encouraged paying staff for professional development and training including: continuing education requirements for licensure, stipends for attaining accreditation, paid training on evidence-based practices, and a professional learning collaborative with other behavioral health providers. One comment stressed using existing training programs rather than paying to develop new ones.

A few comments said technology could help address the workforce shortage, citing telehealth or Executive Functioning programming delivered via video/audio lessons or computer games.

Several comments expressed concern about schools and community providers competing for limited clinical staff. Instead, they recommended a Community-Partnered School-Based Behavioral Health Services Model, in which community agency-employed clinicians partner with schools to provide services in school buildings. Some comments recommended priority be given to programs that already have staff versus programs that need to hire new staff. Funds should not be used to supplant existing services.

The Consortium will continue to discuss recommendations to build the behavioral health workforce, such as stipends or scholarships for students pursuing degrees in behavioral health who commit to work in underserved communities after graduation (similar to DSS Title IV-E), loan repayment programs, and stipends for individuals completing internships in high needs areas.

Accountability metrics: Public comment recommended process measures including: total number of unduplicated individuals/families impacted at different stages such as marketing, education, screenings, referrals, assessments, interventions/treatment, social supports, etc.; active participation rate in services offered; number of Tier 2 and 3 (targeted) service encounters; expanded access to behavioral health or substance use treatment; number of partner organizations; and average wait time to access treatment. Outcome measures could include: number of students with decreased anxiety; number of students with decreased risk for suicidality; decreased substance use; attendance measures; attainment of social emotional goals on IEPs or therapy plans; satisfaction surveys; progress or setbacks evidenced using assessment tools (see below); school behavior data; referrals to emergency services; and Youth Risk Behavior Surveillance data.

While overall program data should be standardized across grantees, providers may wish to use different assessment tools to monitor treatment effectiveness at the individual patient level. These measures can then be used to report the number of children making overall progress or experiencing declines. Recommended assessment tools include: Patient Health Questionnaire (PHQ-9), Psychiatric Symptoms Checklist (PSC-17), Screen for Child Anxiety Related Disorders (SCARED), *General Anxiety Disorder (GAD-7),* Vanderbilt Assessment Scale, Personal Wellbeing Index (PWI), A Collaborative Outcomes Resource Network (ACORN) toolkit, Strengths and Difficulties Questionnaire (SDQ), Therapeutic Alliance Scale for Children (TASC), Social Foundations measures in the Early Learning Assessment, Child Behavior Checklist *(*CBCL*),* adaptive functioning assessments, Devereux Early Childhood Assessment (DECA), Columbia suicide assessment, and Psychological Wellbeing Scale (PWB).

Several comments recommended the standardization of data across grantees. One commenter observed, "In 2015, the School Behavioral Health Accountability Act (SB 494 / HB 713) was passed, which required the development of a standardized reporting mechanism to demonstrate the effectiveness of CP-SBH programs in the state through the collection of data on student outcomes, including academic, behavioral, social and emotional functioning and progress. This was a main recommendation from a 2015 report issued by the University of Maryland Center for School Mental Health, in collaboration with DHMH, the Maryland State Department of Education, and a range of stakeholders. Unfortunately, this has not been implemented or reported on, and significant gaps still remain around the collection of standardized data."

The Consortium will continue to discuss the use of metrics related to disengagement from school, students who become justice involved/juvenile services referrals, academic outcome measures, parent participation, and employee satisfaction. The Consortium will also continue to discuss partnering with the Maryland Longitudinal Data System.

Developing grant applications: Comments requested assistance in developing proposals and grant applications, such as: grant writing classes, webinars, pre-bid information sessions, help connecting providers within communities, and training on available data sets. The RFP should contain clear: instructions, applicant requirements, expectations, guidelines, deliverables, timelines, and evaluation criteria. One person commented that it would be helpful if the RFP identified payer sources and specifically allowed braided funding.

Criteria for evaluating grant applications: If funding is awarded competitively, comments recommended evaluating: (1) competencies of the applicant agencies, (2) program design and prospects for success, (3) engagement with families and communities, (4) ability to collaborate with partners, and (5) ability to demonstrate measurable outcomes.

(1) Comments recommended that applicants demonstrate: a history of working with children and schools; a deep understanding of the target community; a well-trained, culturally and linguistically competent staff; a credible staffing plan that reflects the community served; and a history of sound financial management. (2) Proposed programs should: be trauma-informed, holistic, and evidence-based; address both immediate needs of students as well as improve behavioral health systems; and address workforce challenges. (3) Programs should: engage with families and communities to understand their needs and when designing interventions, involve youth and other residents in planning and continuous feedback, involve parents in treatment plans, offer family strengthening opportunities, and have alternate treatment plans if parents are absent in the treatment/recovery process. (4) Proposals should describe: number of partners involved/providing services, deep collaboration with the school district and school staff including through a MOU, collaboration between public and private entities including Local Behavioral Health Authorities, and overall ability to be a "team player." (5) Applicants should demonstrate: capacity for data management and outcomes reporting; clear, quantifiable, and impactful outcomes measures; and a compelling cost-benefit ratio.

The Consortium will continue to discuss recommendations that grants be needs-based or formula-based rather than competitive, and ways to ensure smaller organizations are not placed at a disadvantage versus larger organizations with stronger grant-writing capabilities.

Data support: Many comments recommended the Consortium and CHRC provide training and technical assistance to grantees to support their data collection and reporting. Comments also recommended that grant funds be used to support hardware and software purchases including laptops and tablets, Zoom accounts, new EHRs, and customization of existing EHRs.

Comments requested a number of data systems. At the individual student level, several comments requested the Consortium to provide a data collection platform that could be used to deliver measurement-based care, such as Greenspace, and that the Consortium provide training and technical assistance to help grantees use the selected platform. At the Partnership level, comments requested a common platform for partners to share data across agencies and track referrals, enrollment, and participation. At the Consortium/statewide level, comments requested a centralized web portal for grantees to report data, and that this data be aggregated and made public.

The Consortium will consider these public comments as it prepares recommendations. Inclusion of comments in this report does not suggest their adoption by the Consortium.

Appendix A.

Questions for Public Comment

1. How should Behavioral Health Services be defined, for the purposes of the Consortium?

> For reference, “Behavioral Health Services” are defined in the Blueprint bill (HB 1300 (2020); Md. EDUCATION Code Ann. §7-4470) as: “trauma-informed prevention, intervention, and treatment services for the social-emotional, psychological, and behavioral health of students, including mental health and substance use disorders.”
>
> “Behavioral Health Services” are defined in the Maryland Health General Code (Md. HEALTH-GENERAL Code Ann. § _7.5-101) as including: "prevention, screening, early intervention, treatment, recovery, support, wraparound, and rehabilitation services, for individuals with substance related disorders, addictive disorders, mental disorders, or a combination of these disorders.

2. What kinds of behavioral health services should be given top priority for funding in the first round of Coordinated Community Supports Partnership grants?

3. What “tiers” should be given priority during the first round of grants — universal services for all students, targeted/small group services for selected students with greater needs, or intensive/one-on-one services for only students with the greatest needs?

4. In addition to behavioral health services, what other kinds of social services, supports, and wraparound services should the grants fund in order to meet students’ other related needs? What requirements should exist for these “other” grant-funded services to make sure they fit within the Consortium’s mission?

5. How should the program be structured to make sure funding goes where it is most needed? How should areas of need be determined?

6. How could grant funding be used to: address challenges in hiring and retaining behavioral health personnel, build capacity/train/expand the behavioral health workforce, and ensure new staff positions will be sustained?

7. If grant funding is awarded competitively, what should be the criteria for judging applicants?

8. What activities, services, and other capacity building costs should be allowed to be funded in the first round of grants?

9. What behavioral health data should the Consortium use to measure the success of Community Supports Partnerships? What educational health data should the Consortium use to measure the success of Community Supports Partnerships?

10. What behavioral health data or resources could the Consortium provide to grant applicants to help them develop their proposals? What education data or resources could the Consortium provide to grant applicants to help them develop their proposals?

11. What measures should the Consortium use to assess whether its programs are making a difference with individual students? What behavioral health measurement tools should Community Support Partnership grantees be required to use to report their results to the Consortium? What education measurement tools should Community Support Partnership grantees be required to use?

12. What tools, support, and/or digital platforms should the Consortium provide to grantees to help them with data collection and reporting?

Appendix A.

List of individuals providing public comment

1. Gerardo Grasso, LMSW/ Restorative Behavioral Health, Inc.
2. Kristin Dietz, Caroline County Health Dept.
3. Angela Ford, LCSW-C Maple Shade Youth and Family Services
4. Liz Tung, Abell Foundation
5. Jennifer Tuerke, Voices of Hope, Inc.
6. Breianna Hulede, Youth First Care Program
7. Kat Stork Blaher, contracted Local Care Team Coordinator for Caroline County and facilitator for the Caroline Collective Impact Initiative
8. Stefanie Johnson, His Hope Ministries
9. Poonam Ethakotu, LCPC, Sheppard Pratt PGCPS Youth First Care Program
10. Alethea C. Rudolph, Sheppard Pratt
11. Stephanie Mobley, Sheppard Pratt Youth First Care Program
12. Amanda Marcus, Sheppard Pratt
13. Joanna Bache Tobin, Board of Education of Anne Arundel County
14. C. Gray, Anne Arundel County Mental Health Agency
15. Susan Stewart, AHEC West
16. Coleen, Creative Counseling
17. L. Ashby, University of Maryland
18. Sonia Sherlekar, Sheppard Pratt
19. Kami Wagner, Howard County Public School System
20. Jessica Mellon, 4-H Educator, University of Maryland Extension- Allegany County
21. Mary Vansickle Garrett County Public Schools
22. Malcolm Furgol, Frederick County Health Care Coalition
23. Tara Barrett, Worcester County
24. Dr. Paula Langford, LICSW, MAC, The Healing Institute
25. Tawanda Epps
26. Stephanie Reid, Howard County Health Department
27. Anita Mwalui, Community Engagement & Consultation Group Inc.
28. Lopez, Kennedy Krieger
29. Lisa Beauvois, Johns Hopkins
30. Neriza Candelario, School Social Worker
31. Mary Dee Oxen, School Counselor, Carroll County Public Schools, North Carroll Middle School, Hampstead, MD
32. Kathi Green, Carroll County Schools
33. Diana Ray, Holy Apostles College & Seminary
34. Danette Colvin, LCSW-C, Baltimore City Public Schools
35. Scott Birdsong, LCSW-C, ACSW, retired from Sheppard Pratt, currently involved in adjunct field liaison work with UMSSW
36. Denise2942@gmail.com
37. Holly Flanagan, school social worker
38. Nancy Golczewski, parent of four former Harford County Public School students
39. Melissa Romano, Coordinator of Special Education- Birth to 5 Harford County Public Schools
40. Bernard Hennigan, Harford County Public Schools
41. Allyson Martz, Garrett County Public Schools
42. Mozella Williams, MD, CMO West Cecil Health Center, Inc.
43. Lynn Nixon, Worcester County State's Attorney's Office
44. Tara Kearns, Wicomico County Board of Education

45. Abila Tazanu, M.D., pediatrician, mother with Spectrum of Hope- Health, Wellness and Community Services
46. Sue Miller
47. Anneke Hamrick, Baltimore City Public Schools
48. Brianne Hahn, Thrive Behavioral Health
49. Karen Kiesewetter, StayAfloat Tools
50. Geneva Rieu, DHS
51. Monica Kiefer, LCSW-C CPS, Supervisor Anne Arundel County DSS
52. Katie Andrew
53. Brigkealy@outlook.com
54. Adrienne Mickler, Anne Arundel County Mental Health Agency
55. Rich Ceruolo, Policy Director, Parent Advocacy Consortium
56. Dennis D. Embry, Ph.D., President/Senior Scientist, PAXIS Institute & Co-Investigator, Johns Hopkins Center for Prevention and Early Intervention, Board Member, National Federation of Families for Children's Mental Health Scientific Advisor, Children's Mental Health Network
57. Kentavius Jones, Talbot Mentors
58. Leonard Arvi, Salisbury University
59. Thomas M Bruggman, PhD 50
60. Wendy Anne Levy
61. M N Banis
62. Lauren Grimes, Community Behavioral Health Association of MD
63. Marjorie Gold, LCPC
64. Keisha Peterson Department of Human Services, SSA
65. Stacey Jefferson, Behavioral Health System Baltimore
66. Jakobjer, Washington County Public Schools, Offices of Student Services, School Counseling, and Special Education
67. Jason Zhao, Community Health Initiative, Inc.
68. Linda Raines, CEO, BrainFutures
69. Margo Quinlan, Maryland Children's Behavioral Health Coalition
70. Estela, Chesapeake Multicultural Resource Center
71. Carl Fornoff & Regan Vaughan, Catholic Charities of Baltimore
72. Andrea Carroll, Board of Child Care
73. Yecenia Castillo, La Clinica del Pueblo
74. Scott Tiffin
75. Elizabeth Smith, Potomac Case Management Services
76. Barbara Allen, James' Place Inc.
77. Keith Fanjoy, LCSW-C, President & CEO, San Mar Family & Community Services
78. Sam Wilt, LCSW-C, CCTP, C-SSWS, Frederick County Public Schools
79. Megan Pantelis, Thrive Behavioral Health
80. Taylor Clinton, Healing Youth Alliance
81. Catherine Carter, Let Them See Clearly

Kick-Off Meeting of the

Maryland Consortium on Coordinated Community Supports
Wednesday, August 17, 2022

Virtual Meeting
10:00 AM – 11:30 AM

CONSORTIUM MEMBERS IN ATTENDANCE:

1. David D. Rudolph, Chair, Maryland Consortium on Coordinated Community Supports
2. Edward Kasemeyer, Chair, Maryland Community Health Resources Commission (CHRC)
3. Robin Rickard, Executive Director, Opioid Operational Command Center, Maryland Department of Health
4. Emily Bauer, Two-Generation Program Officer, Office of the Secretary, Department of Human Services
5. Cory Fink, Executive Director, Juvenile Services Education Program, Department of Juvenile Services
6. Mohammed Choudhury, Superintendent, Maryland Department of Education
7. Tanya Filson, Director of Community Schools, Maryland Department of Education
8. Chrissy Bartz, Director of Community Based Programs, Choptank Community Health Systems
9. Dr. Derek Simmons, Superintendent, Caroline County Public Schools
10. Tammy Fraley, Allegany County Board of Education
11. Russell Leone, President, Teacher's Association of Anne Arundel County
12. Gail Martin, former Baltimore County Public Schools Team Leader, School Social Work
13. Dr. John Campo, MD, Director of Mental Health, Johns Hopkins Children's Center, Johns Hopkins University Hospital
14. Larry Epp, Ed.D., Director of Outcomes and Innovation, Families and Communities Service Line, Sheppard Pratt Health System
15. Gloria Brown Burnett, Director, Prince George's County Department of Social Services
16. Michael A. Trader, II, Assistant Director of Behavioral Health, Worcester County Health Department
17. Sadiya Muqueeth, Dr.PH, Director of Community Health, National Programs, Trust for Public Lands, and member, Maryland Community Health Resources Commission
18. Linda Rittelmann, Senior Manager, Medicaid Behavioral Health ASO, Maryland Department of Health

WELCOME

Chair Rudolph and Chair Kasemeyer welcomed the group. Senator Melony Griffith shared greetings from the Maryland General Assembly. Chair Rudolph invited attendees to introduce themselves.

OVERVIEW OF BLUEPRINT LEGISLATION AND ACCOUNTABILITY AND IMPLEMENTATION BOARD

Blueprint Accountability and Implementation Board (AIB) Executive Director Rachel Hise shared a presentation on the evolution of the Blueprint for Maryland's Future bill that created the Consortium. The Consortium is part of "Pillar 4" of the overall Blueprint. The AIB monitors implementation of all Blueprint programs, including the Consortium.

OVERVIEW OF CONSORTIUM LEGISLATION

CHRC Executive Director Mark Luckner and Assistant Attorney General Michael Conti discussed the purposes and duties of the Consortium as provided by HB 1300 of 2020 and SB 802 of 2022.

OVERVIEW OF CHRC

CHRC Chair Ed Kasemeyer provided background on the work of the CHRC, which will act as the fiscal agent to execute the Coordinated Community Support Partnership grant program.

IMMEDIATE NEXT STEPS AND SUBCOMMITTEES

Chair Rudolph and Mr. Luckner described four proposed Consortium Subcommittees.

The Framework, Design, & RFP Subcommittee will develop a statewide framework to establish community support partnerships, and issue recommendations that will inform the future Call for Proposals. The Data Collection/Analysis & Program Evaluation Subcommittee will evaluate current available data to establish baseline for measuring the impact of the Consortium and community support partnerships. The Outreach and Community Engagement Subcommittee will engage stakeholders to make them aware of the program and funding opportunity. The Multi-Tiered Systems of Support Best Practices Subcommittee will offer recommendations and best practices for community partnerships to provide behavioral health and wraparound services.

The Framework, Design, & RFP and Data Collection/Analysis & Program Evaluation Subcommittees will meet weekly beginning during the second half of September. They will produce a report for the Consortium in mid-November. The Outreach and Community Engagement Subcommittee will begin meeting in October/November. Mr. Luckner asked Consortium members to contact CHRC staff to select a Subcommittee on which to serve.

Looking ahead, the second full Consortium meeting will occur on September 22, 2022, and the third meeting will be between October 17-21.

ETHICS FILINGS

Mr. Luckner said the Ethics Commission recently advised that Consortium members must submit an appointee exemption form and annual financial disclosure within 30 days of the Consortium's first meeting. AAG Conti urged Consortium members to be as comprehensive as possible in filling out these forms.

ADJOURNMENT

Chair Rudolph made a motion to adjourn the meeting. Mr. Fink seconded the motion. The motion was approved unanimously, and the meeting adjourned at 11:20 a.m.

Meeting of the
Maryland Consortium on Coordinated Community Supports

Thursday, September 22, 2022
In-Person & Virtual Meeting
1450 S. Rolling Road, Halethorpe, MD

9:30 AM – 12:10 PM

CONSORTIUM MEMBERS IN ATTENDANCE:

1. David D. Rudolph, Chair, Maryland Consortium on Coordinated Community Supports
2. Robin Rickard, Executive Director, Opioid Operational Command Center, Maryland Department of Health
3. Emily Bauer, Two-Generation Program Officer, Office of the Secretary, Department of Human Services
4. Cory Fink, Executive Director, Juvenile Services Education Program, Department of Juvenile Services
5. Mohammed Choudhury, Superintendent, Maryland Department of Education
6. Christina Bartz, Director of Community Based Programs, Choptank Community Health Systems
7. Dr. Derek Simmons, Superintendent, Caroline County Public Schools
8. Tammy Fraley, Allegany County Board of Education
9. Gail Martin, former Baltimore County Public Schools Team Leader, School Social Work
10. D'Andrea Jacobs, School Psychologist, Baltimore County Public Schools
11. Dr. John Campo, MD, Director of Mental Health, Johns Hopkins Children's Center, Johns Hopkins University Hospital
12. Larry Epp, Ed.D., Director of Outcomes and Innovation, Families and Communities Service Line, Sheppard Pratt Health System
13. Gloria Brown Burnett, Director, Prince George's County Department of Social Services
14. Michael A. Trader, II, Assistant Director of Behavioral Health, Worcester County Health Department
15. Sadiya Muqueeth, Dr.PH, Director of Community Health, National Programs, Trust for Public Lands, and member, Maryland Community Health Resources Commission
16. Linda Rittelmann, Senior Manager, Medicaid Behavioral Health ASO, Maryland Department of Health

Also in attendance were Brandon Engle, Chief of Staff, Office of Senator Katie Fry Hester; Dr. Mary Gable, Assistant Superintendent, Division of Student Support, Academic Enrichment, & Educational Policy, Maryland State Department of Education; Michael Herschenfeld, Senior Executive Director, Strategic Planning and Continuous Improvement, Maryland State Department of Education; Dr. Shelly Choo, Director, Maternal and Child Health Bureau, Maryland Department of Health; Dr. Maria Rodowski-Stanco, Director, Child, Adolescent and Young Adult Services, Behavioral Health Administration, Maryland Department of Health; Sharon Hoover, Professor, Division of Child and Adolescent Psychiatry and co-Director, National Center for School Mental Health, University of Maryland School of Medicine; AAG Michael Conti; CHRC Executive Director Mark Luckner; other staff; and members of the public.

WELCOME

Chair Rudolph welcomed the group and invited attendees to introduce themselves.

MEETING MINUTES

A review of the August 17, 2022, minutes was held. Robin Rickard made a motion to accept the August 17, 2022, minutes as presented, and the motion was seconded by Derek Simmons. The minutes were approved unanimously.

PRESENTATION BY THE MARYLAND DEPARTMENT OF HEALTH

Linda Rittlemann, Shelly Choo, and Maria Rodowski-Stanco gave a presentation on existing student behavioral health efforts by the Maryland Department of Health, including School-Based Health Centers and Mobile Response & Stabilization Services.

Larry Epp suggested telehealth be used to expand behavioral health services at school-based health centers and school health services. Gail Martin commented on the lack of beds for short-term stabilization. Chair Rudolph asked about staffing challenges and efforts to ensure a face-to-face response within one hour. Dr. Rodowski-Stanco replied that connections via telehealth have helped to ensure higher level providers are able to assist in crisis situations in remote areas. Chair Rudolph encouraged collaboration between the Consortium and the Department on data. Gloria Brown Burnett asked whether legislation would be required to ensure these programs continue in the next administration, and Dr. Rodowski-Stanco responded that these systems are designed to continue.

PRESENTATION BY THE MARYLAND STATE DEPARTMENT OF EDUCATION

Superintendent Choudhury gave a presentation about: student mental health, Community Schools in Maryland, School-Based Health Centers, the Mental Health Response Program, the Maryland Leads initiative, leveraging Medicaid funding, and the collective impact model.

Linda Rittlemann agreed on the need to expand Medicaid coverage for services provided in schools. In response to a question from a member of the public, Superintendent Choudhury confirmed that the position of Director of Community Schools is currently vacant, and that Mary Gable will fill this role on the Consortium while the Department recruits for a new Director of Community Schools.

PRESENTATION BY THE NATIONAL CENTER ON SCHOOL MENTAL HEALTH

Sharon Hoover, Co-Director of the National Center on School Mental Health, gave a presentation about the National Center and some of its resources, including the SHAPE System, "Guidance from the Field," and Classroom WISE; and provided examples of best practices in Maryland and other states.

CONSORTIUM SUBCOMMITTEES AND NEXT STEPS

Chair Rudolph and CHRC Executive Director Mark Luckner described the four Consortium Subcommittees and shared a copy of Consortium members' Subcommittee assignments. The four Subcommittees are: Framework, Design, & RFP; Data Collection/Analysis & Program Evaluation; Outreach and Community Engagement; and Best Practices. The Consortium's 12 legislatively required purposes and duties have each been assigned to a Subcommittee.

Superintendent Choudhury and CHRC Commissioner Sadiya Muqueeth will co-chair the Framework, Design, & RFP Subcommittee, and the other Subcommittee chairs will be announced when they are determined. The Framework and Data Subcommittees will receive structured feedback from the public during the fall of 2022. They will meet weekly, and report out to the full Consortium in November.

The next two meetings of the full Consortium have been scheduled for October 18 and November 15. They will be in-person with a virtual option. The Call for Proposals will be issued by the CHRC during the first quarter of calendar year 2023.

Mr. Luckner told Consortium members they are eligible receive reimbursement for mileage, and to contact Jen Clatterbuck at the Commission for more information.

ADJOURNMENT

Superintendent Choudhury made a motion to adjourn the meeting. Chair Rudolph seconded the motion. The motion was approved unanimously, and the meeting adjourned at 12:10 p.m.

Appendix B.

Meeting of the
Maryland Consortium on Coordinated Community Supports

Tuesday, October 18, 2022
In-Person & Virtual Meeting
1450 S. Rolling Road, Halethorpe, MD

9:30 AM – 11:30 AM

CONSORTIUM MEMBERS IN ATTENDANCE:

1. David D. Rudolph, Chair, Maryland Consortium on Coordinated Community Supports
2. The Honorable Katie Fry Hester, Maryland Senate
3. Robin Rickard, Maryland Department of Health | Executive Director, Opioid Operational Command Center
4. Emily Bauer, Maryland Department of Human Services | Two-Generation Program Officer
5. Cory Fink, Department of Juvenile Services | Deputy Secretary for Community Operations
6. Mohammed Choudhury, Maryland Department of Education | State Superintendent
7. Edward Kasemeyer, Maryland Community Health Resources Commission | Chair
8. Mary Gable, Director of Community Schools | Assistant Superintendent, Division of Student Support, Academic Enrichment, & Educational Policy, Maryland State Department of Education
9. Christina Bartz, Council on Advancement of School-Based Health Centers | Director of Community Based Programs, Choptank Community Health Systems
10. Dr. Derek Simmons, Public School Superintendents Association of Maryland | Superintendent, Caroline County Public Schools
11. Tammy Fraley, Maryland Association of Boards of Education | Allegany County Board of Education
12. Gail Martin, Maryland Chapter of the National Association of Social Workers | former Baltimore County Public Schools Team Leader, School Social Work
13. D'Andrea Jacobs, PhD., Maryland School Psychologists Association | School Psychologist, Baltimore County Public Schools
14. Dr. John Campo, MD, Maryland Hospital Association | Director of Mental Health, Johns Hopkins Children's Center, Johns Hopkins University Hospital
15. Larry Epp, Ed.D., representative of the community behavioral health community with telehealth expertise | Director of Outcomes and Innovation, Families and Communities Service Line, Sheppard Pratt Health System
16. Michael A. Trader, II, representative of local departments of health | Assistant Director of Behavioral Health, Worcester County Health Department
17. Linda Rittelmann, representative of the Maryland Medical Assistance Program | Senior Manager, Medicaid Behavioral Health ASO, Maryland Department of Health

Also in attendance were: Dr. Maria Rodowski-Stanco, Director, Child, Adolescent and Young Adult Services, Behavioral Health Administration, Maryland Department of Health; Nancy Lever, PhD, Associate Professor, Division of Child and Adolescent Psychiatry and co-Director, National Center for School Mental Health, University of Maryland School of Medicine; AAG Michael Conti; CHRC Executive Director Mark Luckner; other staff; and members of the public.

WELCOME

Chair Rudolph welcomed the group and invited attendees to introduce themselves.

MEETING MINUTES

A review of the September 18, 2022, minutes was held. John Campo made a motion to accept the September 18, 2022, minutes as presented at the meeting, and the motion was seconded by Derek Simmons. The minutes were approved unanimously.

SUBCOMMITTEE UPDATES

Chair Rudolph introduced the Consortium's Subcommittee Chairs.

Robin Rickard, who will co-chair the Outreach and Engagement Subcommittee with Tammy Fraley, announced that the Subcommittee will have its first meeting on Monday, October 24 in Rocky Gap, MD. The Subcommittee's first task will be to support outreach around the public comment period and the questions developed by the Framework and Data Subcommittees.

John Campo and Derek Simmons, co-chairs of the Best Practices Subcommittee, said their Subcommittee will look to identify best practices for behavioral health services for all three tiers of the Multi-Tiered System of Supports (MTSS).

Superintendent Choudhury, who co-chairs the Framework, Design & RFP Subcommittee with Sadiya Muqueeth, DrPH, reported that the Subcommittee has met twice, and has finalized questions for the public comment period. The Subcommittee is having robust conversations about how broad or focused the RFP should be, and looks forward to receiving more feedback.

Larry Epp said the Data Collection/Analysis and Program Evaluation subcommittee received a presentation from Matt Duque about MSDE data sources related to attendance, discipline, and other measures. The Subcommittee looks forward to future briefings from other experts, and to continuing discussions about ensuring that data drives ongoing decision-making and measurement-based care. The Subcommittee is finalizing questions for public comment.

DISCUSSION OF OVERALL PROGRAM STRUCTURE

Mark Luckner reviewed the current timeline for program implementation. The public comment period will begin soon and last approximately three weeks. The next full Consortium meeting will take place on November 15, 2022. The Consortium will submit its first required legislative report in December 2022. In spring 2023, the CHRC will issue the first Coordinated Community Supports Partnership Call for Proposals.

Consortium members then held a discussion on four key questions: How should the overall success and impact of the Consortium be determined/measured? How should the overall success and impact of Community Support Partnerships be determined/measured? What are examples of activities that grant funding should support? Should the first round of grants support both planning/capacity building and service delivery?

ADJOURNMENT

Robin Rickard made a motion to adjourn the meeting. John Campo seconded the motion. The motion was approved unanimously, and the meeting adjourned at 11:30 a.m.

Appendix B.

Meeting of the
Maryland Consortium on Coordinated Community Supports

Tuesday, November 15, 2022
In-Person & Virtual Meeting
1450 S. Rolling Road, Halethorpe, MD

9:30 AM – 11:30 AM

CONSORTIUM MEMBERS IN ATTENDANCE:

1. David D. Rudolph, Chair, Maryland Consortium on Coordinated Community Supports
2. Robin Rickard, Maryland Department of Health | Executive Director, Opioid Operational Command Center
3. Emily Bauer, Maryland Department of Human Services | Two-Generation Program Officer
4. Mohammed Choudhury, Maryland Department of Education | State Superintendent
5. Edward Kasemeyer, Maryland Community Health Resources Commission | Chair
6. Mary Gable, Director of Community Schools | Assistant Superintendent, Division of Student Support, Academic Enrichment, & Educational Policy, Maryland State Department of Education
7. Christina Bartz, Council on Advancement of School-Based Health Centers | Director of Community Based Programs, Choptank Community Health Systems
8. Dr. Derek Simmons, Public School Superintendents Association of Maryland | Superintendent, Caroline County Public Schools
9. Tammy Fraley, Maryland Association of Boards of Education | Allegany County Board of Education
10. Gail Martin, Maryland Chapter of the National Association of Social Workers | former Baltimore County Public Schools Team Leader, School Social Work
11. D'Andrea Jacobs, PhD., Maryland School Psychologists Association | School Psychologist, Baltimore County Public Schools
12. Dr. John Campo, MD, Maryland Hospital Association | Director of Mental Health, Johns Hopkins Children's Center, Johns Hopkins University Hospital
13. Sadiya Muqueeth, Dr.PH, Maryland Community Health Resources Commission | Director of Community Health, National Programs, Trust for Public Lands
14. Larry Epp, Ed.D., representative of the community behavioral health community with telehealth expertise | Director of Outcomes and Innovation, Families and Communities Service Line, Sheppard Pratt Health System
15. Gloria Brown Burnett, local Department of Social Services | Director, Prince George's County Department of Social Services
16. Michael A. Trader, II, representative of local departments of health | Assistant Director of Behavioral Health, Worcester County Health Department
17. Dr. Kandice Taylor, member of the public with expertise in equity in education | School Safety Manager, Baltimore County Public Schools

Also in attendance were: Nancy Lever, PhD, Associate Professor, Division of Child and Adolescent Psychiatry and co-Director, National Center for School Mental Health, University of Maryland School of Medicine; AAG Michael Conti; CHRC Executive Director Mark Luckner; other staff; and members of the public.

WELCOME

Chair Rudolph welcomed the group and invited Dr. Kandice Taylor, newly appointed to the Consortium, to introduce herself.

MEETING MINUTES

A review of the October 18, 2022, minutes was held. Gail Martin made a motion to accept the October 18, 2022, minutes as presented at the meeting, and the motion was seconded by Ed Kasemeyer. The minutes were approved unanimously.

PRESENTATION ON SUBSTANCE USE DISORDER PROGRAMS

Robin Rickard, Executive Director of the Opioid Operational Command Center, briefed the Consortium on youth substance use supports.

SUBCOMMITTEE UPDATES

Chair Rudolph invited each of the Consortium's Subcommittee Chairs to provide an update.

Framework, Design & RFP Subcommittee Co-Chairs Superintendent Choudhury and Dr. Sadiya Muqueeth updated the Consortium on the Subcommittee's work. The Subcommittee is proposing a collective impact model for grants using Hubs and Spokes. Hubs will coordinate services, perform fiduciary responsibilities, and collect and report data. Spokes will be the service providers. In the first year, the Subcommittee recommends that grant funds should support both Hubs and Spokes directly, but that eventually all Spokes should be subgrantees of Hubs.

Data Collection/Analysis and Program Evaluation Subcommittee Chair Larry Epp shared some of the Subcommittee's thinking on potential data metrics for overall program evaluation as well as measurement-based care at the individual student level. He shared slides with proposed goals and indicators for further consideration by Consortium members.

Outreach and Engagement Subcommittee Co-Chairs Tammy Fraley and Robin Rickard discussed the Consortium's on-going public comment period. So far, over 55 individuals have provided written or oral comments, and the public comment period will end on November 16. These individuals include both behavioral health and/or education stakeholders from all regions of the state. A summary of some themes can be found in the slides.

Best Practices Subcommittee Co-Chairs John Campo and Derek Simmons said their Subcommittee will continue working to identify best practices for behavioral health services for all three tiers of the Multi-Tiered System of Supports (MTSS) that align with the overall program goals and indicators.

CONSORTIUM LEGISLATIVE REPORT

Chair Rudolph said the Consortium has requested an extension on the deadline to submit its first annual report so that more substantive information can be included. The draft report will be sent to Consortium members in advance of the next meeting on December 13, and will be voted on at that meeting.

NEXT STEPS

Chair Rudolph said the next meeting of the Consortium will be held on December 13, and the following meeting will be held on January 10.

ADJOURNMENT

Robin Rickard made a motion to adjourn the meeting. Gail Martin seconded the motion. The motion was approved unanimously, and the meeting adjourned at 11:30 a.m.