Behavioral Health Care Treatment and Access Commission 2023 Report

Health General Article, Section 13-4807

Maryland Department of Health

January 29, 2024

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The Honorable William C. Ferguson
President of the Maryland Senate
H-107 Maryland State House
Annapolis, MD 21401-1991

The Honorable Adrienne A. Jones
Speaker of the Maryland House of Delegates
H-101 Maryland State House
Annapolis, MD 21401-1991

Re: 2023 Behavioral Health Care Treatment and Access Commission Report (MSAR #14758)

Dear President Ferguson and Speaker Jones,

In keeping with the requirements of House Bill 1148 (Chapter 291, 2023) and Senate Bill 582 (Chapter 290, 2023), I, as the chair of the Commission on Behavioral Health Care Treatment and Access, respectfully submit the Commission's initial report.

Specifically, the report is responsive to the following requirements:

(A) (1) *On or before January 1 each year, beginning in 2024, the Commission shall report to the Governor and, in accordance with § 2-1257 of the State Government Article, the General Assembly on the Commission's findings and recommendations, including funding and legislative recommendations, that are consistent with providing appropriate, accessible, and comprehensive behavioral health services that are available on demand to individuals in the State across the behavioral health continuum.*

(2) Any Legislative Recommendations included in the report required under paragraph (1) of this subsection that require funding shall include an estimate of the funding required to implement the recommendation and information that supports the funding estimate.

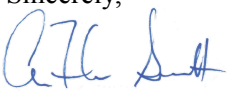
(B) The report required on or before January 1, 2023, shall include the findings of the needs assessment required under § 13-4805 of this subtitle.

I am pleased to submit this report on the initial work and progress made by the Commission. The work of the sub-committees and full commission has been done in close partnership with the Maryland Department of Health, with the ultimate goal of defining and strengthening Maryland's public behavioral health system from prevention to long-term treatment and recovery. It is essential that the public behavioral health system reflects a continuum of care that provides culturally competent crisis services, addresses ongoing mental health and substance use needs, and supports individuals who are re-entering their communities.

This past year, the Moore-Miller administration made a significant down payment, $107.5 million, in the public behavioral health system. These budget dollars have funded statewide priorities that will make a significant impact on addressing current gaps in behavioral health care. These investments include the expansion of the Collaborative Care Model through Medicaid to enable primary care coordination for Medicaid beneficiaries with a mental health diagnosis, increased numbers of high intensity beds in the State, and further development of a statewide crisis network with mobile crisis teams and crisis stabilization units. These investments lay the foundation for future policy recommendations from this Commission. I look forward to the continued partnership with the Commission and its sub-committees.

If you have any questions about this report, please contact Sarah Case-Herron, Director, Office of Governmental Affairs, at sarah.case-herron@maryland.gov.

Sincerely,



Laura Herrera Scott, MD., M.P.H.
Secretary

cc: Marie Grant, Assistant Secretary for Health Policy
Sarah Case-Herron, Director, Office of Governmental Affairs
Alyssa Lord, Deputy Secretary, Behavioral Health Administration
Sarah Albert, Department of Legislative Services (5 Copies) (MSAR #14758)

Introduction

Chapter 291 of 2023 (Behavioral Health Care - Treatment and Access (Behavioral Health Model for Maryland)) established the Commission on Behavioral Health Care Treatment and Access at the Maryland Department of Health (MDH), set to sunset in 2027. Dr. Laura Herrera Scott, Secretary of Health was appointed by the Governor, the President of the Senate, and the Speaker of the House to chair the Commission. The other 37 members to the Commission were selected based on the criteria in the law. A full listing of Commission members is included in Appendix A.

The purpose of the Commission is to make recommendations to provide appropriate, accessible, and comprehensive behavioral health services that are available on demand to individuals in the State across the behavioral health continuum. Specifically, the Commission is tasked with the following responsibilities:

1. Conduct an assessment of behavioral health services in the State to identify needs and gaps in services across the continuum, including community–based outpatient and support services, crisis response, and inpatient care;
2. Examine the methods for reimbursing behavioral health care services in the State and make recommendations on the most effective forms of reimbursement to maximize service delivery;
3. Compile findings of State–specific needs assessments related to behavioral health care services;
4. Review recommendations and reports of State commissions, workgroups, or task forces related to behavioral health care services;
5. Conduct a needs assessment on the State's behavioral health care workforce to identify gaps and make recommendations to ensure an adequate, culturally competent, and diverse workforce across the behavioral health care continuum;
6. Review trends and best practices from other states regarding policy and reimbursement strategies that support access to a comprehensive array of services and ensure quality of care;
7. Examine and make recommendations related to the behavioral health of the geriatric and youth populations in the state;
8. Examine and make recommendations to provide appropriate and adequate behavioral health services to individuals with developmental disabilities and complex behavioral health needs, specifically youth;
9. Assess the health infrastructure, facilities, personnel, and services available for the State's forensic population and identify deficiencies in resources and policies needed to prioritize health outcomes, increase public safety, and reduce recidivism;
10. Make recommendations on expanding behavioral health treatment access for the State's court–ordered population;
11. Make recommendations on action plans regarding the behavioral health care system's capacity to prepare for and respond to future challenges affecting the entire State or

particular regions or populations in the State, including pandemics and extreme weather events;

12. Make recommendations to ensure that behavioral health treatment is provided in the appropriate setting, including methods to divert behavioral health patients from emergency departments by using the Maryland Mental Health and Substance Use Disorder Registry and Referral System established under § 7.5–802 of this article and 2–1–1;
13. Examine and review the use of harm reduction strategies to facilitate access to care; and
14. Examine methods to assist consumers in accessing behavioral health services.

In its first year, the Commission and its workgroups focused on two key tasks: (1) reviewing recommendations and reports of State Commissions, Workgroups, or Task Forces related to behavioral health care services; and (2) assessing behavioral health services in the State to identify needs and gaps in services across the continuum, including community-based outpatient and support services, crisis response, and inpatient care. These two mandates are viewed as foundational tasks that were critical to guide the Commission in its future work.

In the first six months since the law was enacted, the full Commission met twice with opportunities for stakeholder input at each meeting. Stakeholders additionally had the opportunity to submit written comments, for the Commission's review, after each meeting. The statute mandated that four workgroups be established, hold meetings and report back to the full Commission. These workgroups are: (1) Geriatric Behavioral Health; (2) Youth Behavioral Health, Individuals with Developmental Disabilities, and Individuals with Complex Behavioral Health Needs; (3) Criminal Justice- Involved Behavioral Health; and (4) Behavioral Health Workforce Development, Infrastructure, Coordination, and Financing.

This report is organized into 5 sections. First, the report reviews prior recommendations and reports related to behavioral health care services. Second, the report contains the initial findings of the assessment of behavioral health services described above. The third section of this report provides a summary of the Commission's meetings in 2023. The fourth section outlines initial work done by the four statutorily mandated workgroups described above. Reports from each workgroup are included in Appendix B. Finally, the fifth section describes the Commission's initiatives for the coming year and its organizational structure.

Part 1: Review of Prior Recommendations and Reports

The authorizing statute requires the Commission to review prior recommendations and reports of State Commissions, Workgroups, or Task Forces related to behavioral health care services. A multidisciplinary team of eight staff from MDH identified and reviewed reports issued from 2011 – 2022, including the following:

- *Joint Chairmen's Report (JCR)* submissions and other statutorily mandated reports;
- Prior reports from the Behavioral Health Advisory Council; and
- Prior reports issued by the Opioid Operational Command Center (OOCC) including the Data-Informed Overdose Risk Mitigation (DORM) reports.

Staff identified, reviewed, and summarized a total of 65 reports and synthesized the reports' findings and

recommendations for the Commission's review. MDH also sought guidance from librarians at the Department of Legislative Services to ensure that the list of reports in its review was comprehensive. A full list of the reports that staff identified and reviewed through this process are included in Appendix C.

Prior Work of the Behavioral Health Advisory Council. The Commission examined reports and recommendations made previously by the Behavioral Health Advisory Council (BHA). Pursuant to the Maryland Code Annotated, Health - General §7.5–305 and Federal Public Law 102-321, the State of Maryland established the BHAC in 2016 to promote and advocate for:

- Planning, policy, workforce development, and services to ensure a coordinated, quality system of care that is outcome-guided and that integrates prevention, recovery, evidence–based practices, and cost-effective strategies that enhance behavioral health services across the state; and
- A culturally competent and comprehensive approach to publicly funded prevention, early intervention, treatment and recovery services that support and foster wellness, recovery, resiliency, and health for individuals who have behavioral health disorders and their family members.

The BHAC consists of 28 members (or designees) representing State and local government, the Judiciary, and the Legislature, including 13 members appointed by the Secretary of Health representing behavioral health provider and consumer advocacy groups and 14 representatives that include a diverse range of individuals who are consumers, family members, professionals, and involved community members. Many of the BHAC members also serve on the Commission.

MDH staff reviewed BHAC reports submitted between 2016 and 2022. These reports documented findings and/or action areas related to:

- Examining the crisis response system in the State, including gaps in coverage and disparities between urban and rural programs;
- Advocating for expansion of a continuum of care in Maryland, including focusing on recovery housing and recovery services; and
- Developing online support, training, and waivers to allow out of State providers to offer telehealth services to patients in the State.

Through these reports, the BHAC made several recommendations, including-

- Expanding rehabilitation services, such as-
    - working on improvements in sustainability of programs, placement flow, and aftercare opportunities, and
    - developing and expanding recovery housing/halfway housing services for rehabilitation, and addressing competency admission delays in providing service (2021);
- Establishing crisis walk-in and mobile crisis team models for each jurisdiction (2019); and
- Addressing workforce shortages, funding and accountability, transportation accessibility, and public awareness (2018).

Geriatric-Related Reports. The Commission identified four reports related to geriatric behavioral health:

- Bed Registry Workgroup Accomplishments (2022);
- JCR on Cognitive Health Plan for Maryland (2022);
- JCR on Pre-Admission Screening and Resident Review Program (PASRR) (2021); and
- JCR on Individuals with Serious Mental Illness and Aging in Place (2013).

Among other things, these reports focus on (1) examining and evaluating crisis services for older adults,

including policy, operational, and other requirements necessary to promote and deliver crisis services in Maryland; (2) examining appropriate placements in long term care programs for older adults who are Medicaid beneficiaries; and (3) identifying the current cognitive and behavioral health needs of Maryland's aging population and the challenges facing the State to address these needs.

These reports highlighted several recommendations related to older adults and behavioral health. First, a series of recommendations were made related to the Pre-Admission Screening and Resident Review Program (PASRR), including strengthening evaluation tools for aging individuals, exploring opportunities for updating the Level II Evaluation tool, and enhancing PASRR management systems. Developing an enhanced Residential Rehabilitation Program (RRP) mode that incorporates further integration of somatic care into RRP settings was also recommended.

Youth Behavioral Health and Intellectual and Developmental Disabilities-Related Reports.
MDH staff identified a total of nine reports related to youth behavioral health, including:

- JCR on Youth-Centered BH Intervention and Prevention (2022);
- Out of Home Placement and Family Preservation Resource Plan (2022);
- JCR on Voluntary Placement Agreements Review and Access to Intensive BH Services (2021);
- JCR on Increased Capacity for Psychiatric Care for Youth (2020);
- JCR on Treatment Options for Youth with Heroin-Related SUDs (2014);
- JCR on Mental Health Services for Transitional Age Youth (2013);
- JCR on Residential Treatment Center Outcomes (2013).

Among other things, the reports identified focus on:

- The role of youth-centered behavioral health intervention and preventative programs;
- Evidence-informed models to reduce and prevent juvenile justice system involvement
- Documenting the State's capacity for and utilization of out-of-home placements, including analyzing the costs associated with out-of-home placements. It also identifies areas of need across Maryland and strategies each child-serving agency will employ in FY 2023 to develop those resources.
- Reviewing processes in other states for assisting families in accessing high intensity behavioral health services for their children, including states that do not require custody relinquishment;
- Limited treatment options for youth that use heroin; and
- Best practices for mental health services for transitional aged youth.

The reports reviewed provided prior recommendations relating to youth behavioral health. Specifically, the first set of recommendations centered around the Integrated Behavioral Health models for juveniles, and recommended the consideration of a multi-layered group to start the planning process for developing a pilot program in Maryland that would utilize the co-design mode.[1] Additional recommendations involved programs that are designed for transitional aged youth (TAY) and recommended providing additional programs that offer coordinated and consistent transition services, stronger linkages and collaboration, and services for TAY with mild or moderate mental health conditions. The final group of recommendations involved expanding capacity for children and youth, and recommended increasing residential treatment center capacity in partnership with DHS, and continuing efforts to increase the number of providers who administer these services under the Medicaid 1915i/1915(b)(4).
The Commission was unable to identify reports that were specific to behavioral health and intellectual and developmental disabilities.

[1] HB 1155 (2023) was introduced but did not pass.

Individuals with Complex Behavioral Health Needs-Related Reports. Nineteen reports related to complex behavioral health were identified as part of the Commission's review. Among other reports, this includes:

- Data-Informed Overdose Risk Mitigation (DORM) Annual Reports (2020, 2021);
- Opioid Operational Command Center Annual Reports (2018 - present);
- JCR on Medication Adherence for Severe and Persistent Mental Illness Patients (SPMI) (2019);
- JCR on Family-centered Substance Use Disorder Residential Treatment (2019);
- JCR on Affordable Housing for People with Serious Mental Illness (2016);
- Outpatient Services Programs Stakeholder Workgroup (2014);
- Continuity of Care Advisory Panel Report (2013).

Among other things, these reports focus on the following:

- Identifying and coordinating overdose datasets and documenting disparities that were related to overdose deaths within Maryland, as well as examining statewide and jurisdictional specific plans to reduce opioid overdoses.
- Examining expenses and expenditures for individuals with severe persistent mental illnesses (SPMIs) such as schizophrenia, bipolar disorder, or major depression, including dually eligibles (Medicare and Medicaid). These reports considered expenses related to treating this population, the impact on expenditures due to nonadherence to medication, and potential patient benefits and cost savings from the use of advanced medication adherence technology.
- Summarizing affordable housing options and the efforts made to increase affordable housing resources.
- Developing model legislation for an assisted outpatient treatment (also known as outpatient civil commitment).
- Evaluating the dangerousness standard for involuntary admissions and emergency evaluations.

Recommendations relating to complex behavioral health needs include-

- Increasing data collection and analysis relating to the overdose crisis;
- Expanding access to buprenorphine for the treatment of opioid use disorder;
- Expanding targeted naloxone distribution;
- Identifying culturally competent strategies to address increasing overdose death rates among older adults (55+);
- Bolstering targeted outreach and care coordination for Medicaid-eligible populations;
- Evaluating strategies related to medication adherence;
- Conducting additional research to determine the efficacy and cost saving that surround technology, long acting injectables, and clinical approaches;
- Making overdose education and naloxone distribution available to individuals who are at high-risk;
- Increasing access to naloxone and other harm reduction services for active opioid users;
- Expanding access to recovery support services;
- Enhancing data collection, sharing, and analysis to improve the understanding of and the response to the opioid epidemic;
- Building the capacity of the healthcare system to identify opioid use disorders and link patients to specialty care;
- Increasing awareness and education about opioid misuse and decreasing stigma
- Increasing the patient, youth, public safety, and general public knowledge of opioid risks and benefits
- Reducing illicit opioid supply and inappropriate and unnecessary opioid prescribing and dispensing.

The Commission also reviewed prior recommendations made by the Continuity of Care Advisory Panel.

This panel was convened in Fall 2013 to explore the barriers to continuity of care – economic, social, legal and clinical – for individuals with serious mental illnesses. The Panel put forth 25 recommendations to strengthen the public behavioral health service delivery system, improve health outcomes, and address deficiencies that lead to interruptions of care. These recommendations address deficiencies in continuity of care, accessibility of mental health records, services to address the needs of individuals with serious mental illness, workforce training, and mental health literacy. Additional recommendations called for research on delegated decision making, services for court-involved individuals; and involuntary commitment. This Panel recommended that the Secretary convene a workgroup to further examine the implementation of an outpatient civil commitment program (also known as assisted outpatient treatment) in Maryland.

The Commission reviewed additional studies on assisted outpatient treatment. Building upon the Continuity of Care Advisory Panel's work, the Outpatient Services Programs Stakeholder Workgroup (established by Senate Bill 882/House Bill 1267, 2014 examined the development of assisted outpatient treatment programs, assertive community treatment programs, and other outpatient services in the state. The Workgroup considered the evaluation of the dangerousness standard for involuntary admissions, and emergency evaluations. The workgroup developed three proposals for assisted outpatient treatment programs, in line with its statutory mandate.

Criminal Justice-Involved Related-Reports. The Commission identified 16 reports on criminal justice-involved individuals, including reports on state facilities which largely serve court-involved individuals, including-

- Annual Report - Commission to Study Mental and Behavioral Health in Maryland (2019 - 2020);
- Opioid Operational Command Center Annual Reports (2018 - present);
- JCR Report Detailing Direct Care Staffing Issues, Recruitment and Retention (2018 - 2019);
- JCR on Inpatient Psychiatric Bed Capacity Across All Sectors (2018);
- JCR on Appropriate Staffing Levels for Direct Care Employees and Associated Data in BHA-Administered Facilities (2018);
- Forensic Services Workgroup Reports (2016 - 2017);
- JCR on Security Recommendations for State Psychiatric Facilities (2016);
- JCR on Alternatives to Residential Treatment for Commitments Under Section 8-507 (2016); and
- JCR on Treatment and Service Options for Certain Court-involved Individuals (2014).

These reports focus on improving the continuum of mental health services, including:

- A statewide crisis response system;
- Access to substance use treatment for court-involved individuals;
- Improving access to care for those leaving jail and prison;
- Ensuring parity of resources to meet mental health needs; and
- Increasing staffing, bed capacity, and forensic services capacity for MDH facilities.

Recommendations fell into three categories: 1) increasing treatment resources for justice-involved individuals, 2) increasing forensic services, bed capacity, and community crisis services, and 3) serving individuals in the least restrictive setting.

Recommendations related to increasing treatment resources for justice-involved individuals include identifying and connecting patients to treatment and recovery services, implementation of law enforcement diversion programs to connect low-level drug-involved offenders with treatment services, and improving access and quality of opioid addiction treatment in communities. Additional recommendations include enhancing criminal justice services for opioid-addicted offenders to prevent re-entry and recidivism, expanding access to treatment and recovery services for inmates with SUDs in correctional facilities, and supporting the transition of inmates with SUDs leaving incarceration to

outpatient treatment services.

The second set of recommendations suggest expansion of the capacity of the Office of Forensic Services, an increase in outpatient capacity to meet the needs of forensic patients, an increase in bed capacity within MDH facilities, centralized MDH forensic processes, and an increase in community crisis services. The reports also recommended an increase in education to reduce stigma in both the general public and mental health treatment community.

The final set of recommendations centers on serving individuals in the least restrictive setting (8-507 placements). The reports recommended the evaluation and placement of individuals in the least restrictive alternative setting whenever the evaluation does not require a residential treatment placement, including outpatient treatment combined with recovery housing or other supportive housing.

Behavioral Health Workforce Development, Infrastructure, and Coordination-Related Reports. A total of twelve reports were identified on workforce, infrastructure, and coordination:

- JCR on Occupational Therapy in Behavioral Health Services (2019);
- JCRs on Behavioral Health Workforce and Infrastructure (2018, 2019);
- JCR on Feasibility and Potential Impact of Merging Core Service Agencies with Local Addiction Authorities (2017); and
- JCR on Specialty Behavioral Health Information Sharing (2015).

Key findings from these reports include-

- Reimbursement of occupational therapy services is limited to children under the age of 21 in a federally qualified health center (FQHC) or an outpatient mental health center (OMHC) and adults in hospital settings;
- Gaps and unmet needs remain in acute care services, outpatient and residential treatment services as well as other support and community-based services;
- A shortage of behavioral health workforce and transportation are two of the major barriers to access behavioral health services;
- Merging core service agencies (CSAs) and local addiction authorities (LAAs) would support the public health care system (PBHS), as long as mergers allow for local flexibility; and
- Document SUD consent sharing needs under the behavioral health carve-out; and
- High turnover within the behavioral health workforce which is related to burnout and non-competitive salaries offered by the public behavioral health system
- Public behavioral health workforce of local PBHSs. The recommendations include a review of local behavioral health plans that identified gaps in current capabilities and the capacity of the behavioral health workforce of the local PBHSs. Specific recommendations include hiring and retention of- psychiatrists, especially in rural areas, which affects medication-assisted treatment (MAT) services, nurses throughout the system, licensed social workers, counselors, substance use disorder (SUD) providers, and culturally and linguistically competent providers and interpreters; and providers trained in co-occurring disorders.

Further recommendations include addressing transportation, culturally appropriate services, and outreach and engagement.

Another recommendation was to merge core service agencies (CSAs) and local addiction authorities (LAAs) to support the public health care system (PBHS). The merger should allow for local flexibility, use of guiding principles to motivate greater integration, and increased clarity from the State BHA to support Local Systems Management, including the development of a multiyear plan to support local behavioral health integration.

Behavioral Health Financing-Related Reports. 6 reports were identified on behavioral health financing

including-

- JCR on Increases in Psychiatric Rehabilitation Program (PRP) Expenditures (2021);
- JCR on SUD Residential Treatment Practices and 1115 Waiver;
- Report on Delivery and Payment Systems (2019);
- JCR on Expenses and Use of Behavioral Health Services by Medicaid and ACA Eligibility (2015);
- JCR on Local Treatment Grants (2013); and
- JCR on Specialty Physician Rate Increase (2013)

These reports focus on:

- Outlining increased spending in certain areas of the public behavioral health system, namely PRP and new residential substance use benefits under the State's Section 1115 waiver;
- A history of rate setting in the PBHS, an overview of the delivery system, including accreditation and licensure, and behavioral health integration; and
- Both fee for service and grants-based expenditures on behavioral health.

Recommendations related to PRP expenditures include the development of cost containment strategies and quality management systems for PRP programs and the offering of training and capacity building for PRP programs. Recommendations related to rates include that all providers participating in the PBHS should act within the scope of practice of their license or certificate to receive reimbursement and community-based behavioral health services should be provided at the local level by providers who are licensed at the independent practice level to provide treatment or by programs with accreditation-based licensing through BHA's Licensing Unit. Further recommendations include the continued licensing of DUI education through BHA's Licensing Unit, and rate increases for federally funded grant programs, and specialized pilot programs should be contingent on increases in federal funding within federal requirements (funds are not be used to supplant other funding). A rate study was also recommended including an evaluation of the job classifications and salaries of direct care and licensed clinicians working in the public sector in comparison to those working in the private market. Finally, the exploration of value-based payment mechanisms was also recommended to improve the quality of services.

Part 2: Needs Assessment

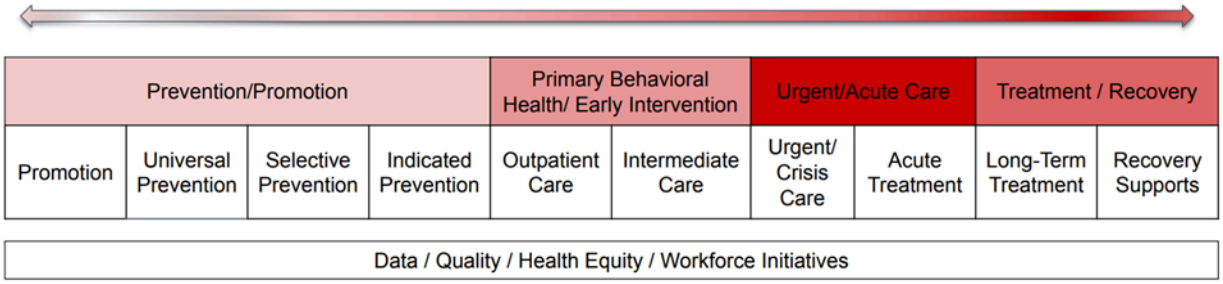
The Commission is required to conduct an assessment of behavioral health services in the State to identify needs and gaps in services across the continuum of care, including community-based outpatient and support services, crisis response, and inpatient care. The Commission is required to compile findings of this assessment.

The needs assessment presented in this section contains four components:

- An analysis of morbidity and mortality data as it relates to behavioral health;
- An analysis of adult utilization data for the public behavioral health system;
- An analysis of children's utilization data for the public behavioral health system; and
- An assessment of currently funded services.

Key findings from an initial needs assessment are presented in this section. This initial assessment is a first step to understanding gaps in behavioral health care in our state. Additional analysis will be conducted by the Commission.. A copy of the needs assessment presented to the Commission is included in Appendix D. The Commission assessed and analyzed this information within the context of a behavioral health continuum of care (Figure 1).

Figure 1, Behavioral Health Continuum of Care



Morbidity and Mortality Data. Untreated behavioral health conditions have serious consequences, including reduced life expectancy. This is reflected in both national trends, and Maryland-specific data. Suicide is the 10th leading cause of death for all ages in the United States, and the second leading cause of death for individuals aged 10–34. Mortality is also impacted by overdose deaths. In 2021 life expectancy in the US declined, primarily due to increases in COVID-19 and drug overdose deaths.[2]

Overdose and suicide fatality data in Maryland tells a similar story. There were 627 deaths due to intentional self-harm (suicide) in 2021. The age-adjusted mortality rate for suicide was 9.8 per 100,000 population in 2021, 5.4% higher than the 2020 rate of 9.2 per 100,000 population.[3] In 2022, there were 7.6% fewer fatal overdoses in Maryland compared to 2021 (decreasing from 2,800 to 2,586). There were 2,581 fatal overdoses in the 12 months ending in May 2023. This was a 2.9% decrease compared to the 12 months ending in May 2022, when there were 2,659 fatal overdoses in Maryland.

Analysis of PBHS claims for Adults. The Commission analyzed public behavioral health system (PBHS) claims for fiscal year 2021.[4] Claims data was broken out into two categories: (1) mental health, and (2) substance use disorder services. Several key findings were noted:

- **Billing providers.** There are fewer providers billing for SUD treatment services than mental health services. During FY 21, 973 distinct providers submitted SUD claims and 2,600 distinct providers submitted mental health services claims.
- **Regional disparities.** A full continuum of care does not exist in many parts of the state. A disproportionate number of providers are located in the Baltimore metropolitan region, with fewer providers in the Western, Eastern, and Southern parts of the state. Approximately 43% of mental health and substance use disorder providers who submitted claims were from Baltimore City and Baltimore County.

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[2] Sources: Centers for Disease Control and Prevention, Medicaid and CHIP Payment and Access Commission
[3] Data from the Opioid Operational Coordination Center Data Dashboard and the Vital Statistics Administration 2021 Annual Report

[4] This data is for all "active" billing Maryland Public Behavioral Health System (PBHS) providers who submitted a claim for services rendered in Fiscal Year 2021. The data are based on ASO-OPTUM claims paid through 01/31/2023. Data is un-duplicated within each provider for the number served-by service category.

- **Outpatient services.** Outpatient services were the most commonly used mental health and SUD services. For mental health, approximately 217,000 individuals accessed outpatient services, representing 93% of all mental health service users. For SUD service users, approximately 47,000 individuals, representing 45% of all SUD service users, accessed outpatient services.

Analysis of PBHS claims for children and youth. The Commission also analyzed PBHS claims for fiscal year 2021 for children and youth. Similar to the analysis for adults, claims were broken out as they relate to SUD and mental health. Several key findings were noted:

- **Psychiatric rehabilitation and support services.** Among the services studied, psychiatric rehabilitation services, which provide rehabilitation and support services to aid in the development and enhancement of independent living skills, were the most utilized services.
- **Limited Access to Intensive Community-based Services.** Few children and youth with intensive behavioral and emotional challenges are accessing community-based behavioral health services, including intensive care coordination and in-home programs.
- **Differences in utilization exist between boys and girls.** Findings show that compared to males, females are more likely to enter services in the teen and young adult years and are more likely to use inpatient hospital and Emergency Department services.
- **Regional disparities.** In many parts of the state, a full continuum of care does not exist. All jurisdictions, except Charles, Howard, Montgomery, Prince George's, and St. Mary's had PBHS service use rates that were higher than the state average of 128.6 per 1,000 eligible. Three jurisdictions (Charles, Montgomery, and Prince George's Counties) had utilization rates of less than 100 per 1,000 eligible).

Currently Funded Services. Using the continuum as a framework, the Commission assessed currently funded services across Maryland's 24 jurisdictions. Key findings indicate that there are a number of services paid for in the PBHS that are covered by Medicaid - some with good jurisdictional representation and others with limited availability. Specifically, services with limited availability include detoxification, partial hospitalization, and mental health residential treatment. There is also limited availability for children's services, such as Targeted Case Management, Residential Treatment Centers, Respite, and Inpatient SUD Services.

Part 3: Overview of Commission Meetings

The Commission held two meetings in 2023. Presentations given to Commission members on November 9 and December 18 can be found in Appendix E.

November 9, 2023

During the Commission's first meeting, the Commission discussed the formation and responsibility of each Workgroup and commission members were assigned to a workgroup.[5] The statutorily created workgroups include Geriatric Behavioral Health; Youth Behavioral Health, Individuals with

[5] Prior to the first meeting, MDH sent a survey to each commission member for indication of their two Workgroup choices. Where possible, MDH tried to ensure that commission members received their first choice.

Developmental Disabilities, and Individuals with Complex Behavioral Health Needs; Criminal Justice-Involved Behavioral Health; and Behavioral Health Workforce Development, Infrastructure, Coordination, and Financing.

The Department presented a needs assessment that described the current behavioral health landscape in Maryland. As described above, the needs assessment addressed the behavioral health continuum of care; provided analyses of service utilization by adults, children, and youth; and described currently funded services in the public behavioral health system. After the presentation, the Commission provided an opportunity for public comment.

In order to help facilitate each workgroup's review of prior recommendations and reports, MDH staff presented a literature review of all relevant reports. The Commission members had an opportunity for comment, followed by public comment. In addition, the Commission discussed efforts made through the MDH and Department of Education's partnership in the Consortium on Coordinated Community Supports.

December 18, 2023

The second meeting of the Commission began with the approval of the minutes from the November 2023 meeting. In addition, each Workgroup Chair provided an overview of the discussions that took place during their meeting and the areas that the workgroup identified for further investigation. After the Workgroup Chairs' presentation, the Commission staff reviewed the application process for members of the public to apply to join a workgroup. The staff also informed the members of the annual reporting requirements of the Commission and reviewed the Commission's work in 2024. To help ensure coordination, uniformity, and transparency between each of the Workgroups, the Commission announced that future Commission meetings would include a discussion and an overview of areas that impact each of the four Workgroups. Opportunities for public comment were provided during the meeting, however, no public comments were made.

Part 4: Initial Workgroup Reports

Each of the statutorily required workgroups met once in 2024 and submitted a final report to the full Commission. The four workgroup reports can be found in Appendix C.

Geriatric Behavioral Health

The Geriatric Behavioral Health Workgroup is Chaired by Ben Steffen, Executive Director of the Maryland Health Care Commission. This Workgroup held its first meeting on November 30, 2023. The Workgroup examined a wide range of issues including the additional need for healthcare facilities; the specific needs of incarcerated individuals; workforce needs (especially licensed occupations), including the lack of behavioral health providers who take Medicare or have geriatric expertise; and the increase in the number of people 55 and older who need substance use treatment.

After conducting its review, the Workgroup identified areas where further investigation is required. These areas included (1) increased specialized workforce needs such as geropsychiatry, (2) opportunities for adults 50 years of age and older who are unemployed to help fill workforce gaps (specifically those entering the workforce after prison sentences and substance use treatment), (3) service needs including geriatric substance use disorder and services for those transitioning from institutional settings, (4) the need for affordable, supported, and permanent housing, (5) supports and interventions that decrease loneliness, and (6) transitional aged adults who need help preparing for late life.

Youth Behavioral Health, Individuals with Developmental Disabilities, and Individuals with Complex Behavioral Health Needs

Alyssa Lord, Deputy Secretary for the Behavioral Health Administration, chairs the Youth Behavioral Health, Individuals with Developmental Disabilities, and Individuals with Complex Behavioral Health Needs Workgroup. The group held its inaugural meeting on December 4, 2023. The Workgroup discussed the current efforts of the Behavioral Health Continuum of Care and MDH's Children, Youth, and Family Strategy, while concentrating on suicide prevention, 9-8-8 crisis support, mobile crisis teams, and the new Medicaid 1115 waiver opportunities. The workgroup discussed the importance of support services for parents and guardians of youth with complex behavioral health needs, timely management of patients stepping down from acute care, and the utilization of the Center for School Safety and Judy Centers. The workgroup identified the need for a clear roadmap of where to look for services, as well as the need for a sustainable funding stream over multiple years. To make improvements in this area, the workgroup preliminarily determined the need to expand career development ladders, extend opportunities to focus on youth populations, and increase in-home behavioral health services for youth with autism spectrum disorder.

The group also discussed co-occurring intellectual and developmental disabilities (co-occurring I/DD), including the need for community-based services, the importance of specialized training, and the need to expand training/resources for I/DD-BH dual diagnosis youth outside of school. The group's preliminary recommendations included non-pharmacological interventions and trauma-informed care and support systems, specialized training opportunities for students interested in serving this population, and training on de-escalation and specialized communication for emergency services.

The workgroup also discussed complex behavioral health needs, focusing on the importance of comprehensive resource listing, an increase in community-based treatment, and the engagement of mental health (MH) providers. Preliminary recommendations in this area include expanding provider capacity and the provider workforce and increasing Medicaid reimbursement through a tiered system related to quality of care.

In all three areas, the workgroup identified the need for earlier exposure to specialized populations for pre-professional students, tiered funding for providers in the public mental health system to increase competitiveness and quality, and adequate support for non-medical staff.

Criminal Justice-Involved Behavioral Health

Dr. Aliya Jones, representative of an acute care hospital, chairs the Criminal Justice-Involved Behavioral Health Workgroup. On December 8, 2023, the workgroup met to discuss State court-ordered psychiatric infrastructure, State employee retention, the MDH Facilities Master Plan, behavioral health crisis services, and the need to review the current landscape of recovery housing.

The workgroup determined a need for current data (including an analysis of patient days by sector and average wait time, quality of care, and location of providers) as well as standardization across providers and the need to review the current landscape of recovery housing. Additional areas identified by the group included evaluating the needs of employees caring for individuals in adult psychiatric hospitals and the State's Apprenticeship Program.

Behavioral Health Workforce Development, Infrastructure, Coordination, and Financing

Commissioner Kathleen Birrane, Maryland Insurance Commissioner, chairs the Behavioral Health Workforce Development, Infrastructure, Coordination, and Financing Workgroup which met on December 5, 2023. The workgroup discussed its broad interpretation of "workforce" when examining areas of review, as well as policy and reimbursement trends and practices from other states that can support access to a comprehensive array of services and to ensure quality of care. The workgroup also discussed Community Care Behavioral Health and Federally Qualified Health Centers, reimbursement structures, essential health plans, and the impact of external events on the ability to deliver services. The workgroup also discussed telehealth (including integration of telehealth and its usefulness), crisis stabilization resources, and defining complex and specialty behavioral health needs.

After the discussion, the Workgroup determined that further information was needed, including workforce surveys to evaluate the needs of the State's behavioral health care workforce, reimbursement strategies and practices used in other states that support access to comprehensive services and ensuring quality of care, and actions plans for the system's ability to prepare and respond to future challenges impacting not only the state but also specific regions and populations. The Maryland Mental Health and Substance Use Disorder Registry and Referral System, 2-1-1, harm reduction strategies, and methods used to support consumers in evaluating behavioral health services were additional areas identified for further investigation.

Part 5: Future Work

The Commission is committed to improving access to behavioral healthcare in Maryland and notes that there is significant work underway to begin addressing gaps in our continuum of care. Both the full Commission and its four workgroups identified topics to examine moving forward including new initiatives related to mobile crisis services, crisis stabilization, 9-8-8 (also known as the Suicide and Crisis Hotline), and the partnership between MDH and the Community Health Resources Commission and the Consortium on Coordinated Community Supports. The Commission has agreed that topic areas impacting all workgroups will be discussed during Commission meetings to ensure that each workgroup has an understanding of other workgroups' positions and can move forward with recommendations in an organized and coordinated manner. Future work will continue to focus on ensuring the full continuum of

care is available to all Marylanders across the state. Individuals with behavioral health conditions must receive services in the most integrated settings appropriate to their needs.

Appendix A - Commission Members

Commission Chair

- Laura Herrera Scott, Secretary of Health

Commission Members

- Senator Malcolm Augustine, Member from the Senate of Maryland
- Delegate Bonnie Cullison, Member from the Maryland House of Delegates
- Stephen Ligett-Creel, Designee for the Department of Human Services
- Alexa Herzog, Designee for the Department of Juvenile Services
- Deputy Secretary Alyssa Lord, Deputy Secretary for Behavioral Health
- Kathleen Birrane, Maryland Insurance Commissioner
- Megan Renfrew, Designee for the Executive Director of Health Services Cost Review Commission
- Ben Steffen, Executive Director of the Maryland Health Care Commission
- Mark Luckner, Executive Director of the Maryland Community Health Resources Commission
- Sheena Patel, Designee for the Executive Director of State-Designated Health Information Exchange
- James Rhoden, Designee for the Executive Director of the Governor's Office of Crime Prevention, Youth, and Victims Services
- Secretary Carol Beatty, Secretary of the Maryland Department of Disabilities
- Renard Brooks, Designee for the Secretary of the Department of Public Safety and Correctional Services
- Emily Keller, Special Secretary of Opioid Response
- Appointed by the Governor:
    - Linda Raines, representative of the Mental Health Association of Maryland
    - Kathryn Spencer Farinholt, representative of the National Alliance on Mental Illness
    - Shannon Hall, representative of the Community Behavioral Health Association of Maryland
    - Johnathan Davis, representative of a provider of residential behavioral health services
    - Dr. Aliya Jones, representative of an acute care hospital
    - Stacey Garnett, representative of an inpatient psychiatric hospital
    - Dr. Paula Anne Smith- Benson, individual with experience as a consumer of behavioral health services
    - Debra Bennett, family member of an individual with experience as a consumer of behavioral health services
    - Mercia Cummings, representative of a provider of substance abuse treatment services
    - Dr. Arlene Tyler, representative of a school-based health center
    - Tamar Rodney, individual with expertise in Social Determinants of Health
    - Matthew Eisenberg, individual with expertise in health economics
    - Oleg Tarkovsky, representative of a health insurance carrier
    - Linda Dietsch, representative of a managed care organization
    - Benjamin Charlton, representative from the Office of the Public Defender
    - Rachel London, representative of the Developmental Disabilities Coalition

- Kevin Amado Sr. representative of the Maryland Chapter of the National Council on Alcoholism and Drug Dependence
- Dr. Stephanie Wolf, representative of the Maryland Psychological Association
- Leslie Seid Margolis, representative of Disability Rights Maryland
- Lawanda Williams, representative of a Federally Qualified Health Center
- Kathryn Dilley, representative of a local behavioral health authority
- Clara Baker, individual with an intellectual disability who uses self-directed behavioral health services

Appendix - B Workgroup Reports Submitted to the Full Commission.

Geriatric Behavioral Health Workgroup

December 8, 2023

Secretary Laura Herrera Scott, Chair
Commission on Behavioral Health Care Treatment and Access
201 West Preston Street
Baltimore, Maryland 21201

Dear Secretary Herrera Scott:

Re: The 2023 Geriatric Behavioral Health Workgroup Report

In keeping with the requirements of House Bill 1148 (Chapter 291, 2023) and Senate Bill 582 (290, 2023), the Geriatric Behavioral Health Workgroup respectfully submits its report containing recommendations to improve behavioral health care for the geriatric population. Specifically, the report details the following:

> *Beginning in 2023, the Workgroup established under Subsection (A) of this section shall report and make recommendations to the Commission on or before December 1 of each year.*

If you have any questions about this report, please contact Stefani O'Dea, stefani.odea@maryland.gov or Milan Reed, milan.reed@maryland.gov.

Sincerely,

DocuSigned by:
Ben Steffen
8B10E2A5EE71406...

Ben Steffen
Chair
Geriatric Workgroup

Introduction

The Geriatric Behavioral Health Workgroup respectfully submits its first annual report containing recommendations to improve behavioral health care for the geriatric population.

The Workgroup held its inaugural meeting on November 30, 2023, in which four members of the Workgroup and six guests (members of the public) were in attendance. During the meeting, the Workgroup discussed the three charges assigned, and how they would shape each recommendation. To obtain a better understanding of the areas for improvement, reports and data impacting the geriatric population were discussed and insights provided by Workgroup members with various areas of expertise.

Workgroup Charges

1. **Examine and make recommendations related to the behavioral health of the geriatric population in the state.**

There is a need to expand the workforce, especially licensed occupations, to better support older adults. There is a lack of behavioral health providers who take Medicare, and have geriatric expertise. Hospitals and physicians that do accept Medicare and have geriatric expertise, such as Hopkins and University of Maryland, have long waitlists. It is important to shore up the behavioral health workforce to be better able to diagnose and treat geriatric patients and refer to available resources. Workforce needs include an increase in Geropsychiatry, cross training physician/specialty workforces, and providing opportunities for unemployed individuals who are 50+ to fill some of the workforce gaps.

The need for additional healthcare facilities and improved reimbursement for behavioral health services (public and private) should be considered. The group focused on 3-4 actionable recommendations that are in line with the Moore-Miller priorities and also with the impending fiscal challenges. Public member, Judge Marina Sabett, discussed how the geriatric population is very difficult to plan for. It is important to understand what Crisis Intervention Teams (CIT) are doing in respect to intercept and coordination.

Public member, Aliya Jones, MD, discussed the challenges caregivers face. Caregivers are not equipped to care for elderly family members, especially those who are physically combative. Service needs include geriatric substance use disorder and services for those transitioning from institutional settings (jails & prisons, hospitals, nursing facilities, inpatient substance use disorder facilities). Substance Abuse Treatment Services require logistical and medical enhancements to meet the need of a growing aging population. Older adults transitioning from institutional settings require housing and support to live in the community. There is a need for affordable, supported, permanent housing. Other pertinent needs included supports and interventions that decrease loneliness, which has a negative impact on somatic and behavioral health, and a focus on transitional aged adults who need help preparing for late life.

2. **Examine and review reports related to the behavioral health of the geriatric population in the state.**

The geriatric youth group had three reports to discuss that directly focused on the geriatric population. The group discussed an increase in action needed at the federal level regarding Medicare reimbursement. Historically Medicare is limited with the types of professionals that can be reimbursed for providing behavioral health treatment. Medicare generally reimburses for inpatient and outpatient treatment but not specialty services, which is important in the State's ability to meet current federal regulations and ensure proper long-term placement and care (PASRR Program, 2022).

The group also discussed how loneliness is a major issue and must be addressed and is associated with poor health outcomes, as well as how the state has significant problems finding resources for elderly patients, especially those with Dementia. This indicates the State's ability to adequately provide resources for the aging population, and supply individuals with the necessary behavioral health needs (Cognitive Health Plan, 2021), (Individuals with Serious Mental Illness and Aging, 2013).

Themes also discussed across all three reports is the need for adequate community services to reduce reliance on institutional services.

3. **Explain how the workgroup will incorporate the examination and review of the use of harm reduction strategies amongst older adults.**

Group discussion led to talking about harm reduction strategies. One public member, Kim Wireman, who has a line of work related to Geriatric Health, stated that over the last three years, there has been an increase in the number of people 55 and older presenting for substance use treatment. There are logistical and somatic considerations to treating an older population. She suggested that a separate track may be needed and perhaps changes to American Society of Addiction Medicine, ASAM. There are no separate Code of Maryland Regulations, COMAR, for geriatric substance use disorder, and after residential treatment, safe, affordable,and permanent housing is needed as this is key to recovery. She also mentioned that the transition from nursing facility to care to home presents a high risk for opioid overdose and an opportunity for prevention.

Appendix- A Workgroup Members

Workgroup Chair

● Ben Steffen, Maryland Healthcare Commission

Workgroup Members

- Megan Renfrew, Designee for the Executive Director of the Health Services Cost Review Commission
- Renard Brooks, Designee for the Secretary of the Department of Public Safety and Correctional Services
- Lawanda Williams, Representative of a Federally Qualified Health Center
- Delegate Bonnie Cullison, Member from the Maryland House of Delegates
- Linda Raines Representative of the Mental Health Association of Maryland

Workgroup Staff

- Milan Reed, Health Policy Analyst, Office of the Secretary, Maryland Department of Health
- Stefani O'Dea, Director of the Office of Older Adults and Long Term Services and Supports, Behavioral Health Administration

Appendix B- Reports Reviewed:

- Bed Registry Workgroup Accomplishments (2022)
- 2022 JCR (p. 106-107) PASRR Program
- 2021 JCR (p.253-255) Cognitive Health Plan for Maryland
- 2013 Joint Chairmen's Report, page 71, M00L01.03- Individuals with Serious Mental Illness and Aging in Place

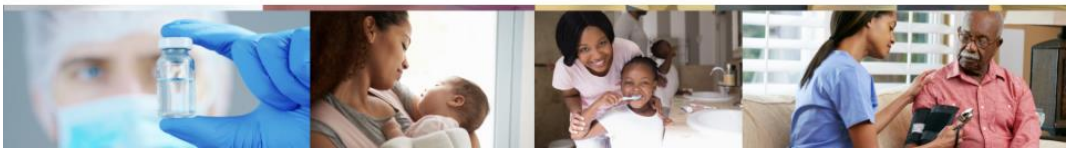
Appendix C- Meeting Presentation Given on 11/30 to Workgroup Members

Maryland
DEPARTMENT OF HEALTH

Geriatric WorkGroup Presentation Summary of JCRs

Stefani O'Dea, MA
Behavioral Health Administration

November 30, 2023



2022 PASRR Report

Purpose: Requested information about the State's current Pre-Admission Screening and Resident Review (PASRR) program

- Ability to meet current federal regulations
- Opportunities to improve PASRR program

PASRR is guided by federal regulations and requires all individuals being considered for admission to a Medicaid-certified nursing facility be screened prior to admission to ensure appropriate placement in long-term care.

Recommendations: (1) Explore opportunities for updating the Level II Evaluation tool; and (2) Explore the enhancement of PASRR data management systems

2

Maryland
DEPARTMENT OF HEALTH

2021 Cognitive and Behavioral Health Plan

Purpose: Report on the development of a Cognitive Health Plan for Maryland's Aging Population, which includes information on the current cognitive and behavioral health needs of Maryland's aging population, the challenges the State is expected to face in meeting these needs, adequacy of State services to meet these needs, a plan to coordinate MDOA and BHA services, and a multi-year plan to meet the future cognitive and behavioral health needs of Maryland's aging population.

Provided demographic data on 60+ population by jurisdiction and cognitive and behavioral health data for older adults.

3

Maryland DEPARTMENT OF HEALTH

2021 Cognitive and Behavioral Health Plan

Recommendations to complete a plan:

- Establish an internal interagency coordinating process
- Identify existing groups to assist
- Review the Alzheimer's 2022-2026 plan

4

Maryland DEPARTMENT OF HEALTH

2021 Cognitive and Behavioral Health Plan

Recommendations to be included in multi-year plan

- Expand use of telehealth, include phone based, to reduce barriers to access treatment
- Expand workforce (eg peers, volunteers, workforce incentives)
- Improve prevention of cognitive and behavioral health conditions
- Enhance caregiver support
- Creative solution to improve independent living (rep payee programs, transportation, supported decision making,
- Explore hospital diversion (e.g. geriatric expertise within mobile treatment and mobile crisis teams)
- Explore models for post hospital transition beds within nursing facilities, assisted living programs for those who need 24 hour support

5

Maryland DEPARTMENT OF HEALTH

2013 RRP and Aging in Place

Purpose: Discussion of best practices regarding aging in place for individuals with serious mental illness.

Recommendations: Consideration of an enhanced RRP model which includes RRP services plus personal care services and nursing oversight, and barriers regarding reimbursement for nursing support in RRPs.

6

Maryland DEPARTMENT OF HEALTH

Discussion

- Which recommendations are a priority?
- What additional priorities are there?

Maryland
DEPARTMENT OF HEALTH

Youth Behavioral Health, Co-Occurring Intellectual and Developmental Disabilities with Behavioral Health, and Complex Behavioral Health Workgroup

December 14, 2023

Secretary Laura Herrera Scott,
Chair of the Commission on Behavioral Health Care Treatment and Access
201 W. Preston Street
Baltimore, MD 21201

Re: 2023 Youth Behavioral Health, Co-Occurring Intellectual and Developmental Disabilities with Behavioral Health, and Complex Behavioral Health Workgroup Report

Dear Secretary Herrera Scott:

In keeping with the requirements of House Bill 1148 (Chapter 291, 2023) and Senate Bill 582 (Chapter 290, 2023), the Youth Behavioral Health, Co-Occurring Intellectual and Developmental Disabilities with Behavioral Health, and Complex Behavioral Health Workgroup respectfully submits its report detailing the first meeting of the Workgroup held on December 4, 2023.

Specifically, the report details the following:

> *On or before December 1 each year, beginning in 2023, the Workgroups established under Subsection (A) of this section shall report and make recommendations to the Commission.*

If you have any questions about this report, please contact Will Payne, DDA Health Policy Analyst at, will.payne@maryland.gov, and Rachel Masciarelli-D'Ambrosi, BHA Special Programs Mental Health Services Coordinator, at rachel.masciarelli-dambrosi@maryland.gov.

Sincerely,

Alyssa Lord

Alyssa Lord, Deputy Secretary for Behavioral Health
Chair
Youth Behavioral Health, Co-Occurring Intellectual and Developmental Disabilities with Behavioral Health, and Complex Behavioral Health Workgroup

Youth Behavioral Health, Co-Occurring Intellectual and Developmental Disabilities with Behavioral Health, and Complex Behavioral Health Workgroup

Introduction

The Youth Behavioral Health, Co-Occurring Intellectual and Developmental Disabilities with Behavioral Health, and Complex Behavioral Health Workgroup respectfully submits its first annual report containing recommendations to improve behavioral health care for these populations.

The Workgroup held its inaugural meeting on December 4, 2023, in which 11 of 11 workgroup members were in attendance. During the meeting, the Workgroup discussed the four focus areas assigned, and how the focus areas would shape each recommendation. To obtain a better understanding of the areas for improvement, reports, and data impacting these populations were discussed with specific insight provided by the Workgroup members' area of expertise.

Workgroup Charge

The following charges as outlined in §13-4804 have been identified as within the scope of the Youth Behavioral Health, Co-Occurring Intellectual and Developmental Disabilities with Behavioral Health, and Complex Behavioral Health Workgroup.

1. Examine and make recommendations related to the behavioral health of the youth population in the State of Maryland.
2. Examine and make recommendations to provide appropriate and adequate behavioral health services to individuals with co-occurring intellectual/developmental disabilities and behavioral health needs.
3. Examine and make recommendations to provide appropriate and adequate behavioral health services to individuals with complex behavioral health needs.
4. Examine and review the use of harm reduction strategies to facilitate access to care for youth and those with complex needs.

Review of Reports and Data

The workgroup incorporated the recommendations sourced from these reports in its survey and discussion components at its first meeting, to rank and prioritize the most impactful recommendations.

Overview of Current Efforts

The MDH Behavioral Health Administration (BHA) utilizes a model known as the Continuum of Care to describe behavioral health and substance use services. The model is intended to be a patient-centered, whole-person model of integrated behavioral health and substance use care, which recognizes the need for different services across a period of time. It includes pillars of prevention/promotion, primary behavioral health, urgent/acute care, and treatment/recovery. These areas are intended to work simultaneously in a coordinated fashion, rather than existing in

silos. Underpinning the continuum are the core tenets of equity, data-driven decisions, transparency, and maintaining and expanding the workforce.

Some of the elements of the Continuum are already in place. We need to maintain these elements while also being creative to build new areas and to meet Marylanders' diverse needs sustainably. This workgroup is critical in helping us to think through the levers to execute this vision.

MDH is actively working towards an expansive Children, Youth, and Family Strategy. Elements of this strategy include veteran-focused Hixson grant and suicide prevention, strategies to increase utilization of 988 Lifeline (inclusive of discussions with 911 to ensure seamless connectivity to care), and the release of the Crisis NOFO to support the expansion of mobile crisis teams to crisis stabilization centers. We have also engaged in robust partner engagement that will allow us to not only meet the intentions of the continuum but also actualize and operationalize services and programs.

The Centers for Medicare and Medicaid Services has recently shared a new 1115 waiver opportunity for states to improve care for individuals leaving jail or prison. This opportunity will allow states to cover a suite of services for up to 90 days before an individual's expected release date, for individuals at high risk of substance use disorders and other health conditions. These services can help individuals get the care they need when reentering the community. Maryland is actively exploring how we can leverage this opportunity to improve healthcare outcomes for some of our most vulnerable citizens. Much of this work is being supported by a $107.5 million investment by the Governor and the Administration.

Workgroup Focus Areas

1. **Examine and make recommendations related to the behavioral health of the youth population in the State of Maryland.**

The workgroup surveyed its members to prioritize recommendations outlined in prior Maryland state government reports and academic sources. Among 7 respondents in the workgroup's 11-person membership (excluding the chair), the top two priorities for Youth Behavioral Health were focused on **strengthening Maryland's 24/7 mobile crisis system** and **Medicaid reform and Medicaid expansion**. Survey respondents additionally provided open responses noting the importance of support services for parents/guardians of youth with complex behavioral health needs, timely management of patients stepping down from acute care, and utilization of the Center for School Safety (annual grants) and Judy Centers.

The workgroup additionally identified a significant information barrier. Maryland lacks a **comprehensive statewide resource for stakeholders to determine the correct path for**

accessing appropriate services based on their needs. The current Public Behavioral Health System (PBHS) map was developed by county-level or in some cases regional-level availability and is therefore fragmented in its level of detail and level of accuracy.

A second barrier exists in the youth behavioral health system's overreliance on Hospitals and Schools to make these determinations. **The Local Education Authority (LEA) working to assist with a behavioral health need could improve their direct collaboration with mental health providers and training of staff to be knowledgeable of community resources.** Local support groups are not often linked with schools. Further exploration is needed regarding where Center for School Safety annual grants are being allocated to locate lower-resourced areas.

A third barrier for youth behavioral health centers on workforce concerns. Workforce limitations result in many services, while funded, being unavailable due to a lack of staffing for the positions to fulfill the continuum of resources. Often, employees gain entry-level experience in direct support positions but subsequently have no way to further their career in the field, resulting in moving to another type of employment. Thus, **expanding career development ladders, including adequate pay raises** as professional advances in their career, would result in improved staff and knowledge retention, and heightened service availability. Additionally, **colleges, universities, and pre-professional programs in Maryland that educate students in the behavioral health professions should train students and extend opportunities to focus on youth populations** long-term.

Currently, many of Maryland's mental health services are grant-funded and must be paid through general funds or federal grants that have to be reallocated at set intervals. This funding model could be significantly improved by **braiding and blending Medicaid and grant funding to improve the sustainability of all Medicaid expansion efforts** and develop highly competitive rates for areas such as 1915i and 1115 Waivers. This expansion can link with some of the state programs such as those for children with incarcerated parents or returning home. Expanded collaboration with Local Departments of Social Services (LDSS) can include behavioral health training and resource knowledge, to support youth and families earlier. This measure can reduce the risk of an out-of-home placement by working with mental health providers to utilize early intervention measures and decrease the risk of higher acuity.

2. **Examine and make recommendations to provide appropriate and adequate behavioral health services to individuals with co-occurring intellectual/developmental disabilities and behavioral health needs.**

The workgroup surveyed its members to prioritize recommendations outlined in prior Maryland state government reports and academic sources. Among 7 respondents in the workgroup's 11-person membership (excluding the chair), the top two priorities for members related to

improving the availability of non-pharmacological interventions and **improving trauma-informed care and support systems**, including provider training, as well as law enforcement and emergency services training. Open comments also noted the importance of community-based treatment and wrap-around support.

Individuals with co-occurring diagnoses of intellectual or developmental disability (I/DD) and behavioral health needs often access services for their developmental disability through a state Medicaid Waiver Program, such as the Community Pathways, Family Supports, and Community Supports Waivers, while accessing services for their behavioral health needs through the public mental health system (the Medicaid State Plan). Individuals with the most significant short-term or long-term needs may be cared for in an inpatient psychiatric or neurobehavioral unit, intermediate care facility (ICF/ID), or, if the court is involved (as often is the case) through a State Hospital, where resource sharing, training, and communication-related to complex I/DD-BH patients is generally observed to be relatively better than in other contexts.

However, provided that a person is not institutionalized, or otherwise being cared for in an inpatient behavioral health context, outpatient resources to address I/DD and behavioral diagnosis co-occurrence in the public mental health system are scarce. The workgroup observes a lack of specialization in I/DD topics by public mental health providers, who are frequently untrained for the context of serving an I/DD patient. Providers are often poorly supported in their efforts to serve such patients. This training gap may manifest as unfamiliarity with the use of assistive communication devices in a therapeutic context, lack of comfort with a patient's communication abilities/style, and overreliance on pharmaceutical interventions when other therapies are available.

Gaps in public mental health services for this specialized, high-needs population could be addressed in several ways. These means are suggested by the content of prior academic whitepapers and research papers on this topic. First, **providers must be rewarded when they seek training, expertise, and appropriate qualifications to interact productively with I/DD patients.** A stepped funding system should be created for mental health providers, offering higher reimbursement to those with expertise and ability in treating dual-diagnosis patients. Additionally, the **colleges and universities that are training Maryland's behavioral health workforce must develop specialized training opportunities for students interested in serving this population**, to enable earlier and better-structured career preparation in this area. Co-learning models for providers are being successfully rolled out by MDH's Developmental Disabilities Administration (DDA) and Behavioral Health Administration (BHA) in the form of the 2023 Dual Diagnosis Cohort, a monthly working group of DDA provider agencies which are interested in improving their services for I/DD-BH co-occurrence. This cohort will be expanded

in the coming years to reach more providers and perform more focused research on effective methods for improving care.

A second area where training must be emphasized is related to law enforcement and first responders/emergency services. Individuals with I/DD-BH co-occurrence bear a heightened risk of negative interactions with emergency services because of the potential combination of lessened communication abilities and challenging behaviors. Therefore, **training on de-escalation and specialized communication for emergency services is essential to ensure safe and effective interactions with individuals in this population**. Maryland currently trains all law enforcement on a 3-year rotating schedule to ensure basic knowledge about these topics. Such training programs could be expanded.

3. **Examine and make recommendations to provide appropriate and adequate behavioral health services to individuals with complex behavioral health needs.**

The workgroup surveyed its members to prioritize recommendations outlined in prior Maryland state government reports and academic sources. Among 7 respondents in the workgroup's 11-person membership (excluding the chair), the top two priorities for complex care needs focused on **expanding provider capacity and the provider workforce** and **increasing Medicaid reimbursement through a tiered system related to quality of care.** Additional survey comments focused on the importance of a comprehensive resource listing for providers, guardians, youth, and others, the importance of braiding/blending of funding, increased community-based treatment, and decreased facility-based treatment.

The workgroup notes that sustainable funding streams and long-term career development opportunities, including competitive increases in pay throughout the career course, are key to retaining skills and knowledge within the public mental health system for individuals with complex behavioral health needs. The workforce in this context focuses equally on medical and therapeutic providers as well as direct support professionals and non-medical staff, all of whom have vital competencies related to ensuring individuals can be successful in their communities. An additional solution for the rapid ramp-up of the available workforce is expanded community health worker (CHW) funding, although there must be mechanisms to maintain quality within CHW programs.

Solutions related to workforce improvements for complex needs are consistent with the workgroup's recommendations related to youth behavioral health and I/DD-behavioral health co-occurrence. **In particular, workforce discussions in all three focus areas focused on earlier exposure for pre-professional students related to specialized populations, tiered funding for providers in the public mental health system to increase competitiveness and**

quality, and adequate support for non-medical staff, including Direct Support Personnel (DSP) and Community Health Workers (CHWs).

4. **Examine and review the use of harm reduction strategies to facilitate access to care for youth and those with complex needs. In its future work, how will the workgroup incorporate the examination and review of the use of harm reduction strategies amongst youth and those with complex needs?**

This topic has been tabled until the 2024 Workgroup meetings due to the breadth of material coverage necessary for the first workgroup meeting.

Conclusion

With its first meeting, the Youth Behavioral Health, Co-Occurring Intellectual and Developmental Disabilities with Behavioral Health, and Complex Behavioral Health Workgroup reviewed relevant existing reports relating to this population, reviewed existing datasets available, and identified areas where current data is needed to inform decision-making. The Workgroup is also interested in identifying any potential inequities related to the population that may need to be addressed. The Workgroup looks forward to continued discussions with presentations from Subject Matter Experts regarding the critical topic areas discussed including:

- Improving the availability of non-pharmacological interventions and improving trauma-informed care and support systems,
- Providers must be rewarded when they seek training, expertise, and appropriate qualifications to interact productively with I/DD patients,
- Colleges and universities that are training Maryland's behavioral health workforce must develop specialized training opportunities,
- Expanding provider capacity and the provider workforce and increasing Medicaid reimbursement through a tiered system related to quality of care,
- Workforce discussions in all three focus areas focused on earlier exposure for pre-professional students related to specialized populations, tiered funding for providers in the public mental health system to increase competitiveness and quality, and adequate support for non-medical staff,
- Psychiatric capacity and planning, staff and patient safety, and crisis services.

They also are interested in receiving any additional reports that are in progress (once available) related to this population. The Workgroup plans to meet quarterly in 2024 and remains committed to working to provide comprehensive recommendations to the Behavioral Health Care Treatment and Access Commission regarding these populations.

Appendix A: Workgroup Members

Workgroup Chair

- Alyssa Lord, Deputy Secretary for Behavioral Health

Workgroup Members

- Senator Malcolm Augustine, Member of the Senate, appointed by the President of the Senate
- Stephen Ligett-Creel, Secretary of Human Services Designee
- Carol Beatty, Secretary of the Maryland Department of Disabilities
- Stacey Garnett, Representative of an Inpatient Psychiatric Hospital
- Mercia Cummings, Representative of a Providers of Substance Use Treatment Services
- Dr. Arlene Tyler, Representative of a School-Based Health Center
- Tamar Rodney, an Individual with Expertise in Social Determinants of Health
- Linda Dietsch, Representative of a Managed Care Organization
- Rachel London, Representative of the Developmental Disability Coalition
- Leslie Sied Margolis, Representative of Disability Rights Maryland
- Clara Baker, an Individual with an Intellectual Disability who uses Self-Directed Behavioral Health Services

Workgroup Staff

- Will Payne, Developmental Disabilities Administration, Health Policy Analyst Advanced, Maryland Department of Health
- Rachel Masciarelli-D'Ambrosi, Behavioral Health Administration, Special Programs Mental Health Services Coordinator, Maryland Department of Health

Appendix B: Reports Reviewed

Youth Behavioral Health

- 2022 JCR (p. 255-256) - Report on youth-centered behavioral health intervention and prevention programs
- FY22 Maryland Out-of-Home Placement and Family Preservation Resource Plan
- 2021 JCR (p. 250-251) Voluntary Placement Agreements review and access to intensive behavioral health services
- 2020 JCR (p. 242-244) Increased Capacity for Psychiatric Care for Youth
- 2014 Joint Chairmen's Report, Page 81, M00L01.01 – Treatment Options for Youth with Heroin-Related Substance Use Disorders
- 2013 Joint Chairmen's Report, page 69 M00L01.02 – Mental Health Services for Transitional Age Youth
- 2013 Joint Chairmen's Report, page 70 M00L01.03 – Residential Treatment Centers Outcomes
- 2012 Joint Chairmen's Report (p. 60 M00L01.01) – Program Direction- Public and Private Residential Treatment Centers

Co-Occurring Intellectual/Developmental Disabilities with Behavioral Health

State of Maryland government reports are limited on this topic. Therefore, we included a set of academic articles related to the topic in our literature review.

- Persons With Intellectual and Developmental Disabilities in the Mental Health System: Part 1. Clinical Considerations
- Co-occurring mental Illness and Behavioral Support Needs in Adults with Intellectual and Developmental Disabilities
- All-Cause, 30-Day Readmissions Among Persons With Intellectual and Developmental Disabilities and Mental Illness

Complex Behavioral Health

- Report of the Continuity of Care Advisory Panel
- Health-General Article §7.5-205.1(c) – Outpatient Civil Commitment Pilot Program Report
- 2020 JCR (p. 104) Assertive Community Treatment Transition
- 2019 JCR (p 102) - Report on Medication adherence for severe and persistent mental illness patients
- 2016 JCR (p 71-72) - Report on affordable housing for people with severe mental illness
- 2013 Joint Chairmen's Report, page 71, M00L01.03 – Individuals with Serious Mental Illness and Aging in Place
- 2011 Joint Chairmen's Report, Pg. 68 – M00K01.01 – Progress Update on Behavioral Health Integration
- Health-General §10-621—Annual Report on Facilities Requesting to be designated Emergency Facility
- BHAC - Strategic Plan: 24/7 Crisis Walk-In and Mobile Crisis Team Services

Appendix C: Meeting Presentation Given on 12/4/2023 to Workgroup Members

The presentation follows on the next pages of the report.

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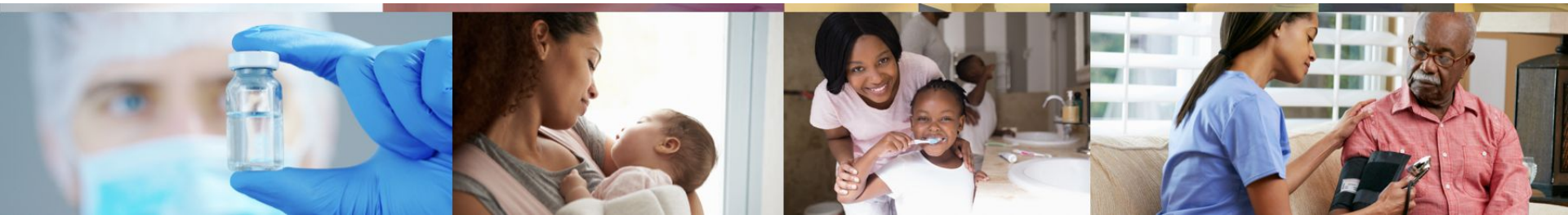
Behavioral Health Care Treatment and Access Commission:
Youth Behavioral Health, Individuals with Intellectual/Developmental Disabilities, and Individuals with Complex Behavioral Health Needs

First Workgroup Meeting

December 4, 2023



Agenda

- Introductions (1p-1:10p)
  - Chair: Deputy Secretary Alyssa Lord

- Overview & Current Efforts (1:10p-1:20p)
  - Youth BH (1:20p-1:50p)
  - Co-Occurring I/DD & BH (1:50p-2:20p)
  - Complex BH (2:20p-2:50p)

- Next Steps (2:50p-3p)

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Behavioral Health Continuum of Care

Prevention/Promotion				Primary Behavioral Health/ Early Intervention		Urgent/Acute Care		Treatment / Recovery	
Promotion	Universal Prevention	Selective Prevention	Indicated Prevention	Outpatient Care	Intermediate Care	Urgent/ Crisis Care	Acute Treatment	Long-Term Treatment	Recovery Supports

Data / Quality / Health Equity / Workforce Initiatives

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BHA Focus Areas

- Prevention/Promotion:
  - Suicide Prev/Problem Gambling
  - Veteran's Services
  - Peer Services
- Primary BH/Early Intervention:
  - BH Children's Strategy
- Urgent/Acute Care:
  - Mobile Crisis/Crisis Stabilization Center Regulations
- Treatment/Recovery:
  - RRP, ALU Bed Expansion
  - Housing/Wrap Around Supports
- Policy/Planning:
  - Licensing/Accreditation
  - State BH Strategic Plan
  - Planning/Grants
- Operations:
  - Shared Services (HR, Fiscal, Procurement)
- Medical Director:
  - Resident Grievance System Expansion/Regulations

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Youth Behavioral Health

Survey Results

Create a system for 24/7 mobile crisis and crisis stabilization services.	71.43%
Develop a Medicaid funding authority to support services for transitional age youth, and evaluate the role of Medicaid expansion/Medicaid reform.	57.14%

Open Answers:

The Center for School Safety is a unidentified partner

Provide support services for parents/guardians of youths with complex behavioral health needs.

Timely management of patients stepping down from acute care

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Co-Occurring I/DD with BH

Survey Results

Increase the availability of training and resources related to non-pharmacological interventions for individuals with I/DD and behavioral health diagnosis co-occurrence.	85.71%
Introduce trauma-informed care and support systems for individuals with I/DD in the mental health system.	57.14%

Open Answers:

Increase community-based treatment options and wrap-around services and supports so families can stay together

Increase training for DSP and providers, law enforcement and first responders

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Complex Behavioral Health

Survey Results

Expand provider capacity and expand the provider workforce.	85.71%
Improve Medicaid Reimbursement Process for quality control and increase reimbursements with a tiered system.	85.71%

Open Answers:

Centralize resource access, website or agency, for providers, guardians and youth.

Address braiding and blending of funding

Increase access and opportunity for people to get treatment and support in the community

Less facility based care

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Next Steps

- Upcoming Items:
  - 2023 Report
  - 2024 Meetings (2x required)
    - Additional Topic: Harm Reduction
    - Recommendations
    - Implementation

Criminal Justice-Involved Behavioral Health Workgroup

December 14, 2023

Secretary Laura Herrera Scott,
Chair of the Commission on Behavioral Health Care Treatment and Access
201 W. Preston Street
Baltimore, MD 21201

Re: 2023 The Criminal Justice-Involved Behavioral Health Workgroup Report

Dear Secretary Herrera Scott:

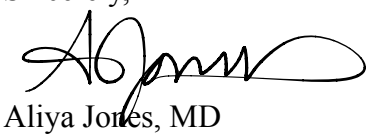
In keeping with the requirements of House Bill 1148 (Chapter 291, 2023) and Senate Bill 582 (Chapter 290, 2023), the Criminal Justice-Involved Behavioral Health Workgroup respectfully submits its report detailing the first meeting of the Workgroup held on December 8, 2023.

Specifically, the report details the following:

> *On or before December 1 each year, beginning in 2023, the Workgroups established under Subsection (A) of this section shall report and make recommendations to the Commission.*

If you have any questions about this report, please contact Jordan Fisher, Chief of Staff for MDH Operations at, Jordan.Fisher@maryland.gov and Wes Schrum, Health Policy Analyst for MDH Operations at Wesley.Schrum@maryland.gov.

Sincerely,



Aliya Jones, MD
Chair
Criminal Justice-Involved Behavioral Health Workgroup

Introduction

The Criminal Justice-Involved Behavioral Health Workgroup (Workgroup) respectfully submits its first annual report detailing the items discussed at the Workgroup's first meeting including the charge of the Workgroup, reports and data reviewed, areas where presentations would be beneficial to the Workgroup, and planned content for future reports and cadence for future meetings.

The Workgroup held its inaugural meeting on December 8, 2023, in which all nine (9) Workgroup members were in attendance – Appendix A details workgroup membership. During the meeting, the Workgroup discussed the four charges assigned, and how these charges would be utilized to guide discussion. To obtain a better understanding of the existing landscape, behavioral health reports and data relating to the criminal justice-involved population were discussed with specific insight provided by the Workgroup Members' individual areas of expertise.

After reviewing each report, the Workgroup concluded that a wide range of historical data has been captured in the reports and should be compared with current data to analyze trends; however, to best guide the Workgroup moving forward, current data is needed. Additionally, the Workgroup identified subject matter experts who could provide clarity and insight on current initiatives to present at future workgroup meetings.

Workgroup Charge

The following charges as outlined in §13-4804 have been identified as within the scope of the Criminal Justice-Involved Behavioral Health Workgroup:

1. Assess the health infrastructure, facilities, personnel, and services available for the state's forensic population and identify deficiencies in resources and policies needed to prioritize health outcomes, increase public safety, and reduce recidivism;
2. Make recommendations on expanding behavioral health treatment access for the State's court-ordered population;
3. Examine and review the use of harm reduction strategies to facilitate access to care for justice-involved population(s); and
4. Explain how the Workgroup will incorporate the examination and review of the use of harm reduction strategies to care for justice-involved population(s).

Review of Reports and Data

Reports were reviewed based on the Workgroup charges in the following areas: (1) Existing State Court-Ordered Infrastructure, (2) Expanding State Court-Ordered Infrastructure, and (3) Current State of Harm Reduction. There were no previously identified reports for future state harm reduction strategies for the justice involved population. Workgroup members have identified additional reports which may be beneficial for review in this area which will be addressed in further meetings. For further information, Appendix B includes a complete list of reports reviewed. Appendix C includes the presentation prepared for the Workgroup's first meeting. An overview of the Workgroup's discussion and findings is provided below based on existing court-ordered infrastructure and existing harm reduction programs and strategies.

Existing Court-Ordered Infrastructure and Identified Needs

The Workgroup concluded that the data surrounding existing State Court-Ordered Psychiatric Infrastructure was consistent over time as it demonstrated a need for the Maryland Department of Health (MDH) to increase staffing and bed capacity for the adult psychiatric hospitals to align with the increase in commitment and evaluation orders from the Maryland Judiciary. The Workgroup determined that to guide recommendations, current data would be required, including an analysis of patient days by sector, average wait time, and individuals who are clinically ready for discharge and awaiting an appropriate discharge placement. The Workgroup also requests an update on barriers to patient discharge including Psychiatric Residential Rehabilitation Program availability, Assisted Living Facility placements, and other lower levels of care for individuals discharging from the MDH system.

State employee retention in the MDH adult psychiatric hospitals was also explored by the Workgroup. In order to evaluate the needs of employees caring for this population, the Workgroup agreed that updated data showing the number of PINs, and salaries/benefits for nursing staff (to evaluate whether total compensation is in-line with private sector nursing staff in-light of increased salaries due to the COVID pandemic) will need to be obtained. Further in their evaluation, the Workgroup noted the importance of the security of both patients and staff at the MDH adult psychiatric hospitals. They requested information surrounding occurrences and frequencies of assault and injuries within MDH forensic facilities. Other areas of exploration for safety include the purchasing of vehicles for patient transportation, the implementation of de-escalation training and training in mental health first aid, as well additional training opportunities for staff. The Workgroup requested data on the types of wellness programs that are available to staff and the utilization rate of those programs by staff.

The Workgroup began discussing the Cannon Report and noted that it indicated an increased demand for adult psychiatric beds, additional staff, and the need for facility upgrades. There were

questions about the MDH Facilities Master Plan with a focus on the need for capacity planning for Spring Grove Hospital Center due to the recent land transfer to the University of Maryland Baltimore County. The Workgroup requested a status update from the Behavioral Health Administration (BHA) on the updates to Involuntary Commitment criteria and plans for implementation of new standards.

To better evaluate the resources available to the State's court-ordered population, the Workgroup identified the need for updated data regarding the State's Apprenticeship Program including referrals. They agreed that it would be beneficial for a presentation from MDH regarding current efforts in this area at a future meeting. They also discussed the Community Forensic Aftercare Program and discussed the need for current data to evaluate the program. Requested data includes the number of individuals being monitored by the program, the number of individuals on conditional release, the number of hospital warrants, and the number of staff dedicated to the program.

Existing Harm Reduction Programs and Strategies

The Workgroup discussed the §8-505 and §8-507 process for court-ordered alcohol/substance abuse evaluations and treatment. The Workgroup agreed that current data identifying trends and outcomes experienced by this population would be critical to evaluate the effectiveness of the program. The Workgroup also expressed interest in identifying whether the funding provided for these services meets the demand of the services. Additional data points of interest to the Workgroup include: demographics of individuals referred, average length of stay, quality of care provided by vendors, location of providers, care coordination upon program completion, success rates, and any standardization of treatment across providers.

Discussion included a review of behavioral health crisis services. The Workgroup identified the need for standardized quality measures for crisis stabilization. The Workgroup requested a presentation regarding 988 transition and crisis services generally. The Workgroup is also interested in utilization of existing crisis services throughout the state, current funding allocations, and whether services are being utilized at the volume anticipated based on population. The 911 diversion program was also discussed including the need for data regarding existing 911 diversion and criminal justice diversion programs across the State. The Workgroup requested an updated data map indicating crisis services including mobile crisis teams, Forensic Alternative Service Teams, and stabilization facilities by jurisdiction throughout the State. They are also interested in a status update regarding plans for the Medicaid reimbursement for crisis services.

The Workgroup addressed the need to review the current landscape of recovery housing including any regulatory requirements. They would like to explore whether there is adequate

housing available to meet the needs of this community and to devise a measure to gauge the outcomes of the Maryland Recovery Net Program. Additional data exploring wellness and recovery programs including The Maryland Interagency Opioid Coordination Plan, the status and funding for diversion programs within Baltimore City and other jurisdictions, and re-entry programs was also requested. Further, medically appropriate placement and treatment, including medications utilized for court-ordered treatment was discussed by the Workgroup. Medication Assisted Treatment (MATs) with jails and prisons was identified through public comment as an additional area that the group should plan to evaluate — Workgroup members agreed with this recommendation.

Conclusion

With its first meeting, the Criminal Justice-Involved Behavioral Health Workgroup reviewed relevant existing reports relating to this population, reviewed existing datasets available, and identified areas where current data is needed to inform decision-making. The Workgroup is also interested in identifying any potential inequities as related to the justice-involved population that may need to be addressed. The Workgroup looks forward to continued discussions with presentations from Subject Matter Experts regarding the critical topic areas discussed including MDH adult psychiatric capacity and planning, staff and patient safety, and crisis services. They also are interested in receiving any additional reports that are in progress (once available) related to this population. The Workgroup plans to meet quarterly in 2024 and remains committed to working to provide comprehensive recommendations to the Behavioral Health Care Treatment and Access Commission regarding the State's justice-involved population.

Appendix A – Workgroup Members

Workgroup Chair

- Dr. Aliya Jones, Representative from an Acute Care Hospital

Workgroup Members

- Kevin Amado Sr., Representative from the Maryland Chapter on the National Council on Alcoholism and Drug Dependence
- Special Secretary Emily Keller, Special Secretary of Opioid Response
- Kathryn Spencer Farinholt, Representative from the National Alliance on Mental Illness
- James Rhoden, Designee for the Executive Director of the Governor's Office of Crime Prevention, Youth, and Victim Services
- Jonathan Davis, Representative of a Provider of Residential Behavioral Health Services
- Alexa Herzog, Designee for the Department of Juvenile Services
- Benjamin Charlton, Representative for the Office of the Public Defender

By Invitation from the MDH Secretary

- The Honorable Marina L. Sabett, Associate Judge, District Court of Maryland, District 6, Montgomery County

Workgroup Staff

- Jordan Fisher, Chief of Staff for Operations and the MDH Healthcare System, Maryland Department of Health
- Wesley Schrum, Health Policy Analyst for Operations and the MDH Healthcare System

Appendix- B Reports Reviewed

- 2023 JCR: Efforts Made to Improve Timeliness of NCR/IST Placements
- 2020: Apprenticeship Program at State Facilities
- 2019-2021 Annual Report: Commission to Study Mental and Behavioral Health MD
- 2018 & 2019: Detailing Direct Care Staffing Issues, Recruitment, and Retention
- 2018: Inpatient Psychiatric Bed Capacity Across All Sectors
- 2018: Appropriate Staffing Levels for Direct Care Employees & Associated Data in BHA Administrated Facilities
- 2017: Implementing the Recommendations of the Forensic Services Workgroup
- 2017: BHAC - Strategic Plan: 24/7 Crisis Walk-In and Mobile Crisis Team Services
- 2016-2017: Forensic Services Workgroup: Report of Recommendations
- 2016: Security Recommendations for State Psychiatric Facilities
- 2016: Alternatives to Residential Treatment for Commitments under Section 8-507 of the Health-General Article
- 2014: Treatment and Service Options for Certain Court-Involved Individuals
- 2013: Continuity of Care Advisory Panel
- 2012: Mental Hygiene Administration- Program Direction- Various Information on the Redevelopment of Spring Grove Hospital Center
- 2011: The Potential Demand for State-Run Psychiatric Hospital Capacity

Appendix C – Meeting Presentation Given on 12/8 to Workgroup Members

- The presentation follows on the next pages of the report.

Maryland
DEPARTMENT OF HEALTH

Commission on Behavioral Health Care Treatment and Access

Criminal Justice-Involved Behavioral Health Workgroup

December 8, 2023

Agenda

- Welcome/Introductions
- Workgroup Charge
- Review of Identified Reports
  - MDH Facilities
  - Community Initiatives
  - Omitted Reports
- Workgroup Report & Open Discussion
- Closing

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Welcome and Introductions

- Welcome by Dr. Aliya Jones, Chair
- Introductions:
  - Kevin Amado, Sr.
  - Special Secretary, Emily Keller
  - Kathryn Spencer Farinholt
  - Stephanie Wolf
  - James Rhoden
  - Johnathan Davis
  - Alexa Herzog
  - Benjamin Charlton

Charge of the Criminal Justice Workgroup

1. Assess the health infrastructure, facilities, personnel, and services available for the state's forensic population and identify deficiencies in resources and policies needed to prioritize health outcomes, increase public safety, and reduce recidivism.
2. Make recommendations on expanding behavioral health treatment access for the State's court-ordered population.
3. Examine and review the use of harm reduction strategies to facilitate access to care for justice-involved population(s)
4. Explain how the Workgroup will incorporate the examination and review of the use of harm reduction strategies to care for justice-involved population(s).

Workgroup Charge and Reports

- **Charge 1: Existing State Court-Ordered Infrastructure**
  - 2023 JCR: Efforts Made to Improve Timeliness of NCR/IST Placements
  - 2020: Apprenticeship Program at State Facilities
  - 2018 & 2019: Detailing Direct Care Staffing Issues, Recruitment, and Retention
  - 2018: Inpatient Psychiatric Bed Capacity Across All Sectors
  - 2018: Appropriate Staffing Levels for Direct Care Employees & Associated Data in BHA Administrated Facilities
  - 2017: Implementing the Recommendations of the Forensic Services Workgroup
  - 2016-2017: Forensic Services Workgroup: Report of Recommendations
  - 2016: Security Recommendations for State Psychiatric Facilities
  - 2016: Alternatives to Residential Treatment for Commitments under Section 8-507 of the Health-General Article
  - 2014: Treatment and Service Options for Certain Court-Involved Individuals
  - 2012: Mental Hygiene Administration- Program Direction- Various Information on the Redevelopment of Spring Grove Hospital Center
  - 2011: The Potential Demand for State-Run Psychiatric Hospital Capacity

- **Charge 2: Expanding State Court-Ordered Infrastructure**
  - 2023 JCR: Efforts Made to Improve Timeliness of NCR/IST Placements
  - 2020: Apprenticeship Program at State Facilities
  - 2019-2021 Annual Report: Commission to Study Mental and Behavioral Health MD
  - 2018: Inpatient Psychiatric Bed Capacity Across All Sectors
  - 2018: Appropriate Staffing Levels for Direct Care Employees & Associated Data in BHA Administrated Facilities
  - 2017: BHAC - Strategic Plan: 24/7 Crisis Walk-In and Mobile Crisis Team Services
  - 2017: Implementing the Recommendations of the Forensic Services Workgroup
  - 2016: Alternatives to Residential Treatment for Commitments under Section 8-507 of the Health-General Article
  - 2014: Treatment and Service Options for Certain Court-Involved Individuals
  - 2013: Continuity of Care Advisory Panel
  - 2012: Mental Hygiene Administration- Program Direction- Various Information on the Redevelopment of Spring Grove Hospital Center
  - 2011: The Potential Demand for State-Run Psychiatric Hospital Capacity

Workgroup Charge and Reports Continued

- **Charge 3: Harm Reduction Current State**
  - 2019-2021 Annual Report: Commission to Study Mental and Behavioral Health in Maryland
  - 2017: BHAC - Strategic Plan: 24/7 Crisis Walk-In and Mobile Crisis Team Services
  - 2016: Alternatives to Residential Treatment for Commitments under Section 8-507 of the Health-General Article
  - 2014: Treatment and Service Options for Certain Court-Involved Individuals
  - 2013: Continuity of Care Advisory Panel
  - 2011: The Potential Demand for State-Run Psychiatric Hospital Capacity

- **Charge 4: Harm Reduction Future State**
  - No Identified Reports
  - Workgroup Discussion:
    - Strategies in reports that were successful and those that were not;
    - Experiences from Workgroup members- state agencies and organizations; and
    - Identify potential speakers to address the Workgroup and provide strategies.

Review of Identified Reports Related to MDH Facilities

Criminal Justice-Involved Behavioral Health Workgroup

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2023: Efforts Made to Improve Timeliness of NCR/IST Placements

- MDH Healthcare System has 11 facilities.
  - 5 adult psychiatric facilities and the Office of Court Ordered Evaluations and Placements (OCEP); and
  - 1,056 psychiatric beds operating at full capacity.
- As of June 9, 2023:
  - 160 individuals were on the court-ordered hospital waitlist.
- June 14, 2023:
  - Montgomery County District Court Orders account for 19.5% of the waitlist with Baltimore City being the next highest.
- MDH Initiatives:
  - Moore-Miller Administration's $107.5 million investment in behavioral health;
  - Support waitlist initiatives;
  - Fund additional assisted living placements; and
  - Crisis services.

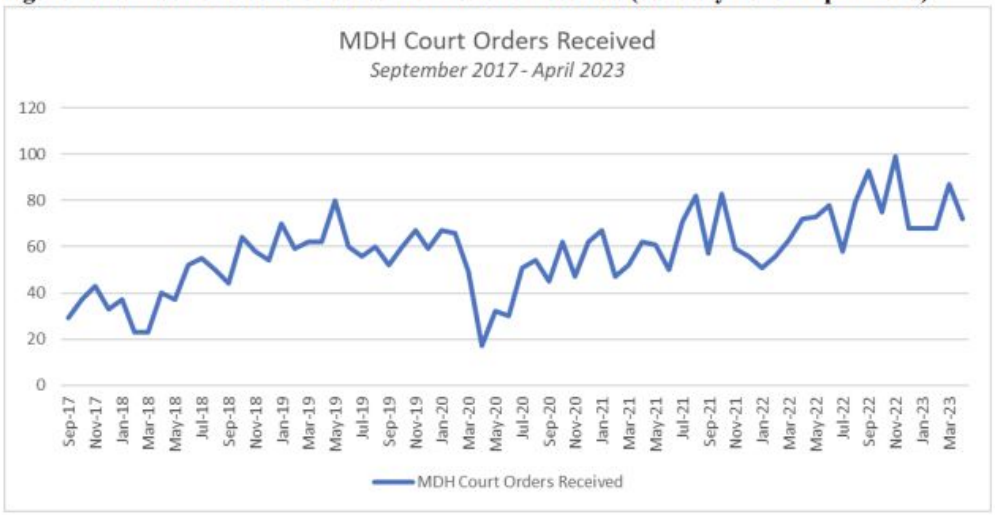
Efforts Made to Improve Timeliness of NCR/IST Placements Data Collected

Table 1. Total Court-Ordered Admissions by Calendar Year

MDH Commitment Orders By Calendar Year *As of April 30, 2023*						
	2018	**2019**	**2020**	**2021**	**2022**	**2023***
Number of Orders	537	747	582	740	865	295

**Note - 2023 is the year to date through April 30, 2023.*

Figure 1. Number of Court Ordered Admissions Received (January 2018 - April 2023)



Note - The raw data for this table is provided in the Appendix as Data Set 2 – MDH Court Orders Received.

- The number of commitment orders from the Maryland Judiciary continues to rise. Beds are operating at full capacity, and to admit a patient, one must be discharged.
- MDH continues to admit and discharge patients as safely and quickly as possible.
- With an average cycle time of 36 business days, if a court ordered individual gets close to the duration (of their charged offense), they receive priority on the waitlist.

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Efforts Made to Improve Timeliness of NCR/IST Placements Data Collected Continued

Figure 2. Number of Court Orders vs. Business Days Trend (Monthly)

Note - The raw data for this table is provided in the Appendix as Data Set 2 – MDH Court Orders Received and Data Set 3 – MDH Cycle Time – In Business Days.

- Along with commitment orders, average cycle times are also increasing.
- Discharge initiatives are key to reducing the backlog of patients.
  - MDH is tracking individuals who are clinically ready for discharge but are difficult to place.
- Factors that can make an individual difficult to place includes immigration status, requirement for 24/7 care, co-occurring disorders, intellectual and/or developmental disabilities, and requirements for special programming (e.g., hearing impaired and deaf individuals, and older adults).

Table 2. MDH Healthcare System Patients Clinically Ready to Discharge but Difficult to Place

Clinically Ready for Discharge *As of May 4, 2023*	
Service Line	No. Pending
Undocumented	5
Intensive Residential Rehabilitation Program	43
24/7 Residential Rehabilitation Program	14
Special Programs	9
Nursing Home	12
Assisted Living Facility	29
Home	11
Capitation	9
Traumatic Brain Injury Services	4
Developmental Disabilities Administration Services	17
TOTAL	**153**

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Commitment and Evaluation Orders: 1/23-11/23

Commitment Orders 2023	
January	84
February	78
March	97
April	86
May	101
June	90
July	79
August	94
September	71
October	90
November	88
Total	**958**

Evaluation Orders 2023	
January	260
February	270
March	337
April	265
May	321
June	294
July	288
August	334
September	274
October	209
November	234
Total	**3,086**

- In calendar year 2022, MDH received **865** commitment orders and **2,183** evaluation orders.
- MDH has **1,056 adult psychiatric beds**. Orders to date in 2023 account for **98.6% of MDH's adult psychiatric capacity**.

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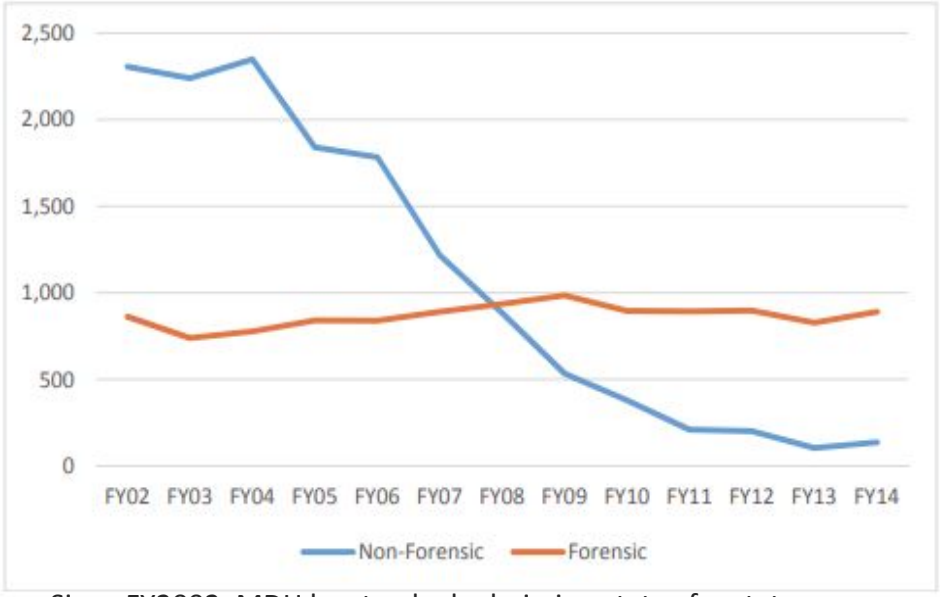
2014: Treatment and Service Options for Certain Court-Involved Individuals

- Review and recommendations of treatment and service options for court-ordered populations in MDH's care, including forensic waitlist.
- **Recommendations given for multiple areas:**
  - Additional funding for expansion of peer support services for local detention centers, courts, and primary care;
  - Need for 10% more bed availability;
  - MDH examine barriers to clinically appropriate movement within forensic service delivery system;
  - Additional evaluation of 8-505 and 8-507 for funding streams for placements including timing and waitlist;
  - Expedite building of forensic database; and
  - BHA develop MFR outcomes for the Office of Forensic Services

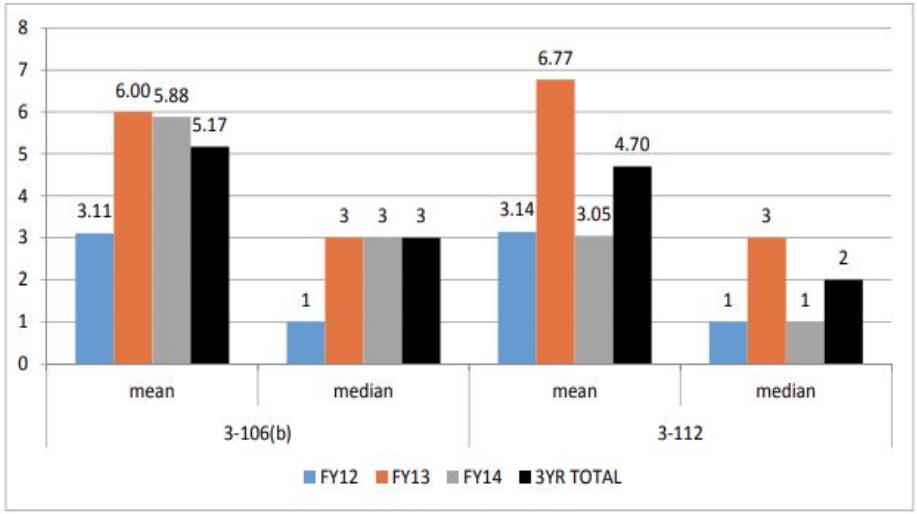
Treatment and Service Options for Certain Court-Involved Individuals: Data Collected

Figure 1
Forensic and Non-Forensic Admissions to State Psychiatric Facilities
Fiscal 2002 - 2014



- Since FY2002, MDH has tracked admission status for state psychiatric hospitals when admissions without court involvement began to be referred to private hospitals regardless of insurance status.
- Total number of admissions to state psychiatric hospitals went down by over 60%, and the number of beds was decreased by approximately 21%.
- MDH admits patients with court involvement to state facilities (accounting for 90%) and
and essentially, no change in forensic admissions from 2002-2014.

Figure 2[3]
Average Wait Time for Residential Placement in a State Psychiatric Facility or State Intellectual Disability Center
Fiscal 2012 through 2014



- Indicates number of days from the date of a court order for residential placement in State-run psychiatric facility or State intellectual disability center for an incompetent to stand trial and dangerous or not criminally responsible finding.
- Facilities include- Perkins, Eastern Shore, Spring Grove, Springfield, Finan, both SETTs and Potomac Center.

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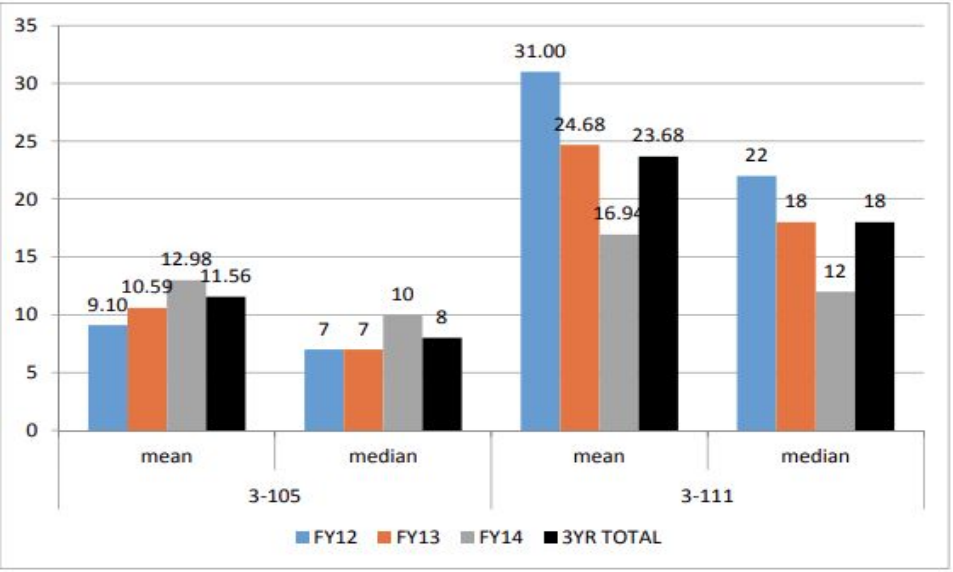
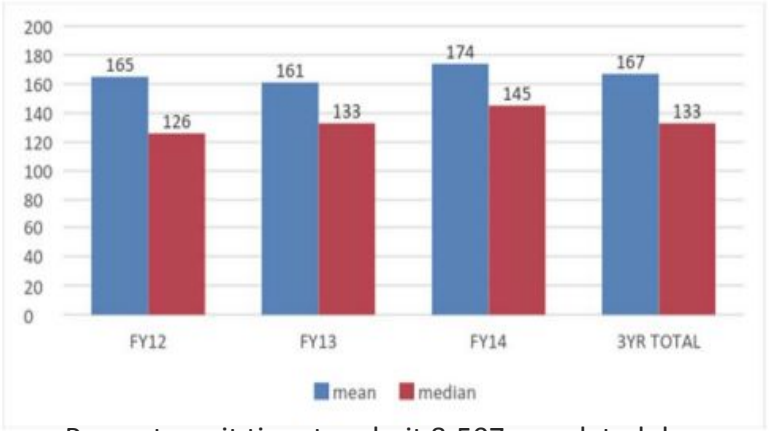
Treatment and Service Options for Certain Court-Involved Individuals Data Collected Continued

Figure 3[5]
Average Wait Time for Residential Placement in a State Psychiatric Facility or State Intellectual Disability Center After the Signing of an Inpatient Evaluation Order for a Competency or Not Criminally Responsible Evaluation Fiscal 2012 - 2014



- Describes number of days from the date of a court ordered evaluation for FY12-FY23, and average wait time for residential placement in a State-run facility or disability center after signing inpatient evaluation order for competency or not criminally responsible. (Aggregated 3 year total is most informative).
- Median- Small number of extreme outliers who took longer to admit.
- Outliers do not indicate failure, but are used to understand outliers to devise a solution.

Figure 4
Time to placement in an 8-507 Residential Slot Fiscal 2012 - 2014



- Presents wait time to admit 8-507 mandated drug treatment beginning from point of initial 8-505 order.
- On average- 167 days or 5.5 months for individuals to be placed, and 50% of them are placed in 133 days or about 4.5 months.

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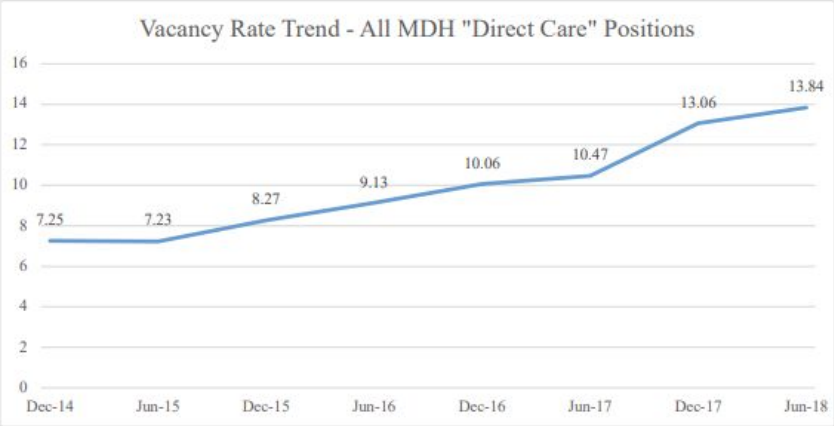
2020: Apprenticeship Program at State Facilities

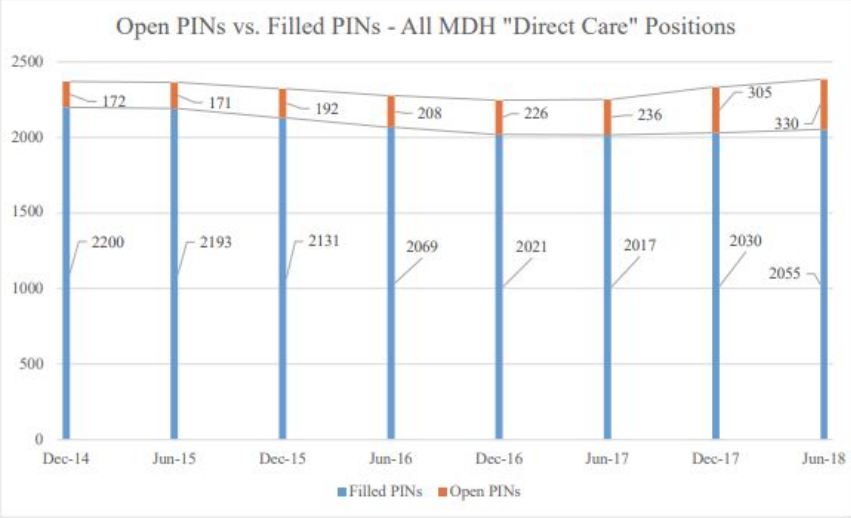
- Details state of Apprenticeship programs at State Facilities.
- **Data Collected:**
  - Spring Grove, Springfield, Clifton T. Perkins, and Finan Center have a Vocational Adjustment Program (VAP).
    - Number of participants for the past three years:
      - Spring Grove: 231;
      - Springfield: 155;
      - Clifton T. Perkins: 160; and
      - Finan Center: 152.
    - FY20 annual wages paid to patient workers:
      - Spring Grove: $134,000;
      - Springfield: $44,912;
      - Clifton T. Perkins: $233,500; and
      - Finan Center: $33,199.
  - Eastern Shore Hospital, and Potomac and Holly Centers do not have VAPs.

2018 & 2019: Detailing Direct Care Staffing Issues, Recruitment, and Retention

- Staffing levels required to operate units of MDH hospitals and facilities, and number of staff MDH will need to operate its desired bed capacity.
- High rate of employee absenteeism (planned, benefitted time, and unplanned time) has significant impact on staffing patterns.
- Overview of staffing model for facilities.
- **Recommendations:**
  - Employee training, pay analysis, create flex pool system, and reduce absenteeism and account for it in staffing model.
  - *Note - Additional training has been undertaken, ASRs approved for nursing staff. Flex pool system has not been created*

Detailing Direct Care Staffing Issues, Recruitment, and Retention: Data Collected





- Vacancy Rate- the number of unfilled (open) PINs allocated to direct care at the 12 facilities, divided by the total number of PINs allocated to direct care.
- Vacancy rate in direct care position has increased from 7.25% in December 2014 to 13.84% in June 2018.
- While the total number of allocated direct care PINs have modestly increased from December 2014 to June 2018, the number of filled direct care PINs have failed to keep pace.

Maryland
DEPARTMENT OF HEALTH

2018: Inpatient Psychiatric Bed Capacity Across All Sectors

- Report on inpatient psychiatric bed capacity in both private and public facilities across the state.
- Provide recommendations on the appropriate inpatient psychiatric bed capacity by sector.

Maryland
DEPARTMENT OF HEALTH

Inpatient Psychiatric Bed Capacity Across All Sectors: Data Collected

Figure 1: Psychiatric Facilities Bed Capacity by Sector, FY13 to FY17

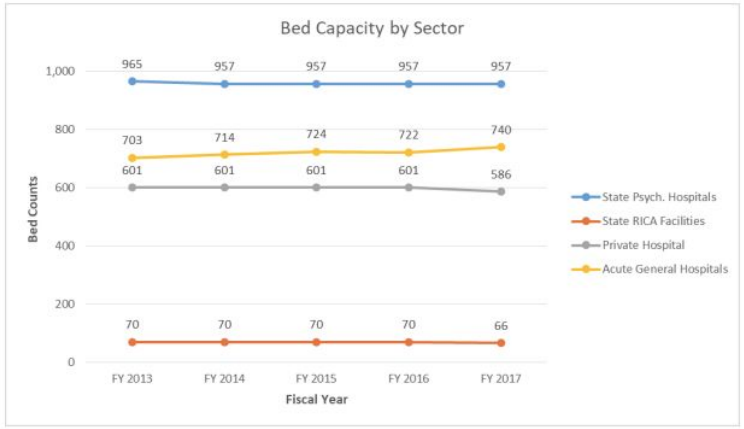
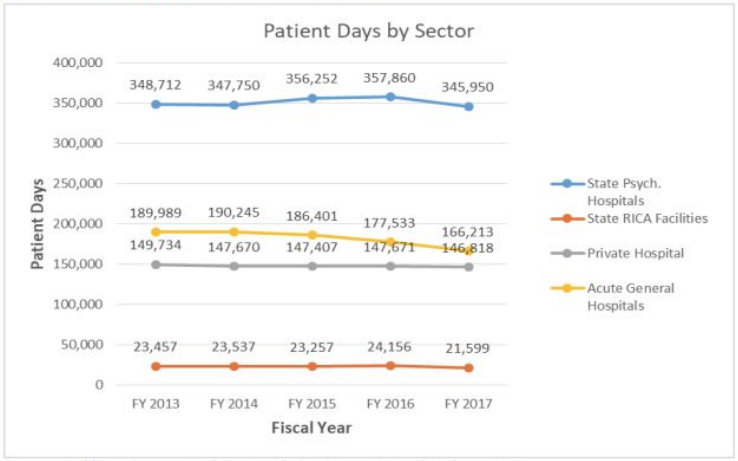
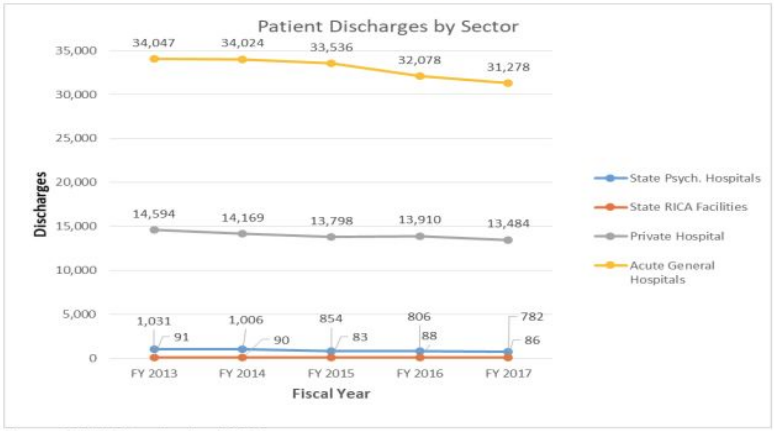


Figure 2: Total Psychiatric Patient Days by Sector



Source: Health Service Cost Review Commission (HSCRC) Inpatient data; HMIS

Figure 3: Discharges from Psychiatric Services by Sector, FY13 to FY17



Source: HSCRC Inpatient data; HMIS

- Figure 1: In FY17 operational bed capacity across the state psychiatric hospitals - 957, two RICAs accounted for additional 66 beds. Operational beds varied from a low of 60 at Eastern Shore Hospital to 355 at Spring Grove Hospital.
- Figure 2: Psychiatric patient days remained relatively stable for State Psychiatric Facilities and Private Psychiatric Hospitals between FY13 to FY17, while showing a steady decline in acute care hospitals from 189,989 to 166,213 over the same period.
- Figure 3: Overall volume of psychiatric patients seen in acute care hospitals was substantially higher compared to private psychiatric hospitals and state facilities.

Maryland DEPARTMENT OF HEALTH

2017: Implementing the Recommendations of the Forensic Services Workgroup

- Report on implementation of recommendations to address the capacity of the State psychiatric hospital system (from Forensic Services Workgroup of 2016).
- **Recommendations:**
  - Reclass facility staff to be forensic classification
    - *Note CI Pay implemented in MDH forensic facilities pursuant to CH 572 of the 2020 Legislative Session.*

2016: Forensic Services Workgroup: Report of Recommendations

- Workgroup charged to develop recommendations to reduce unnecessary congestion in the State Hospital System by improving efficiencies, maximizing throughput, providing immediate system relief, as well as long term recommendations to prevent future backlogs.
- **5 Recommendations:**
  - Increase bed capacity within MDH;
  - Expand capacity of the Office of Forensic Services;
  - Increase outpatient capacity to meet the needs of forensic patients; and
  - Centralize MDH Forensic Processes.

  Note - MDH Adult Psychiatric Capacity is 1,056 beds currently. Centralization of admissions into the MDH Office of Court Ordered Evaluations and Placements (OCEP)

2016: Security Recommendations for State Operated Facilities

- MDH's security review of the State-operated psychiatric hospitals, how the department will implement those recommendations, and what barriers to implementation exits.
- **Recommendations:**
  - Identify all security threats in all areas of the facility;
  - Continual security assessment to promote security education and training;
  - Evaluate classification system for security personnel;
  - Standard police and security personnel uniforms;
  - Broaden scope of MDH Police Officers jurisdiction;
  - Acquire radios to participation in Maryland Statewide Radio System;
  - Make vehicles safer for patient transport and replace aging vehicles;
  - Clifton T. Perkins:
    - Adding two sequential door ways.

Note - Creation of Security Attendants, creation of centralized MDH police.

Security Recommendations for State Operated Facilities: Data Collected

2016 JCR Page 71
Security Recommendations for Psychiatric Facilities

Attachment B
State Psychiatric Facilities - 2016 Questionnaire Responses

		Spring Grove	Springfield	Clifton T. Perkins	Thomas B. Finan	Eastern Shore	JLG RICA	RICA Baltimore
Staffing	Limited	X	X	X		X	X	X
	Personnel for Transport	X				X		
	Classification		X		X			
	Police		X	X			X	X
	Security Officers	X	X	X			X	X
Uniforms	Uniformity	X		X				
	Protective Wear	X	X					
	Firearms		X					X
Uniform Policies & Procedures	Standard Operating Procedures	X	X	X	X			
	Patient Transport	X						
Communications	Radio	X		X				
	Switchboard	X						
Vehicles	Limited Number	X						
	Separation Cage			X				
Training	Mental Health	X	X					X
	Continuous	X	X			X		X
Facility Security (Building)	Employee Proximity Cards			X				
	Cameras			X				

X - Denotes an identified need by facility

Maryland DEPARTMENT OF HEALTH

2016: Alternatives to Residential Treatment for Commitments under Section 8-507 of the Health-General Article

- Appropriateness of utilizing recovery support housing with outpatient services to meet the needs of individuals committed to MDH.
- Overview of 8-507 placement procedure.
- Lists alternatives:
  - Institute for Mental Disease (IMD);
  - Outpatient services; and
  - Recovery housing.
- Maryland State Association of Recovery Residences
  - Established BHA approved application and criteria.

Table 1. M-SARR Membership

Affiliated Housing Providers	69
Recovery Residences	136
Bed Capacity	1271

The totals reflect recovery residences that are state and non-state funded as of 9/9/16.

Maryland
DEPARTMENT OF HEALTH

2012: Mental Hygiene Administration- Program Direction- Various Information on the Redevelopment of Spring Grove Hospital Center

- Reporting on facility program document, development of public-private partnership, and detail how Mental Hygiene Community Based Services Fund can support development of community capacity to reduce demand for State-operated inpatient psychiatric capacity.
- **Recommendation:**
  - No need for additional bed capacity in the State utilization of community based services.

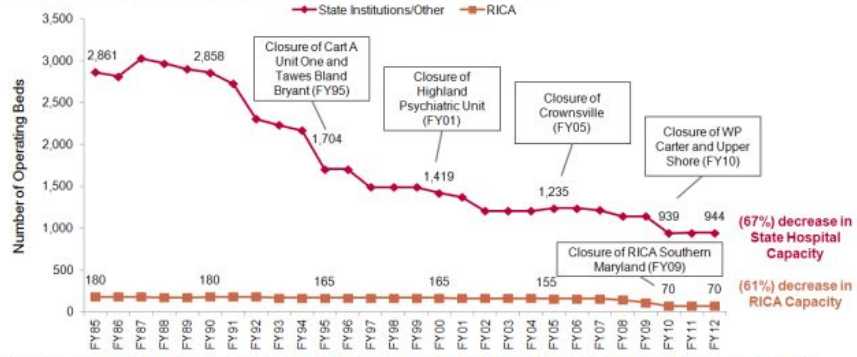
2011: The Potential Demand for State-Run Psychiatric Hospital Capacity

- Report on future demand, community strategies, and best practices for Maryland's State-run psychiatric hospitals.
- **Recommendations:**
  - Additional community support services;
  - Financial incentives to increase provider risk for outcomes; and
  - Expanded community after care services and residential beds.

Criminal Justice-Involved Behavioral Health Workgroup

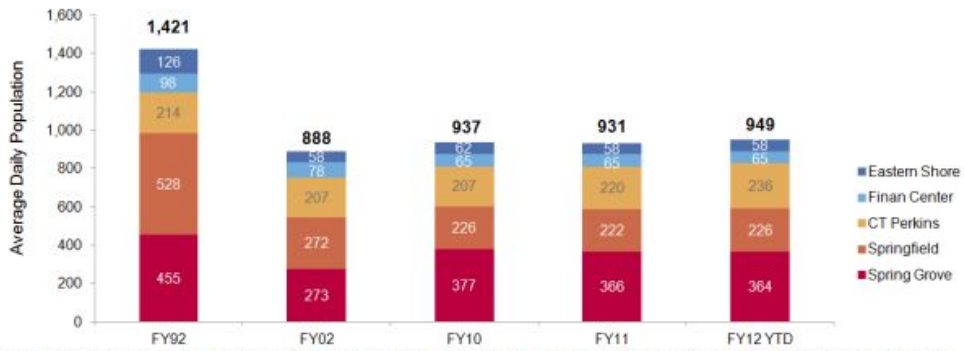
The Potential Demand for State-Run Psychiatric Hospital Capacity Data Collected Continued

Total Maryland State Psychiatric Hospital Capacity, FY85 – FY12



Note: Data includes RICAs but does not include DOMs/ALUs. FY2012 current through December 31, 2011. Operated capacity based on number of beds in buildings now in use. It should be noted that the closure of Crownsville was done with minimum impact on bed capacity, additional capacity being added through the utilization of previously closed buildings at Springfield and Spring Grove. However, since that closure, as noted above, the system has shrunk in terms of bed capacity and number of facilities with the closure of Walter P. Carter and the Upper Shore Community Mental Health Center.

State Psychiatric Hospital Average Daily Population, FY92 – FY12 YTD



Note: Excludes admissions to closed state institutions (Carter, Crownsville, Upper Shore, Highland, Walter P. Carter), Assisted Living Units and Regional Institutions for Children and Adolescents.

- Widespread economic downturn and State deficits have led to cuts in funding for public health services in the past few years.
- Facility capacity declined by 67% since FY85 due to several state hospital closures- Most recent in FY10 of Walter P. Carter Hospital and Upper Shore Community Mental Health Center resulted in shrinking of bed capacity to 944 psychiatric inpatient beds.
- Regional Institute for Children and Adolescents' beds declined by 61% down to 70 beds from 180.

- Admissions to state psychiatric hospitals decreased by 65%- several years of downsizing and MHA policies.
- Recent years, after significant change, average daily population (ADP) has stabilized.
- Down from its high at over 1,400 in 1992, ADP hovers near 950 in most recent fiscal year.
  - Spring Grove's ADP decreased from 377-364; and
  - ADP at Perkins rose from 207-236 in last the three fiscal years.
  - Most recent fiscal year (as of report date)- all state hospitals operating at over 95% occupancy rate.

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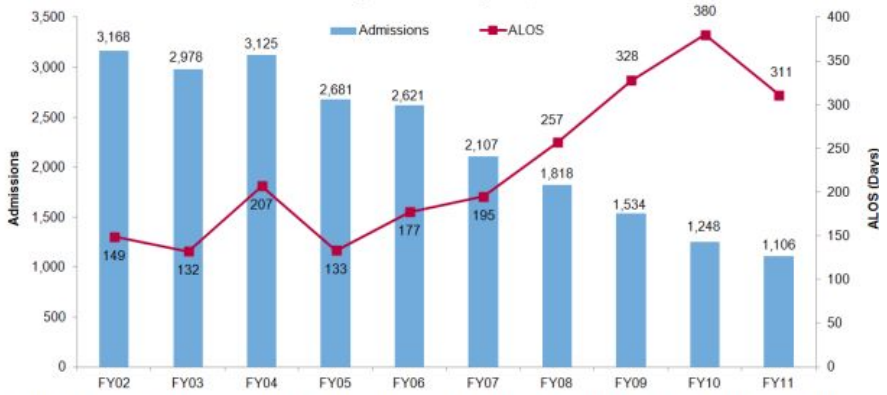
The Potential Demand for State-Run Psychiatric Hospital Capacity Data Collected

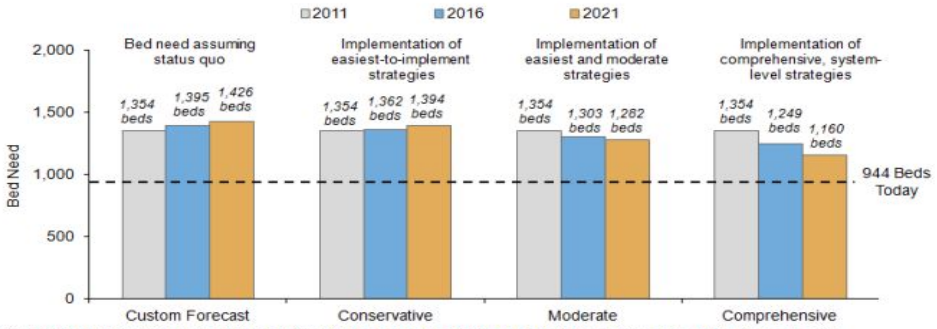
Admissions and ALOS for Total State Psychiatric Hospitals, FY02-FY11



Note: ALOS = average length of stay. ALOS is calculated based on true admission and discharge date. Excludes admissions for Regional Institutions for Children and Adolescents.

- Total admissions declined over the last few years, ALOS increased, reaching a high of 380 days in FY10 and down to 311 days in FY11.
- Overall increase of 109% or 9% year over year in ALOS was reflection of increase in mix of forensically-involved individuals with severe mental illness and movement of civil admissions with shorter stays in community settings.

State Psychiatric Hospital Current and Projected Bed Need by Scenario
95% Target Occupancy, 2011 – 2021



Note: LOS improvements expected for certain patient types resulting from implementation of Moderate and/or Comprehensive scenarios. Recommended occupancy rate for acute care hospitals is 85%; for state hospitals, occupancy rate may not be attainable, therefore was modified to 95%.

- Bed capacity calculated with 95% target occupancy rate:
  - Status Quo- Bed need increases to 1,426 beds by 2021. Bed need continues to grow because of projected admissions growth rate and increasing lengths of stay.
  - Conservative- Bed capacity for Maryland state psychiatric hospitals at 1,394 beds by 2021.
  - Moderate- Needed bed capacity at 1,282 beds by 2021.
  - Comprehensive- Intended to represent best case scenario and potential bed need under best circumstance. Projects needed bed capacity at 1,16 beds by 2021.
- Comprehensive- Greatest impact to reduce bed demand, but requires significant investment in and time to align efforts. Also recommended to address gaps in community services while producing greatest reduced demand for projected bed capacity.

Maryland DEPARTMENT OF HEALTH

Review of Identified Reports Related to Community Initiatives

Criminal Justice-Involved Behavioral Health Workgroup

Maryland
DEPARTMENT OF HEALTH

2019-2021 Annual Report: Commission to Study Mental and Behavioral Health in Maryland

- Study and assess mental and behavioral health services in the State.
- **Included 20 Recommendations:**
  - Design crisis system & improve crisis hotline; *(In Progress)*
  - Formalize a statewide planning body to address the needs of justice involved persons with behavioral health disorders;
  - Develop a mental health-criminal justice center of excellence;
  - Broaden and formalize county-level criminal justice/behavioral health planning committee;
  - Promote standardized training in behavioral health;
  - Clear statutory definition of harm to self and others;
  - Continued exploration of Assisted Outpatient Treatment (AOT) for individuals in the correctional system & returning citizens;
  - Expand Forensic Assertive Community Treatment Teams; and
  - Extended services for Assertive Community Treatment Teams and expand geographical areas of need. *(In Progress)*

2017: BHAC - Strategic Plan: 24/7 Crisis Walk-In and Mobile Crisis Team Services

- Report on crisis response system in the state, and outline recommendations for addressing unmet needs for crisis services.
- **Recommendations:**
  - Specified comprehensive crisis response centers, crisis stabilization centers, crisis treatment centers, and outpatient mental health centers may be included on the Emergency Facilities List.

    Note - Statewide Crisis System in process through Behavioral Health Administration

Maryland
DEPARTMENT OF HEALTH

BHAC - Strategic Plan: 24/7 Crisis Walk-In and Mobile Crisis Team Services: Data Collected

Figure 2 - Crisis Services by Jurisdiction

JURISDICTION	24/7 Clinical Crisis Line	24/7 Hotline	Walk-in Crisis Svcs.	MCT	Crisis Res. Beds	Emerg. Psy. Svcs. (non hospital)	CISM Team	CIT	Hospital Diversion	Pre & Post Booking Diversion	Court - Based Diversion	23 Hour Holding Beds	Urgent Care	Crisis Stabil./ Case Mgmt.	ED Psy. Svcs.
Allegany County	X				X			X					X		X
Anne Arundel County		X		X	X		X	X	X	X		X	X	X	X
Baltimore City	X	X		X	X	X		X	X	X	X	X	X	X	X
Baltimore County	X	X		X	X		X	X					X		X
Calvert Tri County	X				X			F	X		X		X		X
Carroll County					X			X					X		X
Cecil County	X			X				I					X	X	X
Charles Tri County		X			X			F		X			X		X
Frederick County		X	X	X	X			X					X		X
Garrett County		X			X			F					X		X
Harford County				X				X			X		X	X	X
Howard County		X	X	X	X		X	X	X				X		X

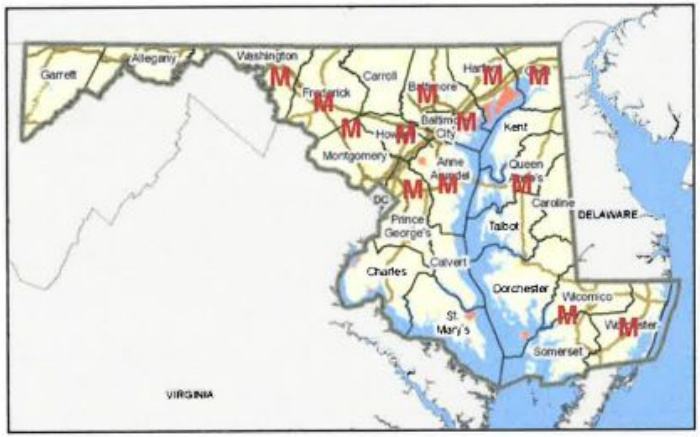
JURISDICTION	24/7 Clinical Crisis Line	24/7 Hotline	Walk-in Crisis Svcs.	MCT	Crisis Res. Beds	Emerg. Psy. Svcs.	CISM Team	CIT	Hospital Diversion	Pre & Post Booking Diversion	Court - Based Diversion	23 Hour Holding Beds	Urgent Care	Crisis Stabil./ Case Mgmt.	ED Psy. Svcs.
Mid-Shore (Caroline, Dorchester, Kent, Queen Anne, Talbot Counties)	X	X		X	X			I			X		X	X	X
Montgomery County	X	X	X	X	X	X	X	X		X			X	X	X
Prince George's County	X	X		X	X	X	X	X	X		X	X	X	X	X
St. Mary's Tri County		X			X			I							X
Washington County		X		X				I					X		X
Wicomico/ Somerset Counties		X		X	X		X	X					X		X
Worcester County	X	X		X	X			X					X		X

Edition: May 5, 2017

KEY
X - service currently in place
I - in process
F - funded, but program not yet developed

Figure 3 – Crisis Walk-in Services by Jurisdiction

Figure 4 – Mobile Crisis Teams by Jurisdiction



Maryland
DEPARTMENT OF HEALTH

BHAC - Strategic Plan: 24/7 Crisis Walk-In and Mobile Crisis Team Services: Data Collected Continued

Jurisdictional/Regional Crisis Services Needed		
Jurisdictions	**Services in Place**	**Services/Enhancements Needed**
Allegany/Garrett Counties	Neither	• 24/7 crisis walk-in services • detox services for ASAM Level III.2-D • MCT
Anne Arundel County	MCT	• 247 crisis walk-in services • detox services for ASAM Level III.2-D
Baltimore City	MCT	• 24/7 crisis walk-in services • increase MCT to 2/47
Baltimore County	MCT	• 24/7 crisis walk-in services • detox services for ASAM Level III.2-D • increase MCT to 2/47
Calvert/Charles/St. Mary's Counties	Neither	• 24/7 crisis walk-in services • detox services for ASAM Level III.2-D • MCT
Carroll County	Neither (funding available for MCT)	• 24/7 crisis walk-in services • detox services for ASAM Level III.2-D • increase MCT to 24/7
Cecil County	MCT	• increase MCT to 24/7
Frederick County	Crisis walk-in services & MCT	• increase both services to 24/7 • detox services for ASAM Level III.2-D
Harford County	MCT	• 24/7 crisis walk-in services • detox services for ASAM Level III.2-D • increase MCT to 24/7
Howard County	Crisis walk-in services & MCT	• detox services for ASAM Level III.2-D • increase MCT to 24/7
Mid-Shore	MCT	• crisis walk-in services • detox services for ASAM Level III.2-D • increase MCT to 24/7
Montgomery County	Crisis walk-in services & MCT	• detox services for ASAM Level III.2-D
Prince George's County	MCT	• 24/7 crisis walk-in services • detox services for ASAM Level III.2-D
Washington County	MCT	• 24/7 crisis walk-in services • detox services for ASAM Level III.2-D • increase MCT to 24/7
Wicomico/Somerset/Worcester Counties	MCT	• 24/7 crisis walk-in services • detox services for ASAM Level III.2-D • increase MCT to 24/7

Maryland DEPARTMENT OF HEALTH

2013: Continuity of Care Advisory Panel

- Explore barriers to continuity of care- economic social, legal and clinical, and make recommendations to strengthen public behavioral health service delivery system, improve health outcomes, and address deficiencies that lead to interruptions of care.
- **15 recommendations:**
  - Pilot expansion program of clinical review panels to extend clinical review panel decisions rendered by MDH to individuals within custody of DPSCS;
  - Promulgate regulations defining dangerousness to promote consistent application of this standard throughout the health care system; and
  - Secretary should convene a Workgroup to expand outpatient civil commitment program in MD.

Omitted Reports

- **2022: Youth-Centered Behavioral Health Intervention and Prevention Programs**
  - Report on role of youth-centered behavioral health intervention and preventative programs as evidence-informed model to reduce and prevent juvenile justice system involvement.
  - Assigned to the Youth Behavioral Health, Individuals with Developmental Disabilities, and Individuals with Complex Behavioral Health Needs Workgroup.
- **2019: Staffing Committee Establishment and Staffing plans at State Psychiatric Facilities**
  - Non-responsive Report
- **2018: Appropriate Staffing Levels for Direct Care Employees & Associated Data in BHA Administrated Facilities**
  - Data provided is identical to 2018-2019 JCR Detailing Direct Care Staffing Issues, Recruitment, and Retention.

Workgroup Report and Open Discussion

- Reactions and recommendations based on the reports.
- Workgroup report will include:
  - Items discussed;
  - Reports reviewed; and
  - The reactions and recommendations of the group.

Closing & Timelines

- Members should review the report and submit final comments by **December 11th at 3:00pm.**
  - *Note - Staff will prepare the report based on today's discussion and will deliver to members over the weekend*
- The final report will be submitted to the commission by **December 14th, at 5:00pm.**
- The full commission will meet via Webex on **December 18th from 12:00pm-3:00pm.**

Maryland
DEPARTMENT OF HEALTH

Behavioral Health Workforce Development, Infrastructure, Coordination, and Financing Workgroup Report

December 14, 2023

Secretary Laura Herrera Scott,
Chair of the Commission on Behavioral Health Care Treatment and Access
201 W. Preston Street
Baltimore, MD 21201

Re: 2023 Behavioral Health Workforce Development, Infrastructure, Coordination, and Financing Workgroup Report

Dear Secretary Herrera Scott:

In keeping with the requirements of House Bill 1148 (Chapter 291, 2023) and Senate Bill 582 (Chapter 290, 2023), the Behavioral Health Workforce Development, Infrastructure, Coordination, and Financing Workgroup respectfully submits its report detailing the first meeting of the Workgroup held on December 8, 2023.

Specifically, the report details the following:

On or before December 1 each year, beginning in 2023, the Workgroups established under Subsection (A) of this section shall report and make recommendations to the Commission.

If you have any questions about this report, please contact Michelle Darling, Director, Office of Workforce Development, BHA, at Michelle.darling@maryland.gov, Jessica Taylor, Health Policy Analyst, Office of Medical Benefits Management, at Jessica.taylor1@maryland.gov or Shayna Dee, Associate Director, Office of Workforce Development, BHA at shayna.dee1@maryland.gov.

Sincerely,

Kathleen A. Birrane
Chair
Behavioral Health Workforce Development, Infrastructure, Coordination, and Financing Workgroup

Legislative Mandate:
The Commission on Behavioral Health Care Treatment and Access was established in the 2023 legislative session.
The Commission was created to recommend "appropriate, accessible, and comprehensive behavioral health services" statewide across the behavioral health continuum of care. HB1148 (Chapter 291), SB582 (Chapter 290).

Workgroup Members and Meetings:
The Workgroup held its first meeting on December 5, 2023, and was Chaired by Commissioner Kathleen A. Birrane.
Given the scope and breadth of work to be completed, Workgroup members identified each Assignment area they are interested in working on and/or leading for the duration of the Commission.

Workgroup Agenda:
Explored Resources and Reports provided by the Commission.
Identified workgroup members by Assignment, 1 - 8, and discussed expectations for future meetings including the development of a work plan, and identifying short and long term recommendations and/or strategies for each.

Assignments and Members Identified:
(1) Conduct a needs assessment of the State's behavioral health care workforce to identify gaps and make recommendations to ensure adequate, culturally competent, and diverse workforce across the behavioral health continuum.

Members: Oleg Tarkovsky, Shannon Hall, Tracey DeShields and Ben Steffen, Michelle Darling and Shayna Dee, BHA

Discussed data provided in the BH Commission Report package, focusing on pages 18 - 22.
Members received information regarding SB283 Task Force Needs Assessment that MHCC and BHA are currently working on.
Members received information on former Workforce Surveys and will continue to explore.

(2) Review trends and best practices from other states regarding policy and reimbursement strategies that support access to a comprehensive array of services and ensure quality of care.

Members: Commissioner Birrane, MIA to lead, Jessica Taylor, Medicaid, Katie Dilley, Jen Clatterbuck, Shannon Hall, and Matt Eisenberg

Discussed data provided in the BH Commission Report package, focusing on pages 18 - 22.
Members agreed to meet to discuss further.

(3) Examine the methods for reimbursing behavioral health care services in the state and make recommendations on the most effective forms of reimbursement to maximize service delivery.

Members: Jen Clatterbuck, Katie Dilley, Matt Eisenberg, Commissioner Birrane and/or MIA designated staff, and Jessica Taylor

Discussed data provided in the BH Commission Report package, pages 18 - 22. Members agreed to meet to discuss further.

(4) Make recommendations on action plans regarding the behavioral health care system's capacity to prepare for and respond to future challenges affecting the entire State or particular regions or populations in the State, including pandemics and extreme weather events.

Members: Matt Eisenberg, Katie Dilley, and Tracey DeShields (and designated staff)

Discussed data provided in the BH Commission Report package, pages 18 - 22. Members agreed to meet to discuss further.

(5) Make recommendations to ensure that behavioral health treatment is provided in the appropriate setting, including methods to divert behavioral health patients from emergency departments by using the Maryland Mental Health and Substance Use Disorder Registry and Referral System Established Under § 7.5–802 of the Health General Article and 2–1–1.

Members: Debra Bennett, Oleg Tarkovsky, and Sheena Patel

Discussed data provided in the BH Commission Report package, pages 18 - 22. Members agreed to meet to discuss further.

(6) Examine and review the use of harm reduction strategies to facilitate access to care.

Members: Debra Bennett and Katie Dilley

Discussed data provided in the BH Commission Report package, pages 18 - 22. Members agreed to meet to discuss further.

(7) Examine methods to assist consumers in accessing behavioral health services.

Members: Debra Bennett, Katie Dilley, Commissioner Birrane and/or MIA designated staff

Discussed data provided in the BH Commission Report package, pages 18 - 22. Members agreed to meet to discuss further.

(8) Explain how the workgroup will incorporate the examination and review of the use of harm reduction strategies to facilitate access to care.

Members: Commissioner Birrane,MIA, Debra Bennett, Shannon Hall (or designee), and Jen Clatterbuck

Discussed data provided in the BH Commission Report package, pages 18 - 22. Members agreed to meet to discuss further.

Appendix A – Workgroup Members

Workgroup Chair

- Kathleen A. Birrane, Maryland Insurance Commissioner

Workgroup Members

- Debra Bennett, Family Member of an Individual with Experience as a Consumer of Behavioral Health Services
- Paula Smith-Benson, Individual with Experience as a Consumer of Behavioral Health Services
- Matt Eisenberg, Individual with Expertise in Health Economics
- Shannon Hall, Representative of the Community Behavioral Health Association of Maryland
- Jen Clatterbuck for Mark Luckner, Executive Director of the Maryland Community Health Resources Commission
- Oleg Tarkovsky, Representative of a Health Insurance Carrier
- Sheena Patel, Designee for the Executive Director of the State Designated Health Information Exchange
- Katie Dilley, Representative of a Local Behavioral Health Authority
- Ben Steffen, Executive Director of the Maryland Health Care Commission
- Tracey DeShields, Maryland Health Care Commission

Workgroup Staff

- Michelle Darling, Director, Office of Workforce Development, Behavioral Health Administration
- Jessica Taylor, Health Policy Analyst, Office of Medical Benefits Management
- Shayna Dee, Associate Director, Office of Workforce Development, Behavioral Health Administration

Appendix - B Reports Reviewed

- Report of the Continuity of Care Advisory Panel
- 2021 JCR (p 101) - Increases in PRP expenditures

- 2020 JCR (p. 104) SUD Residential Treatment Practices and 1115 Waiver
- 2020 JCR (p. 102) Quality Measures for Specialty Behavioral Health Services
- Health-General § 16–201.3(h)(1)—Report on Delivery and Payment Systems
- 2020 JCR (p. 102) Quality Measures for Specialty Behavioral Health Services
- 2019 JCR (p 103-104) - Report on Certified Community Behavioral Health Clinics
- 2019 JCR (p 103) - Report on Occupational Therapy in Behavioral Health Services
- 2018 & 2019 JCR (p 83-84) - Report on behavioral health workforce and infrastructure
- 2018 JCR (p 82) - Report on fidelity audits of supported employment and assertive community treatment programs
- 2017 JCR (p 79) - Report on feasibility and potential impact of merging the core service agencies with local addiction authorities
- 2015 JCR (p 71) - Report on specialty behavioral health information sharing
- 2015 JCR (p 70) - Report on expenses and use of behavioral health services by Medicaid and ACA eligibility
- 2014 Joint Chairmen's Report, Page 80, M00L01.01 – Mental Health Anti-Stigma Education
- 2013 Joint Chairmen's Report (page 71M00L01.03) – Specialty Physician Rate Increase
- 2013 Joint Chairmen's Report, page 69-70 M00L01.02 - Crisis Response Services
- 2013 Joint Chairmen's Report, Page 67, M00K02 - Recovery Support Services
- Re: 2013 Joint Chairmen's Report, Page 66, M00K02 – Local Treatment Grants

Public Comment:
Dan Martin, MHAMD, provided background on the Legislative mandate, the needs assessment and allocation fund to support the workforce.

Next Meeting:
Full Commission Meeting: Dec 18, 2023 12:00 - 3:00 pm.
Future Workgroup meetings to be scheduled.

Appendix C - A List of Prior Reports Reviewed

BH Commission full report of summarized reports w/ hyperlinks

Table of Contents

Geriatric Behavioral Health

- Bed Registry Workgroup Accomplishments (2022)
  - **Purpose**: Summary of key accomplishments of the informal "bed registry" workgroup established in the 2022 interim by Chair Pena-Melnyk. Specifically, the group focused on: **(1)** Decreasing the number of hard to place, high-risk youth and adolescents, including those under the Departments of Human Services and Juvenile Services; **(2)** Implementing Chapter 29 of 2021, the Maryland Mental Health and Substance Use Disorder Registry and Referral System to provide up-to-date statewide hospital psychiatric capacity, and to reduce the number of hospital emergency department boarders; and **(3)** To determine other policy, operational, and other requirements necessary to promote and deliver crisis services in Maryland.
- 2022 JCR (p. 106-107) PASRR Program
  - **Purpose**: This JCR requests information on the State's current Pre-Admission Screening and Resident Review (PASRR) program, the State's ability to meet current federal regulations, as well as opportunities to improve the State's PASRR program. PASRR is guided by federal regulations, and requires all individuals being considered for admission to a Medicaid-certified nursing facility be screened prior to admission to ensure appropriate placement in long-term care.
  - **Recommendations: (1)** Explore opportunities for updating the Level II Evaluation tool: Currently, MDH uses the STEPS assessment for the PASRR Level II Evaluation. The tool was developed by MDH over 30 years ago and benefits from local knowledge regarding the target population. However, with more information available today, compared to 30 years ago, this tool can be strengthened in its SMI and ID analysis. MDH is currently assessing opportunities to enhance this tool, including assessing how a recent standardized assessment, interRAI Home Care, used in subset of Medicaid home and community-based services, may be used. **(2)** Explore the enhancement of PASRR data management systems: MDH is reviewing opportunities to enhance the PASRR data management system. This can improve PASRR program efficiency and effectiveness by strengthening communications between the parties who manage the screenings and evaluations with respect to timeliness, accuracy, and completeness of information.
- 2021 JCR (p. 253-255) Cognitive Health Plan for Maryland
  - **Purpose:** Report on the development of a Cognitive Health Plan for Maryland's Aging Population, which includes information on the current cognitive and behavioral health needs of Maryland's aging population, the challenges the State is expected to face in meeting these needs, adequacy of State services to meet these needs, a plan to coordinate MDOA and BHA services, and a multi-year plan to meet the future cognitive and behavioral health needs of Maryland's aging population.
  - **Data Collected**: Demographic data on 60+ population by jurisdiction and cognitive and behavioral health data for older adults.
  - **Recommendations:** Challenges Maryland faces in addressing this issue: population growth, workforce shortages, racial and ethnic disparities, services not designed for population, forensic/legal guardianship issues, and funding. The report shares that due to the quick turnaround to meet the report deadline, it was not possible to develop a substantive multi-year plan to meet the future cognitive and behavioral health needs of older adult Marylanders. MDOA and MDH recommend the following: **(1)** establishment of internal interagency coordinating process, **(2)** identify existing groups to assist, and **(3)** engage a review of the Alzheimer's 2022-2026 plan.

- 2013 Joint Chairmen's Report, page 71, M00L01.03 – Individuals with Serious Mental Illness and Aging in Place
    - **Purpose:** Discussion of best practices regarding aging in place for individuals with serious mental illness.
    - **Recommendations:** Consideration of an enhanced RRP model which includes RRP services plus personal care services and nursing oversight, and barriers regarding reimbursement for nursing support in RRPs.

Youth Behavioral Health, Individuals with Developmental Disabilities, and Individuals with Complex Behavioral Health Needs

- Report of the Continuity of Care Advisory Panel
    - **Purpose:** The Continuity of Care Advisory Panel was convened in Fall 2013 to explore the barriers to continuity of care – economic, social, legal, and clinical – and make recommendations to strengthen the public behavioral health service delivery system, improve health outcomes, and address deficiencies that lead to interruptions of care.
    - **Recommendations: (1)** DHMH should update information comparing federal privacy statutes and regulations with Maryland's privacy statutes and regulations, including a section devoted to mental health records. **(2)** DHMH should work collaboratively with CRISP to encourage use of its programs by behavioral health providers. **(3)** A behavioral health representative should be on the CRISP Advisory Board. **(4)** DHMH should assess active state and federal EHR incentive programs to ensure economic incentives to encourage EHR utilization among behavioral health providers. **(5)** DHMH should continue to monitor and assess ability to enhance and expand services, and to outline services for individuals with SMI. **(6)** DHMH should sponsor and conduct workforce training in trauma-based care, discharge planning, LGBTQ cultural competency, etc. **(7)** DHMH should develop mental health literacy materials/training that target consumers and providers. **(8)** DHMH should assess issues around the behavioral health provider workforce shortage. **(9)** DHMH should embrace the expansion of telemedicine in both urban and rural communities. **(10)** Amend the Health Care Decisions Act to allow a surrogate to authorize the treatment of a mental disorder. **(11)** Amend statute to allow for short-term or temporary guardianship. **(12)** Recommendations surrounding advance directives. **(13)** Pilot the expansion of clinical review panels to extend decisions rendered by DHMH to individuals within the custody of DPSCS. **(14)** DHMH should promulgate regulations defining dangerousness to promote consistent application throughout the health care system. **(15)** Secretary of DHMH should convene a workgroup to further examine the implementation of an outpatient civil commitment program in Maryland.
- 2022 JCR (p. 255-256) - Report on youth-centered behavioral health intervention and prevention programs
    - **Purpose**: Report on the role of youth-centered behavioral health intervention and preventative programs as an evidence-informed model to reduce and prevent juvenile justice system involvement.
    - **Data Collected:** Current programs that support the behavioral health needs of youth, including those at risk of incarceration or recidivism in Maryland are: **(1)** Adolescent Clubhouse, **(2)** Multisystemic Therapy, Family Functional Therapy, and Family Centered Treatment, **(3)** Children's Cabinet Interagency Fund (CCIF) Program, **(4)** Project Bounceback - Boys & Girls Clubs. Nationally implemented models: Community-based prevention and early intervention programs that are youth-led and youth co-designed are increasing in popularity. The four common features of co-design are: **(1)** Equal value given to expertise by lived experience and expertise by profession or education, **(2)** sharing of decision-making power, **(3)** design-led process, **(4)** use of design methods to support active participation. Examples are: headspace (based in Australia), allcove (in

California), and Blueprints for Healthy Youth Development provides a registry of scientifically proven and scalable interventions.
    - **Recommendations**: Recommend that Maryland explore youth co-designed integrated behavioral health models as a way of reducing juvenile justice involvement. The report noted that a true experience based co-design process does not currently exist in Maryland. Policy makers should consider creating a multi-layered group to start the planning process for developing a pilot program in Maryland that would utilize the co-design model. This group should include different partners including State and private experts, and youth to develop a potential pilot program. Note: HB 1155 (2023) was introduced, but did not pass. Several pieces of testimony cited this JCR.
- FY22 Maryland Out-of-Home Placement and Family Preservation Resource Plan
    - **Purpose:** This report documents the State's capacity for and utilization of out-of-home placements, analyzes the costs associated with out-of-home placements, facilitates an evaluation of Statewide family preservation programs, and identifies areas of need across Maryland and strategies each child-serving agency will employ in FY 2023 to develop those resources
    - **Data Collected**: - Data Dashboard - Out of Home Placement **(1)**The intent of the dashboard is to provide policy decision makers with a visual picture of residential child care programs and the youth who utilize them. Other FY22 Highlights. **(2)** DHS created 49 specialized high-intensity group home beds in the first half of FY 2021. **(3)** BHA allocated $4.8M from an emergency COVID grant for continued development of mobile crisis and stabilization training, technical assistance, implementation, and direct services. **(4)** MDH started the development of an inpatient bed registry and a partnership with Maryland 211 to assist emergency rooms with locating community discharge resources. **(5)** MSDE developed the Maryland School Mental Health Response Program to provide timely consultation and support to Local Education Agencies (LEAs) across Maryland to address student and staff mental and behavioral health concerns.
    - **Recommendations: (1)** Children's Cabinet will continue to improve data collection, reporting, and transparency. **(2)** BHA and MDH Operations have bought six additional high intensity beds for the IDD population, and are actively finalizing RTC licensure/certification for four new "high acuity" RTC beds. **(3)** BHA will continue to work with its RTC and Medicaid partners to expand upon the efforts that began in FY 2022, regarding rate structure and specialized or enhanced bed capacity for the complex youth currently experiencing acute placement challenges. **(4)** DHS will work toward procuring additional in-state services for respite and child placement through expansion with new and existing providers. **(5)** MSDE will also focus on enhancements to the Autism Waiver prospective provider process to include information about electronic visit verification (EVV) for Autism Waiver personal care services
- 2021 JCR (p. 250-251) Voluntary Placement Agreements review and access to intensive behavioral health services
    - **Purpose:** This report provides a review of processes in other states for assisting families in accessing high intensity behavioral health services for their children including states that do not require custody relinquishment or a VPA, DHS, and MDH are still working to provide a succinct assessment and review of other states' processes.
    - **Data Collected**: Discusses current requirements and processes, including those related to voluntary placement agreements (VPA) that may present barriers for children requiring high intensity behavioral health services to access and sustain residential treatment.
    - **Recommendations**: MDH is continuing its efforts to increase the number of providers who administer these services under the Medicaid 1915i/1915(b)(4) waiver.

- Health-General Article §7.5-205.1(c) – Outpatient Civil Commitment Pilot Program Report
    - **Purpose**: Report on the Outpatient Civil Commitment Pilot Program
    - **Data Collected**: **(1)** Data on regulatory changes made to the program. **(2)** Data on implementation activities in FY20. **(3)** Data on who entered and was being treated by the program in FY20 . **(4)** Data on program funding and administrative cost.
- 2020 JCR (p. 104) Assertive Community Treatment Transition
    - **Purpose**: Report on the transition timeline from the Dartmouth Assertive Community Treatment Scale to the Tool for Measurement of Assertive Community Treatment, as well as any incentives, assistance, or other programs planned for providers to ensure compliance with new TMACT standards.
    - **Data Collected: (1)**Timeline estimates- **1.** Develop comms and timelines to inform ACT teams of plans to switch to TMACT (Jan-Mar 2021) **2.** Provide teams with information on rollout of TMACT (Jan-Mar 2021) **3.** Encourage providers to utilize the available resources such as the website: www.institutebestpractices.org/tmact-fidelity (Ongoing since 2013) **4.** Invite mobile treatment teams to participate in TMACT training (Feb-June 2021). **(2)** Data detailing the levels of fidelity- 4.4–5.0: Exemplary Fidelity, 4.0–4.3:High Fidelity, 3.7–3.9:Moderately High Fidelity,3.4–3.6:Moderate Fidelity ,2.7–3.3:Low Fidelity, Below 2.7:Not. ACT Average TMACT fidelity score for current MD ACT teams is 3.7.
    - **Recommendations**: Recommendations on payment service incentives. **(1)** Use 3.0 as the minimum TMACT score to assure that current ACT providers will be eligible to continue to receive the same level of reimbursement while encouraging MTS providers to seek and achieve ACT status. **(2)** Using the current MTS reimbursement rate for MTS ($992.45) - Tier 1, and the current ACT rate for providers who meet the established EBP rate threshold ($1,399.61) - Tier 2. **(3)** Establishing a third tier of reimbursement using a 4.0 as the minimum TMACT score that will provide incentive for ACT teams to provide higher quality services, including enhanced provision of crisis services.

- 2020 JCR (p. 242-244) Increased Capacity for Psychiatric Care for Youth
    - **Purpose**: **(1)** Details the number of beds required to ensure youth psych patients can be placed in treatment 30 hours after arrival at a hospital ER. **(2)** A plan to increase placement bed capacity to meet demand. **(3)** Detail how many beds have been added since 01/01/2020. **(4)** Provide alternate options to allow youth to stay with family during treatment. **(5)** Create a plan for developing or increasing psychiatric crisis response activities for youth. And **(6)** Provide info on psych crisis response activities funded by DHS or MDH.

    - **Data Collected**: Data on placement beds created since 01/01/2020: No beds have been created specifically for youth with behavioral health needs. Funding for psychiatric crisis response activities: DHS provides BHA with funding for the Mental Health Stabilization Services Grant, funding in FY2020 and FY2021 was $1,152,000. FY2021 child serving crisis programs that are funded through BHA have an appropriation of $8,800,240.
    - **Recommendations**: Plan to increase capacity: **(1)** Work with Local Care Teams to make a discharge plan, and uniform Statewide notification protocols. **(2)** Identify regulatory inconsistencies in licensure and facility requirements. **(3)** Create a system for 24/7 mobile crisis and crisis stabilization services. **(4)** Use new options such as the 1915i Medicaid Waiver to increase evidence-based components of intermediate levels of care. **(5)** Expand the bed registry for adults to include children and adolescents. **(6)** Expand interventions earlier in the treatment process. No recommendations for increasing psychiatric crisis response activities, the report only outlines future plans.
- 2019 JCR (p 105-106) - Study on family-centered substance use disorder residential treatment
    - **Purpose:** Report on state capacity, availability, & need for SUD residential treatment centers for women that allow their children to stay with them.
    - **Data Collected**: Population and need for services, DHS data on substance exposed newborns, four residential SUD treatment programs located within three regions of the State dedicate 85 treatment beds to pregnant women and women with dependent children, with additional beds available for the children, and funding data on how much spent for this population.
    - **Recommendations:** Implement START model (Sobriety Treatment & Recovery Teams) to keep children safely with their parents whenever possible and to promote parental recovery and capacity to care for their children.
- 2019 JCR (p 102) - Report on Medication adherence for severe and persistent mental illness patients
    - **Purpose:** Report on individuals within (PBHS) with SPMIs such as schizophrenia, bipolar disorder, or major depression, including dually eligibles to include expenses related to treating this population, impact on expenditures due to nonadherence to medication, and potential patient benefits and cost savings from use of advanced medication adherence technology for the SPMI patient population.
    - **Data Collected:** 2018 data relating to number of individuals, expenses, medication adherence & its impact on health and care usage. Maryland PBHS emergency room and inpatient utilization was higher among nonadherent service users compared to persons who were adherent, but total expenditures were greater for the adherent group. Greater proportion of expenditures for the nonadherent group were spent on emergency and inpatient services.
    - **Recommendations:** Technology, long acting injectables, & clinical approaches all need more research to determine efficacy & cost savings.
- 2016 JCR (p 71-72) - Report on affordable housing for people with severe mental illness
    - **Purpose:** Report on efforts to promote the development of affordable supportive housing for individuals with Serious Mental Illness. Includes a summary of affordable housing with supportive services options from MDH, and efforts made by the Behavioral Health Administration (BHA) to increase affordable housing resources. Current service-connected housing resources: Residential Rehabilitation Programs (RRP); Continuum of Care (CoC), formerly known as Shelter Plus Care. Services providing support to individuals to obtain and maintain independent or supportive housing: Psychiatric Rehabilitation Program (PRP); Targeted Case Management (TCM); Assertive

Community Treatment (ACT). Efforts to increase and support affordable housing: Maryland Partnership for Affordable Housing (MPAH); Permanent Supportive Housing (PSH); Maryland Collaboration for Homeless Enhancement Services (MD-CHES).

- 2014 Joint Chairmen's Report, Page 81, M00L01.01 – Treatment Options for Youth with Heroin-Related Substance Use Disorders
    - **Purpose:** Evaluate Residential Treatment Capacity for Youth with Heroin-Related Substance Use Disorder (Joint with UMD Center for Substance Abuse Research).
    - **Data Collected:** Number of residential facilities that offer treatment, including length of stay, number of youth seeking residential treatment out-of-state, average cost per individual by facility, residential program waiting lists and completion rates, and number of non-residential programs that are able to serve individuals with heroin-related substance use disorders.
- 2013 Joint Chairmen's Report, page 71, M00L01.03 – Individuals with Serious Mental Illness and Aging in Place
    - **Purpose:** Discussion of best practices regarding aging in place for individuals with serious mental illness.
    - **Recommendations:** Consideration of an enhanced RRP model which includes RRP services plus personal care services and nursing oversight, and barriers regarding reimbursement for nursing support in RRPs.
- 2013 Joint Chairmen's Report, page 70 M00L01.03 – Residential Treatment Centers Outcomes
    - **Purpose:** Update on stakeholder group regarding Residential Treatment Center outcomes and development of outcome measures.
    - **Data Collected:** Outcome domains addressed by the RTCs current data collection processes, methods used by RTCs to measure outcome domains, statewide outcomes for youth discharged from RTCs in FY12, and facility specific outcomes for youth discharged from RTCs in FY12.
    - **Recommendations:** Uniform set of core measures to monitor short-term outcomes, establishment of benchmarks for each outcome domain, and continued meetings of the Stakeholder Workgroup.
- 2013 Joint Chairmen's Report, page 69 M00L01.02 – Mental Health Services for Transitional Age Youth
    - Purpose: Mental health services for transitional aged youth discusses best practices nationwide for individuals with serious mental health conditions.
    - Data Collected: Core Service Agencies – Programs for TAY, and survey Results – Needs and/or Gaps in CSA TAY Services.
    - Recommendations: Identified gaps in existing services for TAY.Housing- Crisis, residential treatment, and independent living. Programs designed specifically for transitional aged youth. Coordinated and consistent transition services. Stronger linkages and collaboration. And services for TAY with mild or moderate mental health conditions.
        - Recommendations in development/developing systems of care to support TAY-Establish eligibility and medical necessity criteria that span the child and adult mental health systems to provide continuous, uninterrupted access to Transition Age Youth specific services and supports (eliminates eligibility "cliff"). *Develop a Medicaid funding authority to support these services.*Evaluate the role of Medicaid expansion and health care reform in reimbursing the array of transition services. Position state to capitalize on these changes.Establish systems that facilitate continuity of care between, within, and among various service delivery

systems throughout the transition years. Enhance core competencies of behavioral health practitioners in developmentally appropriate and empirically supported practices to support the needs of Transition Age Youth.

- 2012 Joint Chairmen's Report (p. 60 M00L01.01) – Program Direction- Public and Private Residential Treatment Centers
    - **Purpose:** Provision on information regarding RTCs in the State including vacancy trends, referral trends including acuity labels, review of medical necessity criteria, comparative analysis of costs and adequacy of per diem rates, examination of current outcome measures, analysis of how current RTC system meets the need of Maryland's children.
    - **Data Collected :** vacancy trends and program capacity by bed type, referral trends and patient acuity levels, high intensity psychiatric services received within 90 days prior to RTC Admission, percent of youth entering a RTC with a community-based psychiatric service (paid by MMA) within 90 Days of admission, number of denials, percentage of youth discharged from a RTC who re-entered a RTC within 6-12 months of discharge, or had a psychiatric hospitalized within 23 months of discharge (Paid by MMA Only), comparative analysis of costs & adequacy of per diem rates, examination of current outcome measurement procedures, and UM School of Social Work – Report on Maryland's public and private residential treatment centers (Large amount of responsive data).
    - **Recommendations:** Importance of a consistent set of measures to be developed and implemented in a collaborative fashion by DHMH, RTCs, families, youth, and legislators with technical assistance from evaluation experts, and consideration of longer-term post discharge outcome measures.
- 2011 Joint Chairmen's Report, Page 70, M00K02 - Usage of Non-Opioid Pharmacotherapies for the Treatment of Alcohol Dependence
    - **Purpose:** Usage of non-opioid pharmacotherapies for treatment of alcohol dependence in DPSCS facilities and the general population.
- 2011 Joint Chairmen's Report, Pg. 68 – M00K01.01 – Progress Update on Behavioral Health Integration
    - **Purpose:** Status update on the system of integrated care for individuals with co-occurring serious mental illness and substance abuse issues. Outlines the difference between a "protected carve-in" or a "risk bearing carve out".
    - **Data Collected:** Includes consultant analysis which examines other states and their approach.
    - **Recommendations:** Further information gathering required for determining the specific financing model for behavioral health integration.
- Health-General §10-621—Annual Report on Facilities Requesting to be designated Emergency Facility
    - **Purpose:** The report provides information on the number of facilities that sought designation as emergency facilities and attempted to meet the model facility standards developed under HG § 10-621(c). Under HB 332 (2020), MDH is required (in consultation with stakeholders) to develop a model program structure that ensures that a program wishing to serve as an emergency facility is adequately staffed 24/7, provides the necessary services required for an emergency petition, has written procedures for involuntary admissions through emergency petition, and provides support to respect the due process rights of patients received through emergency petition. Appendix B includes the Model Program Structure of Designated Psychiatric Emergency Facilities.

- BHAC - Strategic Plan: 24/7 Crisis Walk-In and Mobile Crisis Team Services
    - **Purpose:** Report on the crisis response system in the state, including gaps in coverage, and disparities between urban and rural programs. Outlines recommendations for addressing unmet needs for crisis services.
    - **Data Collected: (1)** Data on psychiatric emergency department admission changes FY2007-FY2012. **(2)** Data on trends in youth with ED and/or inpatient hospitalizations FY2007-2012. And **(3)** Data on trends in the number of ED admissions and/or inpatient hospitalizations FY2007-2012.
    - **Recommendations**: Specified that comprehensive crisis response centers, crisis stabilization centers, crisis treatment centers, and outpatient mental health centers (OHMC) may be included on the Emergency Facilities List.
- Opioid Operational Command Center (OOCC) Report- 2018 Annual Report
    - **Purpose:** Work with approximately 20 governmental state partners to implement the statewide plan and track 174 state-level metrics. Work with 24 local jurisdictions in MD to implement the statewide plan. Monitor the extent to which OUTs have implemented these high-priority programs and initiatives, with all jurisdictions making excellent progress. Prevent new cases of opioid addiction and misuse, improve early identification and intervention of opioid addiction, Expand access to services that support recovery and prevent disease and death progression.
    - **Recommendations:** Reduce stigma and improve education around opioid addiction, increase patient, youth, public safety, and general public knowledge of opioid risk and benefits, reduce illicit opioid supply, reduce inappropriate/unnecessary opioid prescribing and dispensing, build capacity of healthcare system to identify opioid use disorders and link patients to speciality care, Improve identification and provision of services to youth at-risk, Identify and connect patients to treatment and recovery services, Implement law enforcement diversion programs to connect low-level drug-involved offenders with treatment services, Improve access and quality of opioid addiction treatment in communities, Enhance criminal justice services for opioid-addicted offenders to prevent re-entry and recidivism into the criminal justice system, Expand access to treatment and recovery services for inmates with SUDs in correctional facilities, Transition inmates with SUDs leaving incarceration to outpatient treatment services, Make overdose education and naloxone distribution available to individuals at high-risk and their communities, Increase access to naloxone, Increase access to other harm reduction services for active opioid users, Expand access to recovery support services, and enhance data collection, sharing, and analysis to improve understanding of and response to the opioid epidemic.
- Opioid Operational Command Center (OOCC) Report- 2019 Annual Report
    - **Purpose**: OOCC goals and objectives for combating the opioid epidemic were adopted as part of the “Interagency Opioid Coordination Plan”, published in Jan 2020. OOCC led the coordination planning process. The OOCC in collaboration with the Interagency Heroin and Opioid Coordination Council (IACC) adopted the “Maryland Interagency Opioid Coordination Plan", which serves as the foundation for the state’s response to addressing the opioid crisis. Prevent problematic opioid use, reduce opioid-related morbidity and mortality, enhance statewide systems to inform strategy, reduce illicit drug supply, expand access to Substance Use Disorder (SUD) treatment in the criminal justice system, expand alternatives to incarceration for individuals with SUD, ensure access to SUD treatment, expand the behavioral health workforce and increase workforce competencies, and ensure access to recovery support services.
    - **Recommendations:** Current grant- HB155/ (Chapter 385) SB164 (Chapter 386)- increases the percentage of eligible costs a state grant can cover after federal funding

has been applied within the MDH's Community Health Facilities Grant Program and Federally Qualified Health Centers Grant Program.

- Opioid Operational Command Center (OOCC) Report- 2020 Annual Report
    - **Purpose:** OOCC is in the process of updating their Coordination Plan for 2021, which will build upon the existing plan and include a new section outlining priority projects. Work closely with MDH offices in their work to reduce opioid related casualties. Enhance state infrastructure to respond to adverse childhood experiences, Establishment of a comprehensive crisis response system, Utilizing data to inform policy and programmatic decisions (DORM falls under this project), Recovery residences expansion, Care coordination, and Wrap-around services for individuals who are justice involved.
    - **Recommendations:** Updated HB277(Chapter 148) / SB367 - requires MSDE to work with MDH to develop guidelines and curriculum on trauma-informed approaches in schools, and HB332 (Chapter 172) / SB441 (Chapter 173) - advises MDH to publish by statue the Emergency Facilities list, which now should include Comprehensive Crisis Response Centers, Crisis Stabilization Centers, and Crisis Treatment Centers.
- Opioid Operational Command Center (OOCC) Reports-2021 Second Quarter Report
    - **Purpose:** OOCC collaborated with Opioid Intervention Teams (OITs), which operate in each of MD's 24 local jurisdictions. These are the 'on-ground' teams that work with local groups to implement the OOCC's overall Coordination Plan and funds through the OOCC's Block Grant program. Continue to make good progress in implementing high-priority programs despite pandemic disruptions.
    - **Recommendations:** Plans to implement all 143 high-priority programs and services that are shown to be effective at the local level.
- Data-Informed Overdose Risk Mitigation (DORM) 2020 Annual Report
    - **Purpose**: HB 922 (2018) - (Chapter 211) - otherwise known as Chapter 211, requires the MDH to produce an annual report examining the prescription and treatment history of individuals in the state who suffered fatal overdoses in the preceding years. Referred to as the DORM initiative - the assessment of enumerated factors associated with fatal and nonfatal overdose risk and programs targeted at opioid use and misuse. **Phase 1**: Identifying and coordinating the centralization of linked overdose datasets and programmatic datasets to establish a broad and holistic progrile of health system interactions for people who died of drug overdose. **Phase 2**: Establishing infrastructure to conduct more rigorous analyses of multiple linked datasets that look at relative risk for fatal and nonfatal overdose.
    - **Recommendations:** Increase data collection and analysis surrounding the overdose crisis and systemic connections to better inform the state's response strategy.
- Data-Informed Overdose Risk Mitigation (DORM)- 2021 Annual Report
    - **Purpose:** Identify and understand data showing that there is a growing disparity in overdose related deaths in the Black community, and big racial disparities in deaths and in treatment for opioid use disorder. Large proportion of people who are dying are engaged with the healthcare system.
    - **Recommendations:** Expand access to buprenorphine for treatment of opioid use disorder (OUD)-Includes expanding access to Black Marylanders, who are at high-risk. Expand targeted naloxone distribution to friends and family of opioid users/reducing barriers for bystander naloxone administration. Address growing racial disparities.Identify culturally competent strategies to address increasing overdose death rates among older adults (55+). Bolster targeted outreach and care coordination for medicaid-eligible

populations. Continue to expand linkages to care for people in high-risk settings (criminal justice system, public behavioral health system, hospitals). And continue to explore cocaine and fentanyl-related deaths to better tailor interventions for people who use drugs.

Additional reports on I/DD (non-MDH reports)

- Persons With Intellectual and Developmental Disabilities in the Mental Health System: Part 1. Clinical Considerations
    - **Purpose:** To assess and discuss individuals with overlapping intellectual and developmental disabilities and mental health conditions. Focused primarily on clinical considerations, the article discusses considerations and challenges for treating this unique population in the mental health system.
    - **Recommendations**:Recognize trauma and introduce trauma- informed care and support systems. Provide behavioral support systems
- Co-Occurring Mental Illness and Behavioral Support Needs in Adults with Intellectual and Developmental Disabilities
    - **Purpose**: To examine rates of co-occurring conditions in a sample population of adults with IDD who use state funded services in Virginia. After identifying four categories, researchers examined differences in individual and system level factors in people with and without co-occurring conditions.
- All-Cause, 30-Day Readmissions Among Persons With Intellectual and Developmental Disabilities and Mental Illness
    - **Purpose:** Examine early hospital readmissions within 30 days of discharge among those with IDD and co-occurring mental illness.
    - Recommendations:Increase post- discharge support and increase attention regarding discharge and planning

Criminal Justice-Involved Behavioral Health

- Annual Report- Commission to study mental and behavioral health in Maryland
    - **Purpose**: To study and assess mental and behavioral health services in Maryland.
    - **Recommendations**: Report provides a progress update on 2019 -2020 recommendations - **(1)** design a comprehensive crisis system, **(2)** continue coordination with the System of Care Optimization and Integration Workgroup; **(3)** increase funding for the Second Chance Act Grant, **(4)** improve the Crisis Hotline; **(5)** promote standardized training in behavioral health, **(6)** ensure proper warnings regarding cannabis use, **(7)** standardize mental and behavioral health programming in schools, **(8)** improve access to information and services; **(9)** clear statutory definition of harm to self and others; **(10)** enact more permanent telehealth reform, **(11)** explore AOT pilot for returning citizens, **(12)** expansion of ACT teams, **(13)** extended services for ACT teams, **(14)** obtain IMD exclusion waiver, **(15)** explore provider reimbursement rates as non-quantitative treatment limitations, **(16)** formalize a statewide planning body to address the needs of justice involved persons with behavioral health disorders, **(17)** develop a mental health-criminal justice center of excellence, **(18)** broaden and formalize county-level criminal justice/behavioral health planning committees, **(19)** standardize and formalize reporting on mental health parity non-quantitative treatment limitations; **(20)** improve access for Maryland's youth and families to vital information.
- Report of the Continuity of Care Advisory Panel
    - **Purpose:** The Continuity of Care Advisory Panel was convened in Fall 2013 to explore the barriers to continuity of care – economic, social, legal and clinical – and make recommendations to strengthen the public behavioral health service delivery system, improve health outcomes, and address deficiencies that lead to interruptions of care.
    - **Recommendations: (1)** DHMH should update information comparing federal privacy statutes and regulations with Maryland's privacy statutes and regulations, including a section devoted to mental health records. **(2)** DHMH should work collaboratively with CRISP to encourage behavioral health providers to use CRISP programs. **(3)** A behavioral health representative should be on the CRISP Advisory Board. **(4)** DHMH should assess active state and federal EHR incentive programs to ensure that the economic incentives are in place to encourage EHR utilization among behavioral health providers. **(5)** DHMH should continue to monitor and assess ability to enhance and expand services, and to outline services for individuals with SMI. **(6)** DHMH should sponsor and conduct workforce training in certain areas, including trauma-based care, discharge planning, LGBTQ cultural competency, etc. **(7)** DHMH should develop mental health literacy materials/training that target consumers and providers. **(8)** DHMH should assess issues around the behavioral health provider workforce shortage. **(9)** DHMH should embrace the expansion of telemedicine in both urban and rural communities. **(10)** Amend the Health Care Decisions Act to allow a surrogate to authorize the treatment of a mental disorder. **(11)** Amend statute to allow for short-term or temporary guardianship. **(12)** Several recommendations surrounding advance directives. **(13)** Pilot the expansion

of clinical review panels to extend clinical review panel decisions rendered by DHMH to individuals within the custody of DPSCS. **(14)** DHMH should promulgate regulations defining dangerousness to promote consistent application of this standard throughout the health care system. **(15)** Secretary of DHMH should convene a workgroup to further examine the implementation of an outpatient civil commitment program in Maryland.

- Forensic Services Work Group: Report of Recommendations
    - **Purpose:** Forensic Services Workgroup (which met in summer 2016) was charged with developing concrete recommendations on how to reduce unnecessary congestion in Maryland's State Hospital System by providing improved efficiencies, maximizing appropriate throughput and providing for immediate system relief, as well as making longer-term recommendations that may require significant system-wide changes to prevent a similar backlog from occurring in the future.
    - **Recommendations: (1)** Increase bed capacity within DHMH. **(2)** Increase availability of Community Crisis Services. **(3)** Expand the capacity of the Office of Forensic Services. **(4)** Increase outpatient capacity to meet the needs of forensic patients. **(5)** Centralize DHMH Forensic Processes. **(6)** Increased education to reduce stigma in both the general public and mental health treatment community.
- BHAC - Strategic Plan: 24/7 Crisis Walk-In and Mobile Crisis Team Services
    - **Purpose:** Report on the crisis response system in the state, including gaps in coverage, and disparities between urban and rural programs. Outlines recommendations for addressing unmet needs for crisis services.
    - **Data Collected: (1)** Data on psychiatric emergency department admission changes FY2007-FY2012. **(2)** Data on trends in youth with ED and/or inpatient hospitalizations FY2007-2012. And **(3)** Data on trends in the number of ED admissions and/or inpatient hospitalizations FY2007-2012.
    - **Recommendations**: Specified that comprehensive crisis response centers, crisis stabilization centers, crisis treatment centers, and outpatient mental health centers (OHMC) may be included on the Emergency Facilities List.
- 2022 JCR (p. 255-256) - Report on youth-centered behavioral health intervention and prevention programs
    - **Purpose**: Report on the role of youth-centered behavioral health intervention and preventative programs as an evidence-informed model to reduce and prevent juvenile justice system involvement.
    - **Data Collected:** Current programs that support the behavioral health needs of youth, including those at risk of incarceration or recidivism in Maryland are: **(1)** Adolescent Clubhouse, **(2)** Multisystemic Therapy, Family Functional Therapy, and Family Centered Treatment, **(3)** Children's Cabinet Interagency Fund (CCIF) Program, **(4)** Project Bounceback - Boys & Girls Clubs. Nationally implemented models: Community-based prevention and early intervention programs that are youth-led and youth co-designed are increasing in popularity. The four common features of co-design are: **(1)** Equal value given to expertise by lived experience and expertise by profession or education, **(2)** sharing of decision-making power, **(3)** design-led process, **(4)** use of design methods to support active participation. Examples are: headspace (based in Australia), allcove (in California), and Blueprints for Healthy Youth Development provides a registry of scientifically proven and scalable interventions.
    - **Recommendations**: Recommend that Maryland explore youth co-designed integrated behavioral health models as a way of reducing juvenile justice involvement. The report noted that a true experience based co-design process does not currently exist in

Maryland. Policy makers should consider creating a multi-layered group to start the planning process for developing a pilot program in Maryland that would utilize the co-design model. This group should include different partners including State and private experts, and youth to develop a potential pilot program. Note: HB 1155 (2023) was introduced, but did not pass. Several pieces of testimony cited this JCR.

- 2020 JCR (p. 97) Apprenticeship Program at State Facilities
    - **Purpose:** The report details the state of Apprenticeship programs at State Facilities.
    - **Data Collected:** Spring Grove, Springfield, Perkins and Finan have a Vocational Adjustment Program(VAP). Eastern Shore Hospital and Potomac and Holly Centers do not have an established VAP program. The Number of patients participating in the VAP for the prior 3 years: Spring Grove: 231, Springfield: 155, Perkins: 160, and Finan: 152. FY20 annual wages paid to patient workers; Spring Grove: $134,000, Springfield: $44,912, Perkins: $233,500, and Finan: $33,199.
- 2019 JCR (p 101) - Report on staffing committee establishment and staffing plans at State psychiatric facilities
    - **Purpose:** Asked for funds to be reverted- did not establish staffing committees nor staffing plans.
- 2018 JCR (p 84) - Report on inpatient psychiatric bed capacity across all sectors
    - **Purpose:** Report on inpatient psychiatric bed capacity in both private and public facilities across Maryland, and provide recommendations on the appropriate inpatient psychiatric bed capacity by sector.
    - **Data Collected:** FY 13-17 data on capacity per sector, total psych patient days by sector, and number of discharges by sector.
- 2018 JCR (p) - Report on appropriate staffing levels for direct care employees and associated data in BHA administrated facilities
    - **Purpose**: Detail what salaries the department would have to provide in order to lower the vacancy rates among these employees, including the impact upon the budget of reclassifying the salaries of these employees to the appropriate rates.
- 2018 & 2019 JCR (p 82) - Report detailing direct care staffing issues, recruitment and retention
    - **Purpose**: The staffing levels required to operate specific units of the various facilities as well as the amount of staff that the department will need to operate its desired bed capacity. High rate of employee absenteeism (both planned, benefitted time, and unplanned time) has a significant impact on staffing patterns. Includes overview on staffing model for facilities, says they are appropriate.
    - **Recommendations**: Employee training, pay analysis, create flex pool for system, reduce absenteeism and account for it in staffing model.
- 2017 JCR (p 71) - Report on implementing the recommendations of the Forensic Services Workgroup
    - **Purpose:** Report on the implementation of certain recommendations from the Forensic Services Workgroup of 2016.
    - **Recommendations:** Disagreed with the recommendation to reclass facility staff to be forensic classification- level of care provided by different facilities is a continuum.
- 2016 JCR (p 71) - Report on security recommendations for State psychiatric facilities
    - **Purpose:** To provide recommendations on the department's security review of the State-operated psychiatric hospitals, how the department will implement those recommendations, and what barriers to implementation exist.

- 2016 JCR (p 72)- Report on alternatives to residential treatment for Commitments under Section 8-507 of the Health-General Article
    - **Purpose:** Appropriateness of utilizing recovery support housing in conjunction with outpatient services to meet the needs of those individuals committed to the Department. Includes overview of 8-507 placement procedure. Lists alternatives: IMD, outpatient services, and recovery housing.
- 2014 Joint Chairmen's Report, Page 78, M00K01 – Treatment and Service Options for Certain Court-involved Individuals
    - **Purpose:** Review and recommendations of treatment and service options for court-ordered populations in the Department's care, including forensic waitlist.
    - **Data Collected**: Forensic and Non-Forensic Admissions to State Psychiatric Facilities (Fiscal 2002 - 2014), Average Wait Time for Residential Placement in a State Psychiatric Facility or State Intellectual Disability Center (Fiscal 2012 – 2014), Total Number of Court-Ordered Substance Use Evaluations and Commitments (Fiscal 2012 – 2014), Time to Placement in an 8-507 Residential Treatment Slot (Fiscal 2012 – 2014), Caseloads for Forensic Staff State Psychiatric Regional Hospitals, Appendix A – Treatment and Service Options For Court Involved Individuals by County, Appendix B – Approved Mental Health Case Management Programs by County, and Appendix C – Diversion Programs by CSA.
    - **Recommendations**: Assertive Community Treatment: The Department should increase funding to expand Assertive Community Treatment for individuals seeking services voluntarily. **Peer Support:** It was recommended that additional funding be appropriated to expand peer support services within each jurisdiction. Expansion should include the public mental health service delivery system, local detention centers, courts and primary care. **Housing:** The Department should increase funding for rental subsidies. **Crisis Services:** Additional funding be appropriated to further integrate and enhance crisis services statewide**. (1)** There is a need for 10% more bed availability in the state hospital system … [discusses community partnerships] .. there will need to be an extra 100 beds added to the state system. The Department should further examine barriers to clinically appropriate movement within the forensic service delivery system. This should include movement into and between regional hospitals and Clifton T. Perkins Hospital Center, transitions from hospitals into the community, and reasons for unsuccessful community placements that necessitate returns to the hospitals. **(2)** The initial analysis of 8-505 and 8-507 wait times revealed that additional evaluation is necessary to assess delays in the evaluation and placement process. Among other things, this evaluation should: **(1)** assess the various funding streams for publicly funded drug treatment placements; and **(2)** identify the number of placements made through the various funding streams, including the timing to placement and whether there is a waitlist for services. Finally, the Department is developing a streamlined, centralized approach to receiving court orders and will notify all administrative judges and criminal court clerks regarding how to forward orders to receive the most expedient response. **(3)** The Department should update this study using data that reflects the demand for substance use services since the implementation of the Affordable Care Act. The study should identify the demand for various levels of care, including residential services, throughout the four regions of the state. **(4)** The Department should expedite the building of the forensics database in order to begin capturing data as soon as possible. The database process allows for the adding of modules based on future interests within the Department, and the Department will involve internal and external stakeholders in these future developments as needed. **(5)** As a part of its budget submission, BHA should develop MFR outcomes to measure the

performance of the Office of Forensic Services. Potential outcomes to measure the Office's performance may include **(1)** timeliness of evaluations; **(2)** timeliness of admissions; **(3)** timeliness of release; and **(4)** timeliness of aftercare planning. **(5)** A joint behavioral health and criminal justice system for the identification of high utilizers of services in both systems. This would then lead to the development of specialized approaches to managing high utilizers once they are identified. **(6)** The Department recommends budgeting for increased forensic staffing, particularly at Spring Grove Hospital Center.

- 2012 Joint Chairmen's Report, Pg. 61, M00L.01.01 – Mental Hygiene Administration – Program Direction – Various Information on the Redevelopment of Spring Grove Hospital Center
    - **Purpose:** Reporting on the facility program document for SGHC, development of public-private partnership, plan to utilize Plot K, detail how the Mental Hygiene Community Based Services Fund can support development of community capacity to reduce demand for State-operated inpatient psychiatric capacity.
    - **Recommendations:** Determined no need for additional bed capacity in the State.
- 2011 Joint Chairmen's Report, Page 72, M00L – Report on the Potential Demand for State-Run Psychiatric Hospital Capacity
    - **Purpose:** Report on future demand, community strategies, and best practices on Maryland's State-run psychiatric hospitals.
    - **Recommendations:** Additional community support services, financial incentives to increase provider risk for outcomes, additional affordable and supportive housing options, greater partnerships with local businesses to provide additional employment opportunities, improved use of technology through the implementation of EHR and additional tele-psychiatry services, and expanded community after care services and residential beds.

Behavioral Health Workforce Development, Infrastructure, Coordination, and Financing

- Report of the Continuity of Care Advisory Panel
  - **Purpose:** The Continuity of Care Advisory Panel was convened in Fall 2013 to explore the barriers to continuity of care – economic, social, legal and clinical – and to make recommendations to strengthen the public behavioral health service delivery system, improve health outcomes, and address deficiencies that lead to interruptions of care.
  - **Recommendations: (1)** DHMH should update information comparing federal privacy statutes and regulations with Maryland's privacy statutes and regulations, including a section devoted to mental health records. **(2)** DHMH should work collaboratively with CRISP to encourage behavioral health providers to use CRISP programs. **(3)** A behavioral health representative should be on the CRISP Advisory Board. **(4)** DHMH should assess active state and federal EHR incentive programs to ensure that the economic incentives are in place to encourage EHR utilization among behavioral health providers. **(5)** DHMH should continue to monitor and assess ability to enhance and expand services, and to outline services for individuals with SMI. **(6)** DHMH should sponsor and conduct workforce training in certain areas, including trauma-based care, discharge planning, LGBTQ cultural competency, etc. **(7)** DHMH should develop mental health literacy materials/training that target consumers and providers. **(8)** DHMH should assess issues around the behavioral health provider workforce shortage. **(9)** DHMH should embrace the expansion of telemedicine in both urban and rural communities. **(10)** Amend the Health Care Decisions Act to allow a surrogate to authorize the treatment of a mental disorder. **(11)** Amend statute to allow for short-term or temporary guardianship. **(12)** Several recommendations surrounding advance directives. **(13)** Pilot the expansion of clinical review panels to extend clinical review panel decisions rendered by DHMH to individuals within the custody of DPSCS. **(14)** DHMH should promulgate regulations defining dangerousness to promote consistent application of this standard throughout the health care system. **(15)** Secretary of DHMH should convene a workgroup to further examine the implementation of an outpatient civil commitment program in Maryland.
- 2021 JCR (p 101) - Increases in PRP expenditures
  - **Purpose**: Analysis of the increase in psychiatric rehabilitation program (PRP) expenditures, utilization, and growth in the number of PRP providers.
  - **Data Collected**: **(1)** Licensed PRP sites in 2019, 2020, and 2021. **(2)** Utilization of PRP services (count of individuals receiving services, rate of Medicaid eligible individuals receiving services). **(3)** Total PRP expenditures by jurisdiction, per person.
  - **Recommendations**: **(1)** Develop cost containment strategies by reviewing the current payment structure through a rate study, and evaluating, developing and implementing lower-cost alternatives to PRP, such as Peer Support programs, low-cost substance use disorder case management programs, and mental health case management. **(2)** Develop quality management systems for PRP programs that include an enhanced compliance system and a monitoring and evaluation system to evaluate program outcomes and compliance. **(3)** Offer training and capacity building for PRP providers and managers to improve the quality of services provided in regulatory compliance, billing practices, service provision, and core competency.

- 2020 JCR (p. 104) SUD Residential Treatment Practices and 1115 Waiver
    - **Purpose:** The report details the effectiveness of residential SUD treatment, best clinical practices in residential SUD treatment, the frequency and length of treatment, opportunities to expand Medicaid coverage to cover residential SUD treatment, and timelines for seeking adjustments or revisions to Medicaid reimbursement policies.
    - **Data Collected**: Effectiveness of residential SUD treatment. Best clinical practices-evidence suggests that the most effective approach is for integrated treatment approaches for individuals with co-occuring mental health and substance use disorders. This approach has led to significant improvements in mental health and substance use outcomes. Waivers for treatment expansion- In 2016, MD Medicaid was granted a waiver amendment to cover substance use disorder services delivered in Institutions for Mental Disease(IMD). On November 19, CMS lifted the IMD exclusion for Medicaid payment for inpatient mental health treatment. Beginning on July 1, 2019, Medicaid was granted a waiver amendment to cover inpatient services for people with a primary SUD diagnosis and a secondary mental health diagnosis for up to 15 days. **Timeline:** Medicaid has reimbursed up to two nonconsecutive 30-day stays of IMD services on the following schedule: Effective July 1, 2017: Coverage of ASAM levels 3.7WM, 3.7, 3.5, and 3.3; Effective January 1, 2019: Coverage of ASAM level 3.1; and Effective January 1, 2020: Coverage for dual eligibles.
- 2020 JCR (p. 102) Quality Measures for Specialty Behavioral Health Services
    - **Purpose:** The report **(1)** details methodology for the selection of quality of care measures, **(2)** lists the quality measures with potential, and **(3)** details the barriers to data collection and the limitations of available data that affects the implementation of identified behavioral health quality metrics.
    - **Data Collected**: 52 behavioral health quality measures were selected for review, of these 22 were presented to the BHA quality measure work group.16 measures were identified in the report. Noted limitations of available data: lack of sufficient evidence base, inadequate data infrastructure, lack of a consistent approach to implement behavioral health quality measurement across different behavioral health settings
    - **Recommendations: (1)** Behavioral health ED visits. **(2)** Follow-up after mental health hospitalization. **(3)** Follow-up after SUD residential treatment. **(4)** 30-day readmission following inpatient psychiatric treatment. **(5)** 30-day readmission following SUD residential treatment. **(6)** Antidepressant medication fills post discharge. **(7)** Antipsychotic medication fills post discharge. **(8)** Medication adherence to antipsychotics for youths and adults. **(9)** Participation in MAT. **(10)** Opioid treatment program/MAT engagement and retention. **(11)** Continuity of pharmacotherapy for OUD. **(12)** Tobacco use and cessation. **(13)** Criminal justice involvement. **(14)** Employment status. **(15)** Telehealth services.
- Health-General § 16–201.3(h)(1)—Report on Delivery and Payment Systems
    - **Purpose:** Report on the behavioral health care delivery system, and recommendations on the payment system.
    - **Data Collected:** Data on the Maryland Public Mental Health System cost/rate setting history of outpatient mental health center reimbursement payments and psychiatric rehab rates. Details of the current system of licensing and accreditation for substance abuse and mental health services. Details of the transfer from a grant to a fee for service structure. Data on potential merging of core service agencies with local addictions authorities into local behavioral health authorities.
    - **Recommendations**: **(1)** Any rates paid by MCOs should not be lower than the rates in effect during the immediately preceding fiscal year for the first fiscal year the MCOs

provide the services, and in full compliance with federal and State parity laws. **(2)** All providers participating in the PBHS should act within the scope of practice of their license or certificate to receive reimbursement. **(3)** Community-based behavioral health services should be provided at the local level by providers who are licensed at the independent practice level to provide treatment, or by programs with accreditation-based licensing through BHA's Licensing Unit to do so. DUI education should continue to be licensed through BHA's Licensing Unit. **(4)** BHA and local jurisdictional behavioral authorities should continue to provide oversight of publicly funded behavioral health services through an integrated system, both at the state and local level. **(5)** Rate increases for federally funded grant programs and specialized pilot programs should be contingent on increases in federal funding, and within federal requirements (funds are not used to supplant other funding). **(6)** Rate study should include an evaluation of the job classifications and salary of direct care and licensed clinicians working in the public sector in comparison to those working in the private market. **(7)** Value-based payment mechanisms should be explored to improve the quality of services.

- 2019 JCR (p 103-104) - Report on Certified Community Behavioral Health Clinics
    - **Purpose:** Report that highlights the progress of the two Maryland CCBHC grantees and explores the potential for broader implementation of this model throughout the State.
- 2019 JCR (p 103) - Report on Occupational Therapy in Behavioral Health Services
    - **Purpose:** Understand the availability of occupational therapy services in PBHS & identify current reimbursement practices for licensed occ therapy practitioners (including which programs are reimbursed) & barriers to reimbursing occ therapy. CMS permits coverage of occ therapy- MD medicaid reimburses community based providers provided to kids as part of EPSDT & adults in hospital settings. PBHS only covers occupational therapy services provided in a Federally Qualified Health Center (FQHC) or Outpatient Mental Health Clinic (OMHC) for kids. And expanded reimbursement for adults would require state plan amendment and scope would be very large and require fiscal impact.
- 2018 & 2019 JCR (p 83-84) - Report on behavioral health workforce and infrastructure
    - **Purpose**: Statewide review of the behavioral health workforce and infrastructure to determine the strengths and weaknesses of PBHS.
    - **Data Collected**: Data on number of behavioral health services by jurisdiction; the occupancy rate of residential-based treatment; number of licensed mental health (MH) and substance use disorders (SUD) providers; and number of certified and non-certified peer recovery specialists (CPRS and PRS).
    - **Recommendations**: Increase the availability of telepsychiatry and videoconferencing which allows access to consultation and education in remote parts of the State; link consumers with local resources such as volunteers and community organizations that could provide transportation to and from behavioral health treatment services; and integrate MH and SUD provider services.
- 2018 JCR (p 82) - Report on fidelity audits of supported employment and assertive community treatment programs
    - **Purpose**: Report on the effect of fidelity audits on evidence-based practices, such as supported employment (SE) and assertive community treatment (ACT).
    - **Data Collected**: Data on the penetration rates of evidence-based practices in the area of SE and ACT (e.g., enhanced mobile treatment), the number and percentage of teams that met eligibility as a function of the number of teams assessed, the number and

percentage of teams who met eligibility conditionally, and the number and percentage of teams who were determined ineligible.

- 2017 JCR (p 79) - Report on feasibility and potential impact of merging the core service agencies with local addiction authorities
    - **Purpose:** Detail the feasibility, costs, and benefits of merging the core service agencies with the local addictions authorities in various jurisdictions.
    - **Recommendations:** Merging under LBHAs is good as long as the locals have flexibility.
- 2015 JCR (p 71) - Report on specialty behavioral health information sharing
    - **Purpose:** To describe the efforts conducted by the behavioral health Administrative Services Organization (ASO) and Medicaid Managed Care Organizations (MCOs) to improve the exchange of information and coordination of care for Medicaid-eligible individuals who use specialty behavioral health services, in the context of federal regulations governing data-sharing. Covers background on integrated BH system carve out, consent issues.
- 2015 JCR (p 70) - Report on expenses and use of behavioral health services by Medicaid and ACA eligibility
    - **Purpose:** Evaluate expenditures and utilization by Medicaid and ACA eligibility.
- 2014 Joint Chairmen's Report, Page 80, M00L01.01 – Mental Health Anti-Stigma Education
    - **Purpose:** Evaluate mental health anti-stigma education efforts, best practices, current applications statewide, and cost of developing a statewide model.
    - **Data Collected:** Number of individuals attending the Anti-Stigma Project workshops, number of individuals trained in Mental Health First Aid, and costs for developing a state-wide anti-stigma education program.
    - **Recommendations**: Strategies include: involving mental health consumers; using existing commemorative events such as Mental Health Awareness Month; using train-the-trainer and peer-to-peer opportunities; and working closely with key partners to promote buy-in.
- 2013 Joint Chairmen's Report (page 71M00L01.03) – Specialty Physician Rate Increase
    - **Purpose**: Increase of specialty physician evaluation & management rates.
- 2013 Joint Chairmen's Report, page 69-70 M00L01.02 - Crisis Response Services
    - **Purpose:** To provide a landscape of crisis services statewide, identify gaps, outline the associated cost, and provide recommendations for funding these needed services. Outlines how additional crisis funding will be utilized by the county.
    - **Data Collected:** Attachment A – Essential Crisis Response System Components, Attachment B – Existing Crisis Services by Jurisdiction, Attachment C – FFS and Grant Funded Existing Crisis Services by Jurisdiction, and Attachment D – Crisis Response and CIT Funding Allocations.
    - **Recommendations:** Expansions of crisis services.
- 2013 Joint Chairmen's Report, Page 67, M00K02 - Recovery Support Services
    - **Purpose:** Reporting on outcome measures for recovery support services, data collection methodology, and timeframe for implementation.
    - **Data Collected:** Number of participants served in FY13 for recovery services, number of providers in FY13 of recovery services, access to Recovery Program Outcome Data regarding abstinence, employment/education, and stability in housing, and Appendix - Draft MFR Template for Recovery Support Services.

    - **Recommendations**: Creation of new outcome measures as outlined in the Appendix focused on abstinence, education/employment, stability in housing, and participation in self-help groups.
- Re: 2013 Joint Chairmen's Report, Page 66, M00K02 – Local Treatment Grants
    - **Purpose:** Fiscal year 2013 local treatment expenditures and initial fiscal year 2014 local treatment grant expenditures by American Society of Addiction Medicine (ASAM) level of care.
    - **Data Collected**: Attachment A – Planned Local Treatment Grant Expenditures FY2014.

Appendix D - Behavioral Health Administration Needs Assessment

Maryland
DEPARTMENT OF HEALTH

BEHAVIORAL HEALTH COMMISSION INITIAL NEEDS ASSESSMENT

Sara Barra, Chief of Staff, Behavioral Health Administration

November 9, 2023

Agenda

- Behavioral Health Continuum of Care
- Morbidity, Mortality and Behavioral Health
- Service Utilization Analysis
- Assessment of Currently Funded Services by Jurisdiction
- Next Steps

Behavioral Health Continuum of Care

Prevention/Promotion				Primary Behavioral Health/ Early Intervention		Urgent/Acute Care		Treatment / Recovery	
Promotion	Universal Prevention	Selective Prevention	Indicated Prevention	Outpatient Care	Intermediate Care	Urgent/ Crisis Care	Acute Treatment	Long-Term Treatment	Recovery Supports

Data / Quality / Health Equity / Workforce Initiatives

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Morbidity, Mortality and Behavioral Health

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National Context

- Untreated behavioral health conditions have serious consequences, including reduced life expectancy
    - Americans with a major mental illness die 14 to 32 years earlier than the general population
- Comorbid medical conditions are often cited as the main factor contributing to shortened life expectancy for those with mental illness
- Suicide is one of the most widely acknowledged contributors to premature mortality among individuals with mental illness
    - Suicide is the 10th leading cause of death for all ages in the United States, and the second leading cause of death for individuals age 10–34
- Mortality is also impacted by overdose deaths
    - In 2021 life expectancy in the US declined, primarily due to increases in COVID-19 and drug overdose deaths.

Sources: Centers for Disease Control and Prevention, Medicaid and CHIP Payment and Access Commission

Maryland Mortality Data

Overdose Data:

- In 2022, there were 7.6% fewer fatal overdoses in Maryland compared to 2021 (decreasing from 2,800 to 2,586).
- There were 2,581 fatal overdoses in the 12 months ending in May 2023. This was a 2.9% decrease compared to the 12 months ending in May 2022, when there were 2,659 fatal overdoses in Maryland.

Suicide Data:

- There were 627 deaths due to intentional self-harm (suicide) in 2021.
- The age-adjusted mortality rate for suicide was 9.8 per 100,000 population in 2021, 5.4% higher than the 2020 rate of 9.2 per 100,000 population.

Data from the Opioid Operational Coordination Center Data Dashboard and the Vital Statistics Administration 2021 Annual Report

Adult Service Utilization Analysis

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National Landscape: Access to Behavioral Health Services in Medicaid

- Nationally, Medicaid is the largest payer of behavioral health services
- When compared to privately insured peers, Medicaid beneficiaries age 18–64 with a mental health condition are:
  - nearly four times as likely to receive inpatient treatment for their mental health condition
  - more likely to report that they needed but did not receive mental health treatment in the past year
- Need for specialty mental health treatment facilities offering supportive services, such as peer support, supported employment, as well as crisis services, including emergency walk-in services

Sources: Medicaid and CHIP Payment and Access Commission

About Public Behavioral Health System Data

Data Source and Time Period

- The data are for all **"active" billing Maryland Public Behavioral Health System (PBHS) providers who submitted a claim for services** rendered for more than $0 in **Fiscal Year 2021.**
- The data are based on ASO-OPTUM claims paid through 01/31/2023.
- Data are un-duplicated within each provider for the number served-by service category.

Data Details

- The data are presented in 2 overarching treatment service categories **1) Substance Use Disorder Services** and **2) Mental Health Services**
- Number of providers billed for SUD and MH services by County and by Service Sub-categories in FY 21
- Number of individuals receiving SUD and MH Treatment by Service Category in FY 21
- Total expenditures by treatment Service Category

Limitations

- **One provider can offer both SUD and MH services** hence data can not be summed to get total providers in both categories, the total would be an overcount
- **An individual may have been served by more than one provider** hence data can not be summed by service type to get total service utilization for a particular service category, the total would be an overcount.
- Some **out of State providers have rendered services** and been reimbursed for services rendered by Maryland Medicaid recipients.

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Active Billing providers under PBHS for FY 2021 reporting period

During FY 21, **973** distinct providers submitted Substance Use Disorder claims and **2,600** distinct providers submitted Mental Health Services claims.

There were approximately **3,000** distinct behavioral health treatment providers submitting claims in FY 21.

Approx **43%** of MH and SUD providers who submitted claims were from Baltimore City and Baltimore County

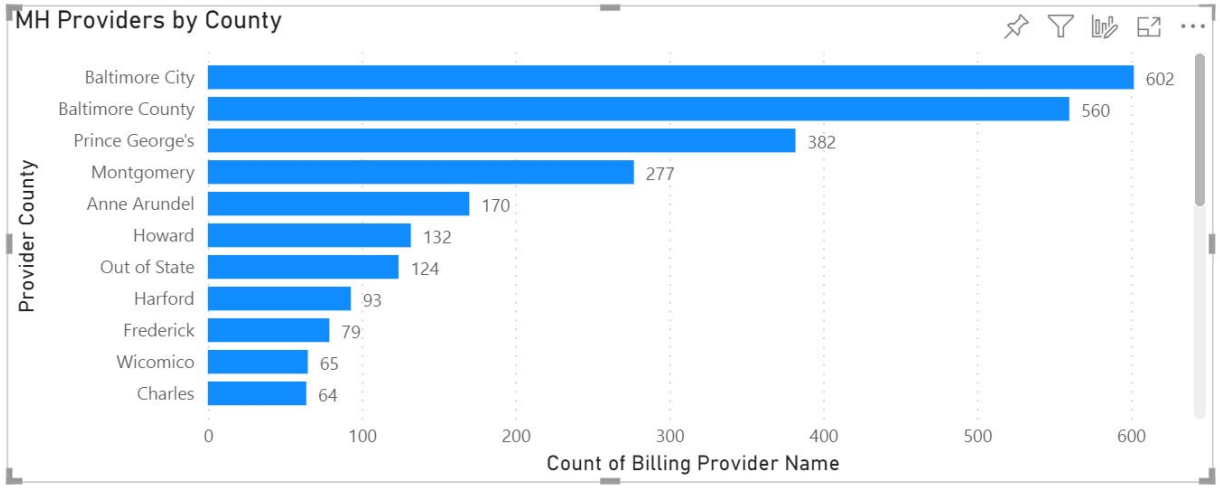
Note: One provider can offer both SUD and MH services hence data can not be summed to get total providers in both categories, the total would be an overcount

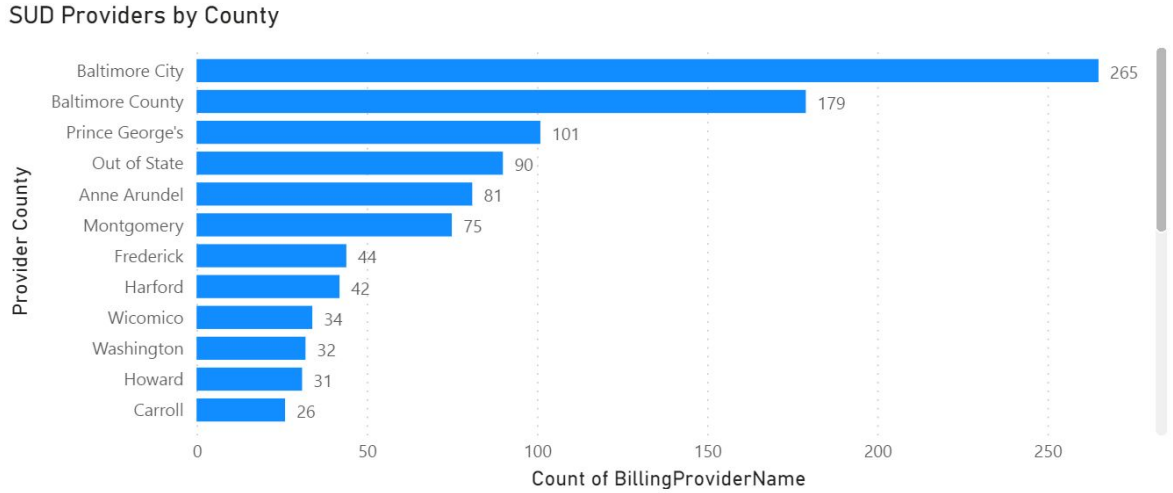
 # Billing Providers for SUD Services

973

 # Billing Providers for MH Services

2,600





Substance Use Disorder (SUD) Treatment Services FY 2021

During FY 21, SUD services claims were submitted by **973** providers across **2,042** locations.

The expenditures for SUD service claims amounted to **$406.58 million**, attributed to the **104,200** individuals who received these services.

Outpatient services were the most commonly used among various SUD services, with approximately 47,000 individuals, representing **45%** of all SUD service users.

The total claims submitted for Opioid Maintenance Treatment were the highest, representing **29%** of the total claims submitted.

Note: An individual may have been served by more than one provider hence data can not be summed by service type to get total service utilization for a particular service category, the total would be an overcount.

 # Billing Providers for SUD Services

973

 # Provider Locations for SUD Services

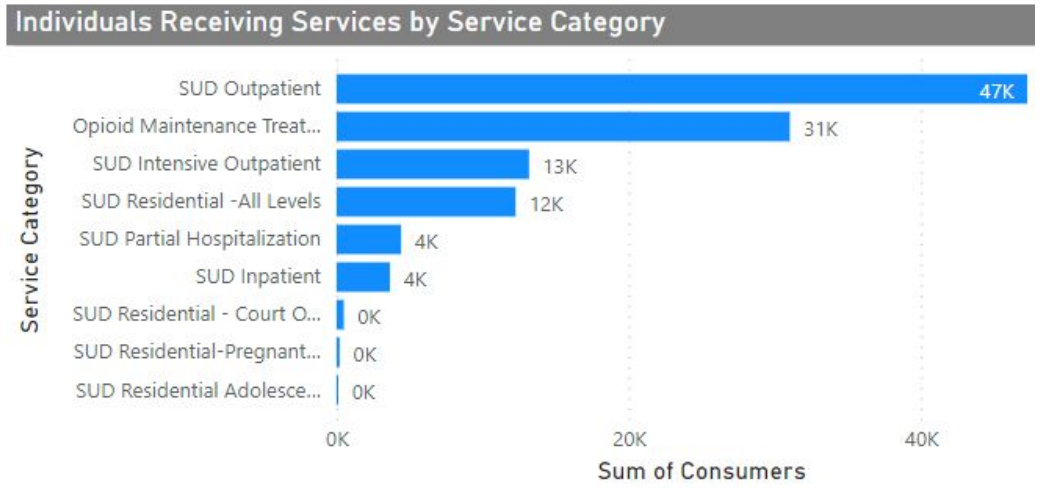
2,042

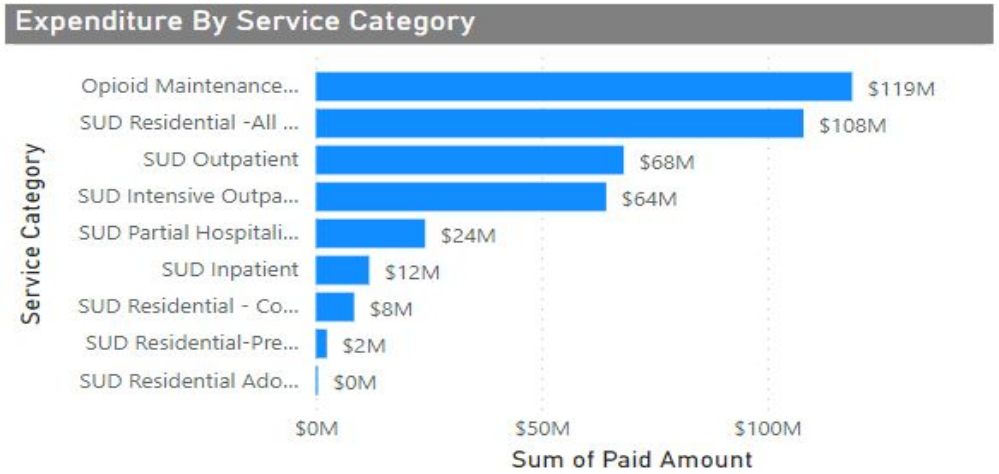
 # Individuals Received SUD Services

104.2K

SUD Service Claims

$406.58M





Mental Health (MH) Services FY 21

During FY 21, MH services claims were submitted by **2,600** providers across **4,481** locations.

The expenditures for MH service claims amounted to **$1.2B**, attributed to the **233,900** individuals who received these services.

Outpatient services were the most commonly used among various MH services, with approximately **217,000** individuals, representing **93%** of all MH service users.

The total claims submitted for **Outpatient Treatment** were the highest, representing **40%** of the total claims submitted.

Note: An individual may have been served by more than one provider hence data can not be summed by service type to get total service utilization for a particular service category, the total would be an overcount.

 # Billing Providers for MH Services

2,600

 # Provider Locations for MH Services

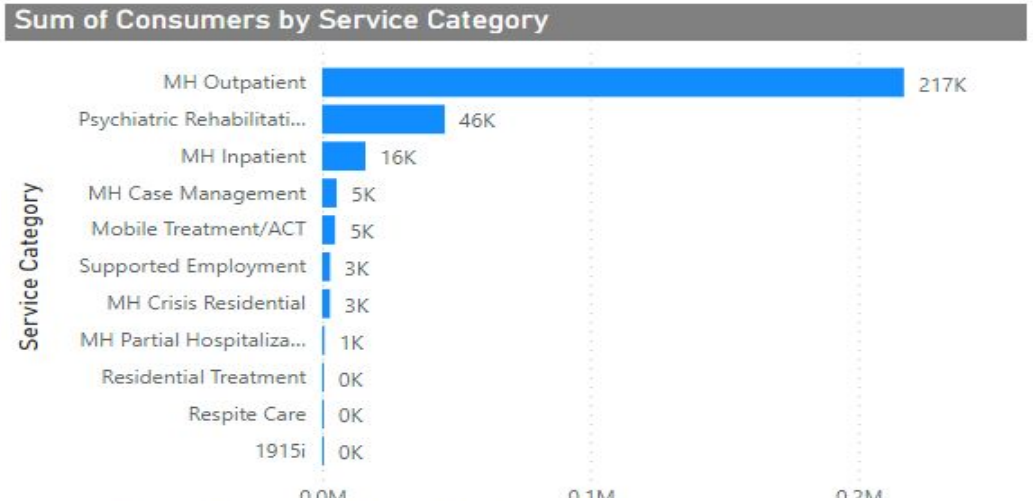
4,481

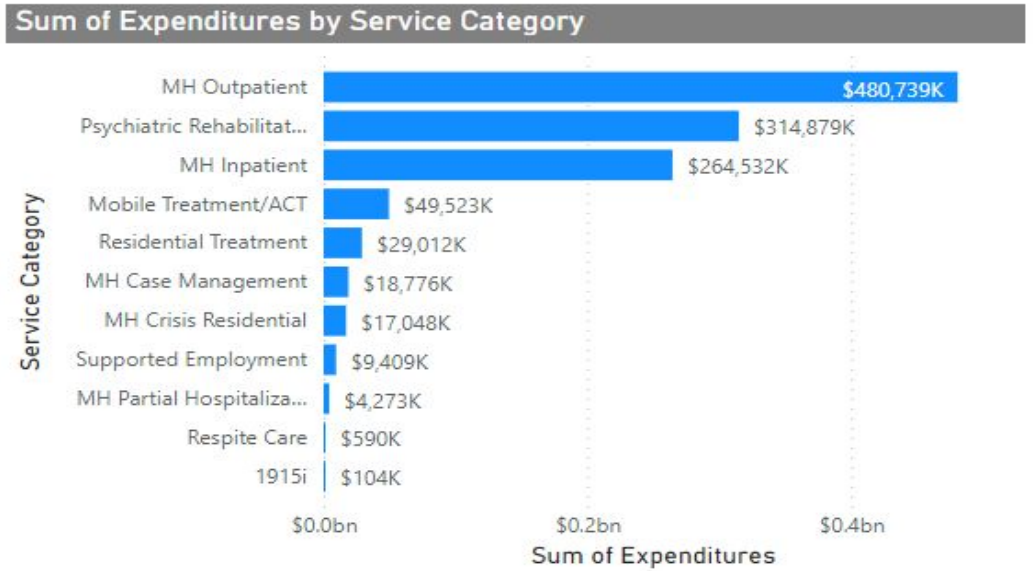
 # Individuals Received MH Services

233.9K

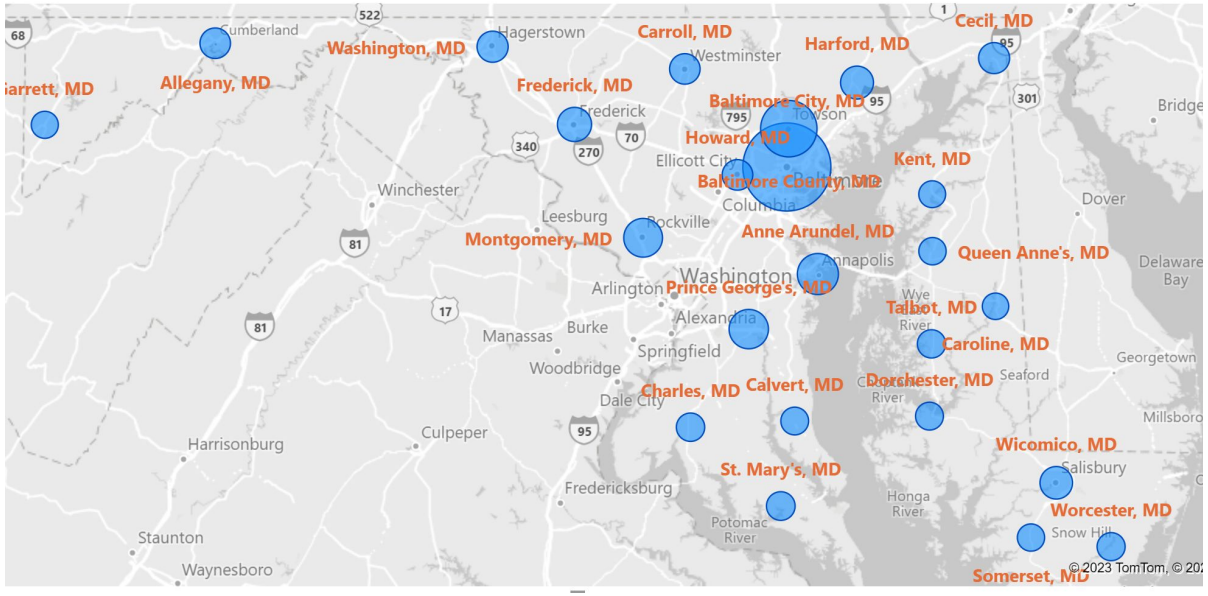
MH Service Claims

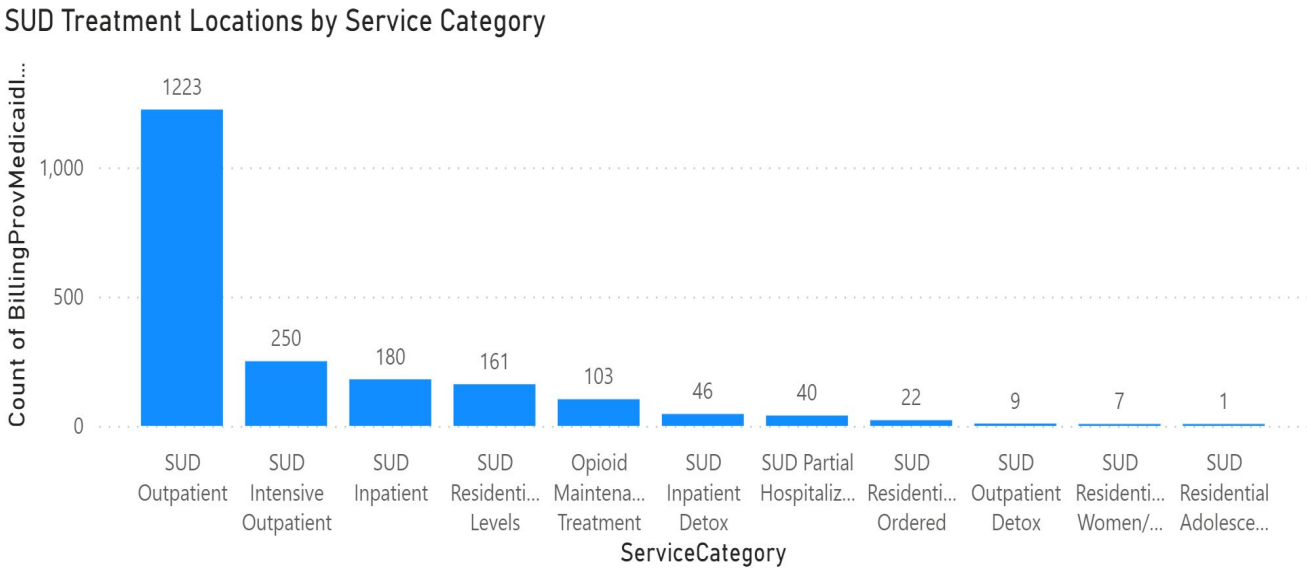
$1.2B





SUD Treatment Service Provider Location Highlights





For Substance Use Disorder Treatment services, Baltimore City has the highest number of treatment locations (609 or 30%) and Baltimore County has the second highest number of substance use disorder treatment locations (298 or 15%).

During FY 21, there were 90 Out of State* providers across 136 locations that rendered SUD treatment services to Marylanders.

The top two Service Categories were Outpatient Services (1223 or 60%) and Intensive Outpatient Services (250 or 12%).

*Out of State covers approximately 15 states and the District of Columbia.

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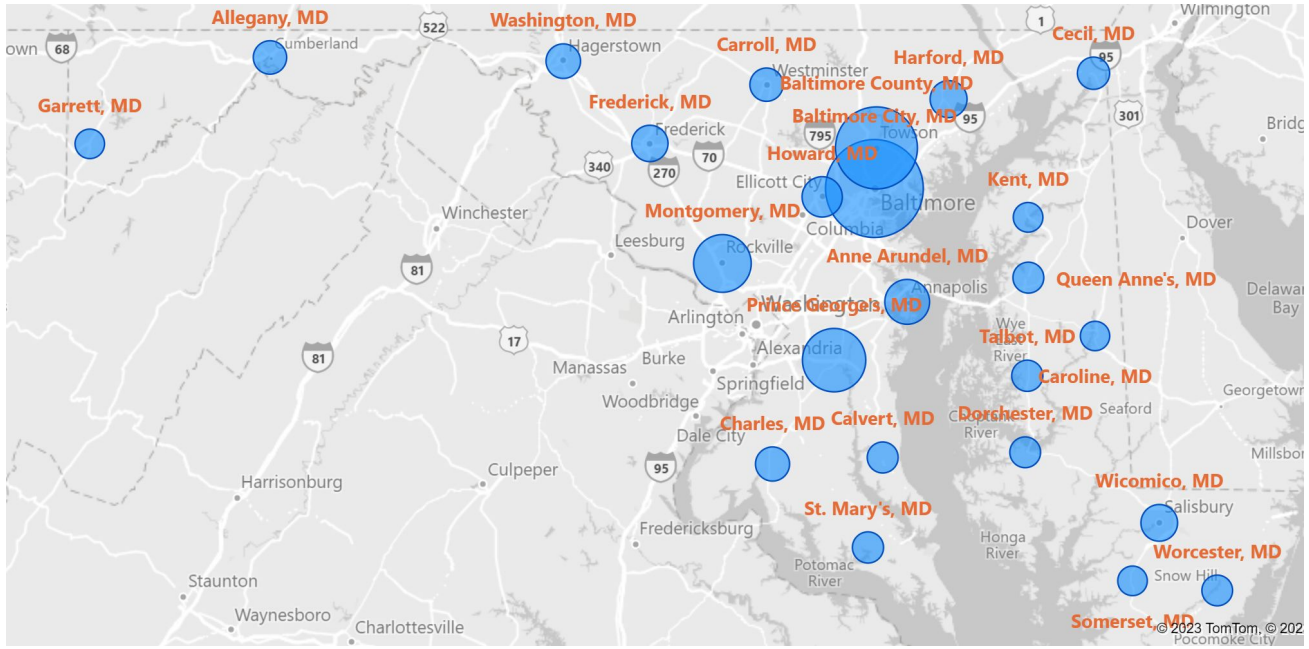
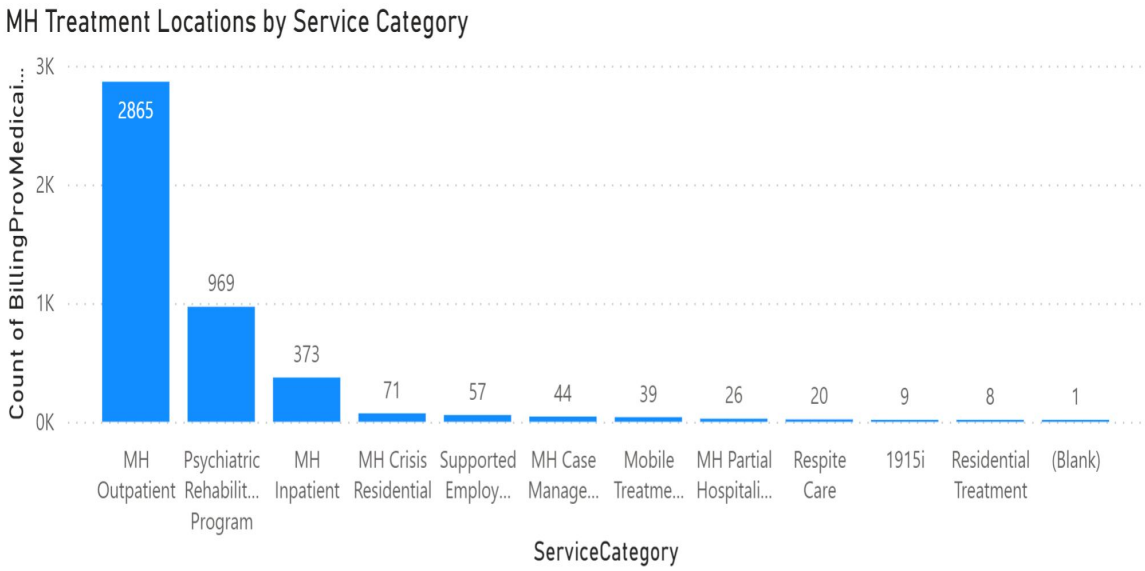
MH Treatment Service Provider Location Highlights





For Mental Health Treatment services, Baltimore City has the highest number of treatment locations (1,035 or 23%) and Baltimore County has the second highest number of all mental health treatment locations (799 or 18%).

During FY 21, there were 124 Out of State* providers across 189 locations that rendered MH treatment services to Marylanders.

The top two Service Categories were Outpatient Services (2,865 or 64%) and Psychiatric Rehabilitation Program Services (969 or 22%).

*Out of State covers approximately 20 states and the District of Columbia.

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Children and Youth Service Utilization Analysis

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National Landscape: Access to Behavioral Health Services for Children in Medicaid

- Behavioral health needs of children and youth often go unmet
- National data shows 54.1 percent of non-institutionalized youth enrolled in Medicaid or CHIP who experienced a major depressive episode received mental health treatment.
  - These adolescents were more likely than those with private coverage to receive treatment in institutional settings, as opposed to outpatient care.
- In 2018, there were nearly 12,000 specialty mental health treatment facilities in the United States, but many did not accept children or youth or offer tailored programming for adolescents with serious emotional disturbance.
  - Only one-third (32 percent) of these facilities offered such programming and participated in Medicaid. (In Maryland, 2018 data indicates only 30% of facilities offers this type of programming.)

Source: Medicaid and CHIP Payment and Access Commission

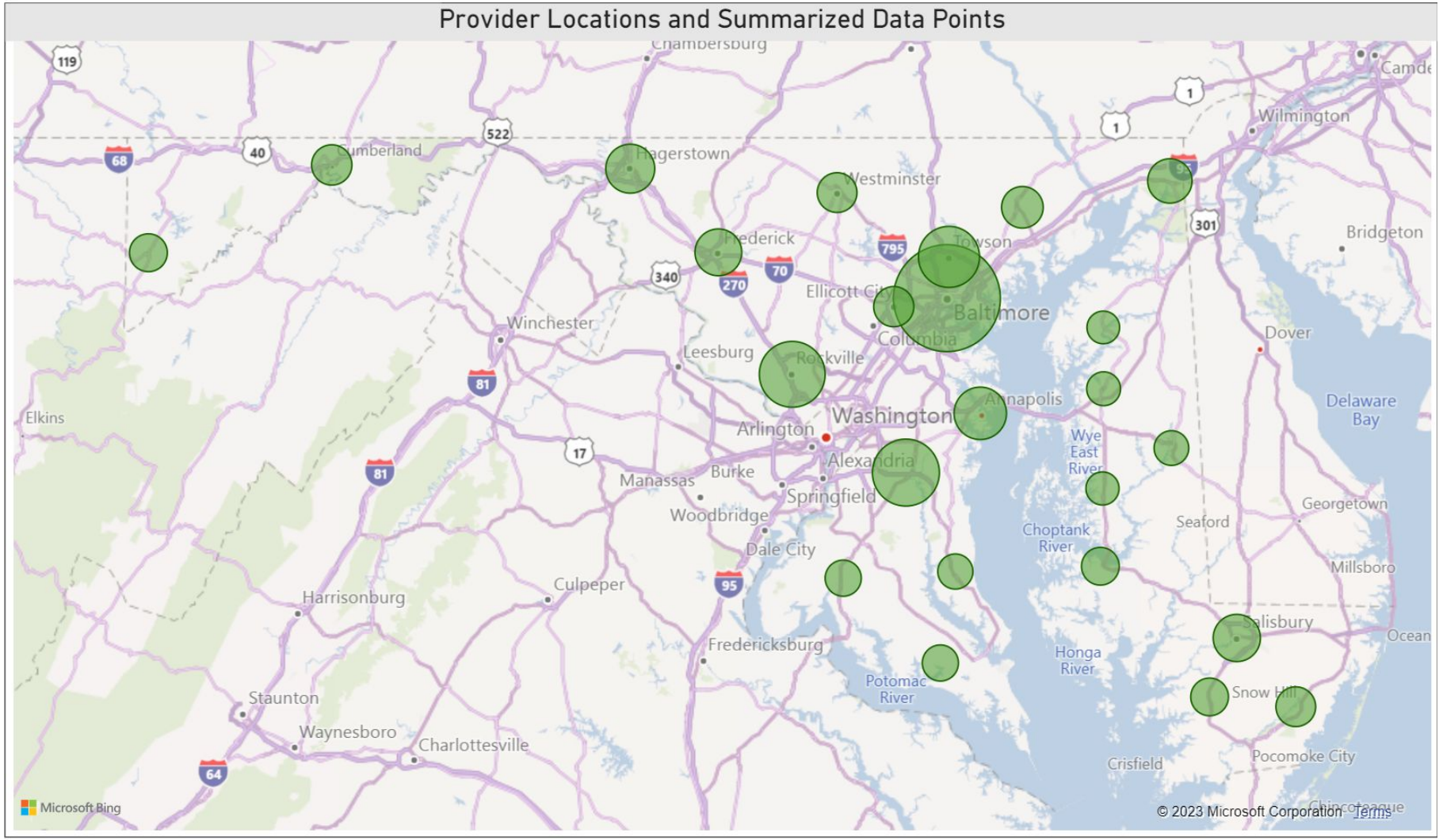
SUD Services Utilization Under 18 population By County of Service Locations: FY21

* 2,397

Customers Served

$2,479,363

Total Expenditure



* Please note that Individuals can have more than one service and could have moved within the FY hence the customer served counts includes duplicates. The max claims paid date is '6/30/2023'.

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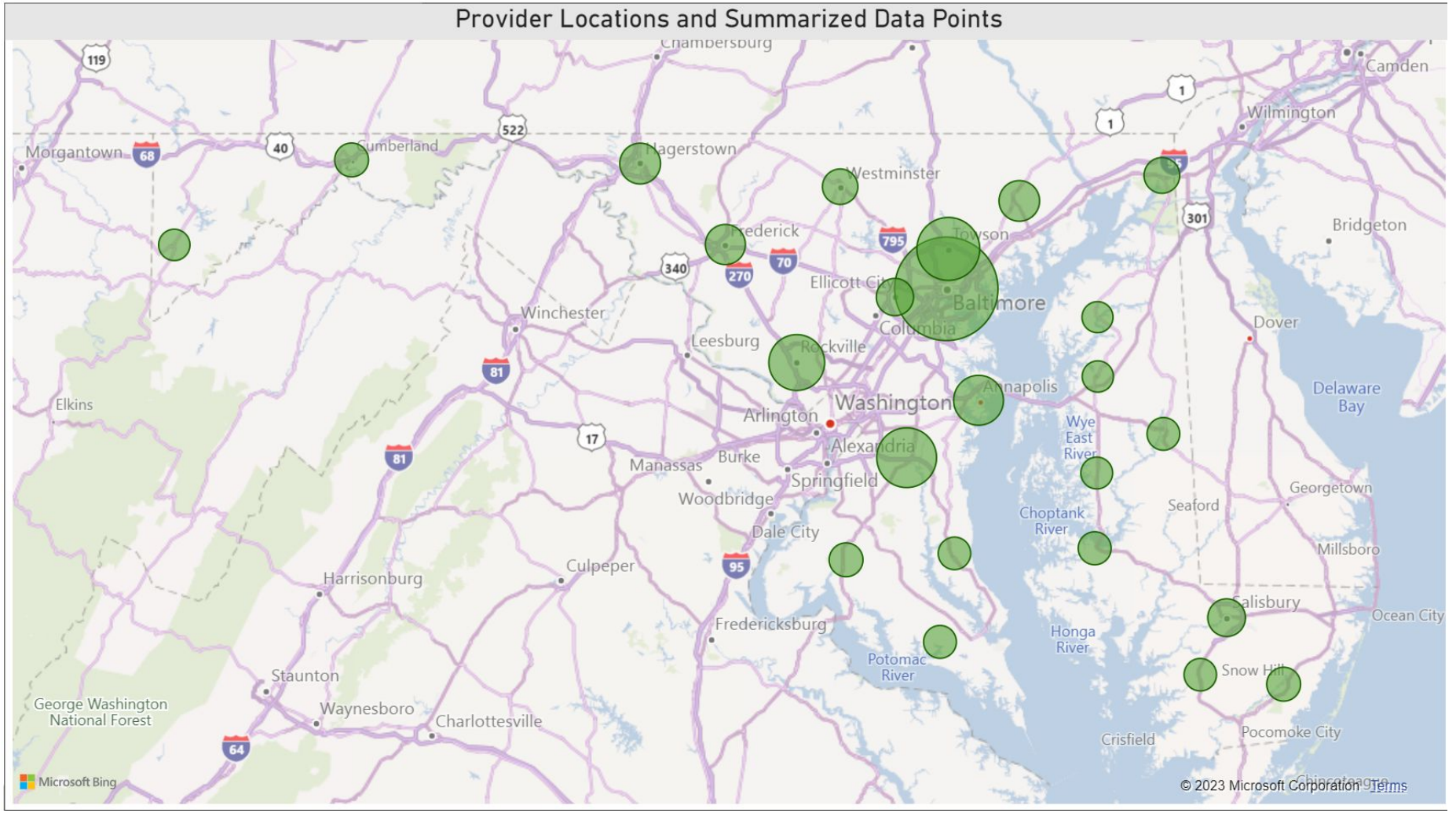
Mental Health Services Utilization By Children Under 18 by County of Service: FY21

* 71,922
Customers Served

$378,743,809
Total Expenditure



* Please note that Individuals can have more than one service and could have moved within the FY hence the customer served counts includes duplicates. The max claims paid date is '6/30/2023'.

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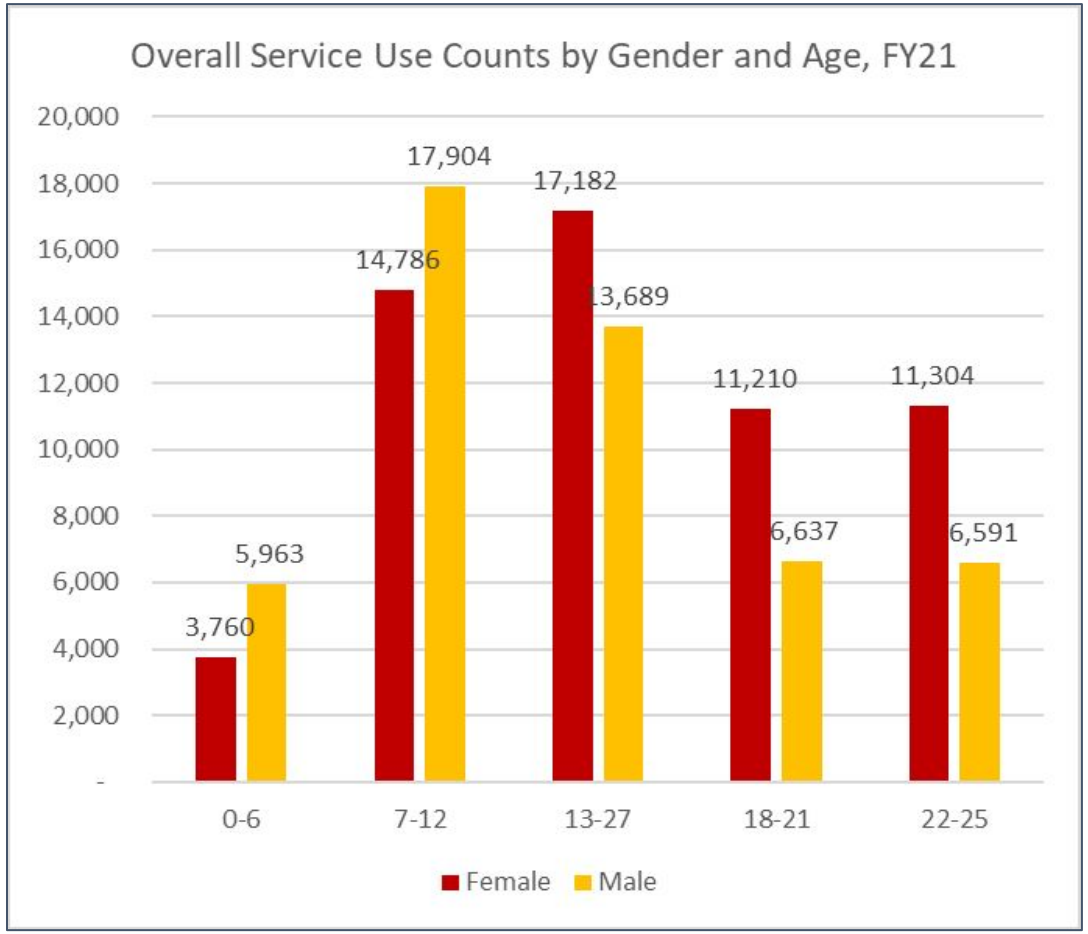
Child and Young Adult Service User Demographics



- Children and young adults (birth to 25 years) represent one-third of the Maryland population (1.9M).
- More than one-half (67.2%) of child and young adult service users were between the ages of 0 to 17 years, while 32.8% were young adults between the ages of 18 to 25 years.
- Males were more likely to enter services at a younger age (birth - 12 years), while females enter services in their teen and young adulthood years and are more likely to use intensive inpatient hospital and Emergency Department Services.

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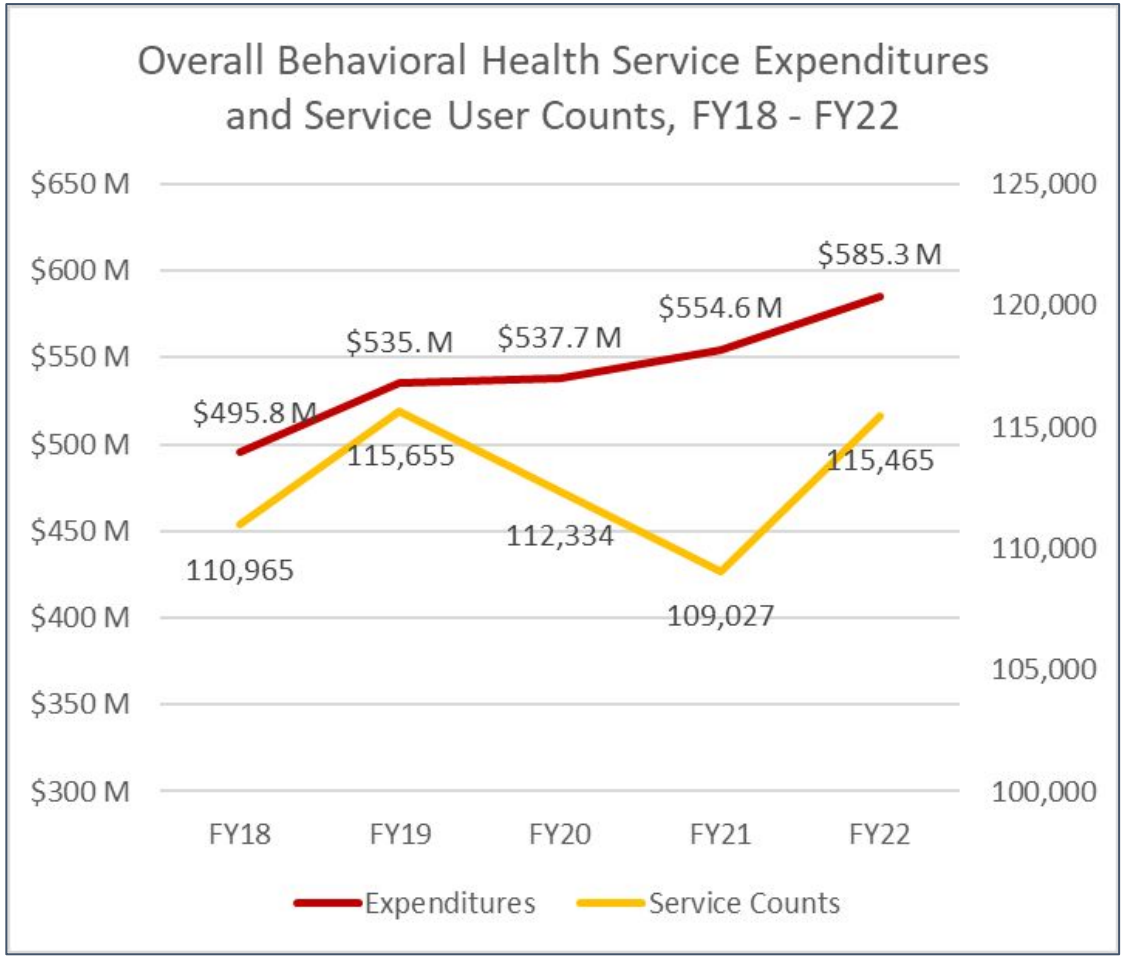
Youth and Young Adult Public Behavioral Health Service Use and Expenditures



Data Source: PBHS Service Claims data FY2018 - FY2021

- In FY 21, a total of 109,027 children and young adults received one or more behavioral health services within the PBHS system statewide with a total expenditure of $554.6M.
- Service use among children and young adults decreased by 5.7% between FY20 and FY21, while expenditures increased over the same period by 3.1%.
- The increase in expenditures was largely driven by increased spending on Inpatient Hospital (9.7% increase); and PRP (42.0% increase)

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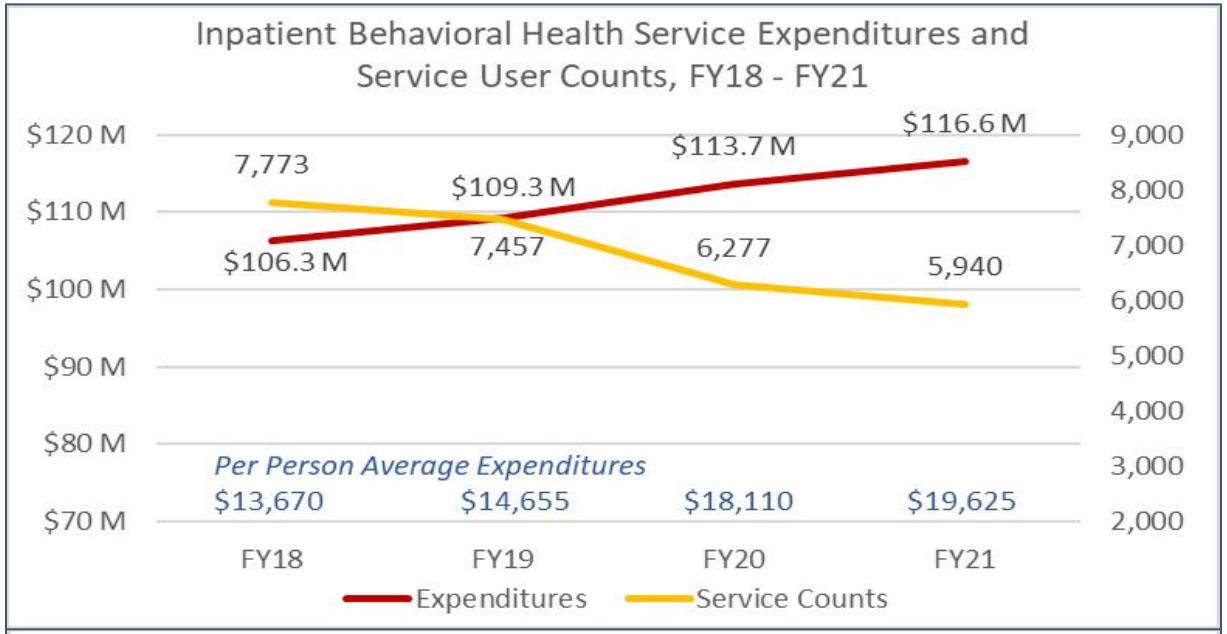
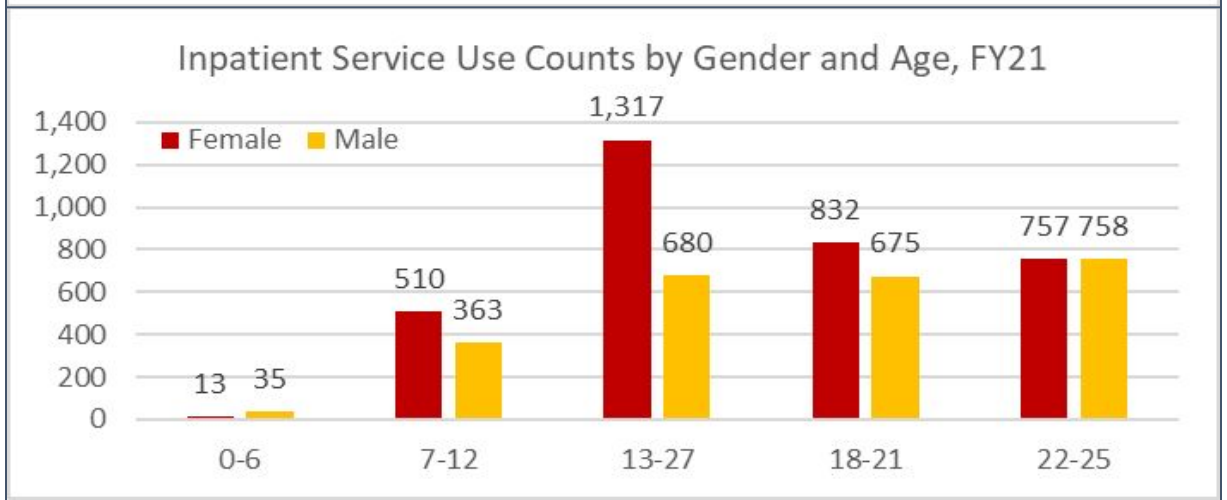
Hospital Inpatient Use and Expenditures





- In FY21, 5,940 (5.4%) children and young adult PBHS recipients used behavioral health inpatient hospital services at a rate of 7.0 per 1,000 Medicaid eligible individuals and represented nearly one quarter (21.0%; $116.6M) of annual public behavioral health expenditures.
- Reduction in inpatient hospital use and overall expenditures in the past year, annual per person expenditures have increased (8.4%). This is consistent with other data demonstrating increased length of stay, and an increase in the intensity of needs of individuals served.
- Females were more likely to use inpatient hospital and ED services with use increasing in this group during the teen years (13 to 17 years) where females were nearly twice as likely to be hospitalized or use ED services than males.

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Additional Key Findings on Children and Youth

- Among services studied, psychiatric rehabilitation services, which provide rehabilitation and support services to aid in the development and enhancement of independent living skills, were the most utilized services.

- Few children and youth with intensive behavioral and emotional challenges are accessing community-based behavioral health services, including intensive care coordination and in-home programs.

- Differences in utilization exist between boys and girls accessing services. Findings show that compared to males, females are more likely to enter services in the teen and young adult years and are more likely to use inpatient hospital and Emergency Department services.

- Spending on substance use disorder treatment was significantly lower than spending on mental health services for youth.

- Disparities in access to key services exist across the state, in part due to provider availability, and social determinants of health that disconnect certain populations from care. Examples of disparities include:
    - All jurisdictions, except Charles, Howard, Montgomery, Prince George's and St. Mary's had PBHS service use rates that were higher than the state average of 128.6 per 1,000 eligible.
    - Three jurisdictions, including Charles, Montgomery and Prince George's Counties had utilization rates of less than 100 per 1,000 eligible.

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Assessment of Currently Funded Services by Jurisdiction

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Assessment of Currently Funded Services

Jursidiction	Assertive Community Treatment	Adolescent Clubhouse	Assisted Living/ ALU	Buprenorphine Initiative	Care Traffic Control	Case Management (MH)	Children in Need of Assistance (SB 512) Assessments	Client Support Services (MH)	Court / DJS Initiatives	Crisis Intervention Team	Crisis Walk-In / Beds / Stabilization / Urgent Care	Crisis Residential	988 Crisis Hotline	Deaf/Hard of Hearing Interpreter Services	Detox (Inpatient/Outpatient)	Detention / Jail-Based Services	Drug Court	ED / Hospital Diversion Initiatives	First Episode Psychosis	Harm Reduction Services	Housing Supports (CoC, PATH)	Inpatient Services (MH)	Inpatient Services (SUD)	LEAD	MCCJTP	Maryland Recovery Net	MH Stabilization Services (Youth)	Mobile Crisis Response	Mobile Response Stabilization Services (MRSS)	Opioid Maintenance Treatment
Allegany	G			G		ASO		G		G	G	ASO	G		ASO		G			G	G	ASO	ASO		G	G	G			ASO
Anne Arundel	G/ASO	G	G	G		ASO		G		G	G	ASO	G	G	ASO	G	R/G		G	G	G	ASO	ASO	O	G	G/ASO	G	G		ASO
Baltimore City	G/ASO	G	G	G	HSCRC	ASO	G	G	G	G	G	ASO	G	G	ASO	G	R		G	G	G	ASO	ASO	G		G/ASO		G	G	ASO
Baltimore County	G/ASO	G		G	HSCRC	ASO		G		G	G	ASO	G		ASO	G	R		G	G	G	ASO	ASO		G	G/ASO		G		ASO
Calvert	G	G		G		ASO		G	G	G	G		G			G	G	G		G	G	ASO	ASO		G	G/ASO		G	G	ASO
Caroline		G	G	G	G			G	G	G	G	ASO	G	G			G	G			G	ASO	ASO		G	G/ASO	G	G		
Carroll	ASO			G	HSCRC	ASO		G		G	G	ASO	G	G	ASO	G	G			G	G	ASO	ASO	OOCC	G	G/ASO		G		ASO
Cecil	ASO	G		G	G	ASO		G		G	G		G	G	ASO		G	G		G	G	ASO	ASO		G	G/ASO		G	G	ASO
Charles	G/ASO					ASO		G		G	G		G	G	ASO	G	G			G	G	ASO	ASO		G	G/ASO		G	G	ASO
Dorchester	ASO	G	G	G	G			G	G	G	G		G	G	ASO		G	G		G	G	ASO	ASO		G	G/ASO	G	G	G	
Frederick	ASO	G		G		ASO		G		G	G	ASO	G	G		G	G	G		G	G	ASO	ASO	G	G	G/ASO		G	G	ASO
Garrett	G			G		ASO		G	G	G	G	ASO	G			G		G		G	G	ASO	ASO		G	G				
Harford	G/ASO	G				ASO				G	G	ASO	G		ASO		G			G	G	ASO	ASO	O	G	G/ASO	G	G	G	ASO
Howard	ASO			G	HSCRC	ASO		G		G	G	ASO	G		ASO	G	G			G	G	ASO	ASO	O	G	G/ASO	G	G		ASO
Kent		G	G	G	G			G	G	G	G		G	G				G			G				G	G/ASO	G	G	G	
Montgomery	ASO	G	G	G		ASO		G	G	G	G	ASO	G	G	ASO	G	G		G	G	G	ASO	ASO			ASO				ASO
Prince George's	ASO	G	G	G	HSCRC	ASO	G		G	G		ASO	G	G	ASO	G	R/G	G	G	G	G	ASO	ASO		G	G/ASO		G		ASO
Queen Anne's	ASO	G	G	G	G	ASO		G	G	G	G		G	G				G			G	ASO	ASO		G	G/ASO	G	G	G	
Somerset		G			G			G				ASO	G	G			R/G	G		G	G	ASO	ASO	OOCC	G	G		G	G	
St. Mary's	G	G	G	G		ASO		G		G	G		G			G	G			G	G	ASO	ASO	O	G	G/ASO	G	G	G	ASO
Talbot		G	G	G	G			G	G	G	G		G	G			G	G			G	ASO	ASO		G	G/ASO	G	G		ASO
Washington	G/ASO	G	G			ASO	G	G		G	G	ASO	G	G		G	G			G	G	ASO	ASO	O	G	G/ASO	G	G	G	ASO
Wicomico	ASO	G		G	G	ASO		G	G	G		ASO	G	G		G	G	G		G	G	ASO	ASO	O	G	G/ASO		G	G	ASO
Worcester		G		G		ASO	G	G	G	G	G	ASO	G	G			R/G	G		G	G	ASO	ASO	G	G	G/ASO		G		ASO

Jursidiction	Outpatient Services (MH)	Outpatient Services (SUD)	Overdose Response Program	Partial Hospitalization (MH)	Partial Hospitalization (SUD)	Peer to Peer Support / Peer Recovery	Psych Rehab Program	Recovery Support Preg Women / Children	Residential Rehabilitation Program	Residential Treatment Center	Residential Treatment (MH)	Residential Treatment (SUD)	Respite Care	Safe Station	SBIRT	School / Preschool Programs	Senior Outreach	SOAR	Spanish-Speaking Therapeutic Services	State Care Coordination	START - Sobriety Treatment and Recovery Teams	STOP - Substance Abuse Treatment Outcomes Partnership	Supportive Employment	Syringe Services Program	TAMAR	Targeted Case Management / 1915i	TAY	Temporary Cash Assistance	Teen Diversion	Older Adult Behavioral Health PASRR	Wellness/ Recovery Centers
Allegany	ASO	ASO	G			G	ASO		ASO			ASO	ASO							G		G	ASO	G				R		G	G
Anne Arundel	ASO	ASO	G	ASO	ASO	G	ASO		ASO			ASO		G					G	G	R	G	ASO	G	G	G	G	R		G	G
Baltimore City	ASO	ASO	G	ASO	ASO	G	ASO	G	ASO	SF/ASO	ASO	ASO	G/ASO		G	G		G	G	G			ASO	G			G	R		G	G
Baltimore County	ASO	ASO	G	ASO	ASO	G	ASO	G	ASO	ASO	ASO	ASO				G	G	G		G		G	ASO	G	G	ASO		R		G	G
Calvert	ASO	ASO	G	ASO		G	ASO		ASO			ASO				G	G			G		G	ASO	G			G	R		G	G
Caroline	ASO	ASO	G				ASO		ASO				G	G		G		G	G	G	R	G	ASO				G	R		G	G
Carroll	ASO	ASO	G		ASO	G	ASO		ASO			ASO								G	R	G	ASO				G	R		G	G
Cecil	ASO	ASO	G		ASO	G	ASO	G	ASO			ASO				G				G	R	G	ASO	G				R		G	G
Charles	ASO	ASO	G			G	ASO		ASO			ASO								G		G	ASO		G	ASO	G	R		G	G
Dorchester	ASO	ASO	G		ASO	G	ASO		ASO			ASO	G/ASO					G	G	G			ASO		G		G	R		G	G
Frederick	ASO	ASO	G	ASO	ASO	G	ASO		ASO		ASO	ASO	G/ASO			G	G	G		G	R	G	ASO	G	G	ASO		R		G	G
Garrett	ASO	ASO	G			G	ASO		ASO				ASO			G	G	G		G		G	ASO				G	R		G	G
Harford	ASO	ASO	G		ASO	G	ASO		ASO			ASO	G			G		G		G		G	ASO	G	G	G		R	G	G	G
Howard	ASO	ASO	G	ASO		G	ASO		ASO			ASO	ASO		OOCC		G		G	G		G	ASO	G			G	R		G	G
Kent	ASO	ASO	G				ASO		ASO			ASO	G/ASO					G	G	G	R		ASO				G	R		G	G
Montgomery	ASO	ASO	G	ASO	ASO		ASO		ASO	SF		ASO	G		G	G	G	G		G		G	ASO	G			G	R		G	G
Prince George's	ASO	ASO	G	ASO		G	ASO	G	ASO			ASO				G	G			G		G	ASO	G	G	ASO	G	R		G	G
Queen Anne's	ASO	ASO	G			G	ASO		ASO				G/ASO					G	G	G			ASO				G	R		G	G
Somerset	ASO	ASO	G	ASO		G	ASO		ASO			ASO								G	R	G	ASO					R		G	G
St. Mary's	ASO	ASO	G			G	ASO		ASO			ASO						G		G		G	ASO	G			G	R		G	G
Talbot	ASO	ASO	G			G	ASO	G	ASO				G					G	G	G	R	G	ASO				G	R		G	G
Washington	ASO	ASO	G	ASO		G	ASO	G	ASO			ASO	ASO			G		G		G	R	G	ASO	G	G		G	R		G	G
Wicomico	ASO	ASO	G	ASO	ASO	G	ASO		ASO			ASO	ASO	G		G				G		G	ASO	G		ASO		R		G	G
Worcester	ASO	ASO	G			G	ASO	G	ASO				G	G		G				G		G	ASO				G	R	G	G	G

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Assessment of Currently Funded Services - Analysis

- There are a number of services covered by Medicaid - some with good jurisdictional representation and others with limited availability (meaning clients have to travel for care)
- There are many services/resources that are grant funded through the Department and other partners
- There are services/resources that not available in all jurisdictions (i.e. the “white space”)
  - ASO services such as detoxification, Partial Hospitalization, and mental health Residential Treatment
  - Children’s services, such as Targeted Case Management, Residential Treatment Centers, Respite, and Inpatient SUD Services

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Next Steps

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Next Steps

- This analysis is Phase 1 - MDH continues to analyze data and trends
- Questions for future discussion:
  - What additional information/analysis is needed to drive workgroup discussion and recommendations?
  - How can we better capture unmet need and demand for services/resources?

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Thank you!

Appendix E - Presentations Given During Commission Meetings in November 2023 and December 2023

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Commission on Behavioral Health Care Treatment & Access

Chair: Laura Herrera Scott, MD, MPH
Secretary, Maryland Department of Health

November 9, 2023

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Welcome & Opening Remarks

Secretary Laura Herrera Scott

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Introduction of Commission Members

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Overview of Workgroup Assignments and Responsibilities

Commission on Behavioral Health Care Treatment and Access

November 9th, 2023

Overview

- The statute for the Commission requires the creation of four workgroups:
  - Geriatric Behavioral Health
  - Youth Behavioral Health, Individuals with Developmental Disabilities, and Individuals with Complex Behavioral Health Needs
  - Criminal Justice-Involved Behavioral Health
  - Behavioral Health Workforce Development, Infrastructure, Coordination, and Financing
- The Secretary will work to establish workgroup chairs.
- Each workgroup must meet **at least** two times per year.
- MDH Staff members have been assigned for each workgroup.

Assigned Workgroup Staff Members

- **Full Commission**
  - *Milan Reed,* milan.reed@maryland.gov
  - *Wes Schrum,* wesley.schrum@maryland.gov
- **Geriatric Behavioral Health**
  - *Stefani O'Dea,* stefani.odea@maryland.gov
- **Youth Behavioral Health, Individuals with Developmental Disabilities, and Individuals with Complex Behavioral Health Needs**
  - *Rachel Masciarelli- D'Ambrosi,* rachel.masciarelli-dambrosi@maryland.gov
  - *Will Payne,* will.payne@maryland.gov
- **Criminal Justice-Involved Behavioral Health**
  - *Jordan Fisher,* jordan.fisher@maryland.gov
  - *Wes Schrum,* wesley.schrum@maryland.gov
- **Behavioral Health Workforce Development, Infrastructure, Coordination, and Financing**
  - *Jessica Taylor,* jessica.taylor1@maryland.gov
  - *Michelle Darling,* michelle.darling@maryland.gov
  - *Secondary Staff- Shayna Dee:* shayna.dee1@maryland.gov

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Geriatric Behavioral Health: Workgroup Charge

- Examine and make recommendations related to the behavioral health of the geriatric population in the state; and
- Examine and review the use of harm reduction strategies to facilitate access to care for older adults.
- **Workgroup members:**
  - **Megan Renfrew,** Designee for the Executive Director of the Health Services Cost Review Commission
  - **Renard Brooks,** Designee for the Secretary of the Department of Public Safety and Correctional Services
  - **Lawanda Williams,** Representative of a Federally Qualified Health Center
  - **Delegate Bonnie Cullison,** Member from the Maryland House of Delegates
  - **Linda Raines,** Representative of the Mental Health Association of Maryland

Youth Behavioral Health, Individuals with Intellectual and Developmental Disabilities, and Individuals with Complex Behavioral Health Needs: Workgroup Charge

- Examine and make recommendations related to the behavioral health of the youth population in the state;
- Examine and make recommendations to provide appropriate and adequate behavioral health services to individuals with developmental disabilities and complex behavioral health needs, specifically youth; and
- Examine and review the use of harm reduction strategies to facilitate access to care for youth.

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Youth Behavioral Health, Individuals with Intellectual and Developmental Disabilities, and Individuals with Complex Behavioral Health Needs: Workgroup Charge, cont.

- **Workgroup Members**
  - **Tamar Rodney,** Individual with Expertise in Social Determinants of Health
  - **Stephen Liggett- Creel**, Designee for the Department of Human Services
  - **Stacey Garnett,** Representative of an Inpatient Psychiatric Hospital
  - **Mercia Cummings,** Representative of a Provider of Substance Use Treatment Services
  - **Rachel London,** Representative of the Developmental Disability Coalition
  - **Leslie Seid Margolis,** Representative of Disability Rights Maryland
  - **Secretary Carol Beatty,** Secretary of the Maryland Department of Disabilities
  - **Dr. Arlene Tyler,** Representative of a School-Based Health Center
  - **Senator Malcolm Augustine,** Member from the Senate of Maryland
  - **Linda Dietsch,** Representative of a Managed Care Organization
  - **Deputy Secretary Alyssa Lord,** Deputy Secretary for Behavioral Health
  - **Clara Baker,** Individual with an Intellectual Disability who uses Self-Directed Behavioral Health Services

Criminal Justice-Involved Workgroup Charge

- Assess the health infrastructure, facilities, personnel, and services available for the state's forensic population and identify deficiencies in resources and policies needed to prioritize health outcomes, increase public safety, and reduce recidivism;
- Make recommendations on expanding behavioral health treatment access for the State's court-ordered population; and
- Examine and review the use of harm reduction strategies to facilitate access to care for justice-involved population(s).

Criminal Justice-Involved Workgroup Charge, cont.

- **Workgroup Members**
  - **Kevin Amado Sr.,** Representative of the Maryland Chapter of the National Council on Alcoholism and Drug Dependence
  - **Special Secretary Emily Keller,** Special Secretary of Opioid Response
  - **Kathryn Spencer Farinholt,** Representative of the National Alliance on Mental Illness
  - **Dr. Aliya Jones,** Representative of an Acute Care Hospital
  - **Dr. Stephanie Wolf,** Representative of the Maryland Psychological Association
  - **James Rhoden,** Designee for the Executive Director of the Governor's Office of Crime Prevention, Youth, and Victim Services
  - **Jonathan Davis,** Representative of a Provider of Residential Behavioral Health Services
  - **Dr. Laura Estupinan- Kane,** Designee for the Department of Juvenile Services
  - **Benjamin Charlton,** Representative from the Office of the Public Defender

Behavioral Health Workforce Development, Infrastructure, Coordination, and Financing Workgroup Charge

- Conduct a needs assessment of the State's behavioral health care workforce to identify gaps and make recommendations to ensure adequate, culturally competent, and a diverse workforce across the behavioral health continuum;
- Review trends and best practices from other states regarding policy and reimbursement strategies that support access to a comprehensive array of services and ensure quality of care;
- Examine the methods for reimbursing behavioral health care services in the state and make recommendations on the most effective forms of reimbursement to maximize service delivery;
- Make recommendations on action plans regarding the behavioral health care system's capacity to prepare for and respond to future challenges affecting the entire State or particular regions or populations in the State, including pandemics and extreme weather events;
- Make recommendations to ensure that behavioral health treatment is provided in the appropriate setting, including methods to divert behavioral health patients from emergency departments by using the Maryland Mental Health and Substance Use Disorder Registry and Referral System Established Under § 7.5–802 of the Health General Article and 2–1–1;
- Examine and review the use of harm reduction strategies to facilitate access to care;
- Examine methods to assist consumers in accessing behavioral health services.

Behavioral Health Workforce Development, Infrastructure, Coordination, & Financing Workgroup Charge, cont.

- **Workgroup Members**
  - **Debra Bennett,** Family Member of an Individual with Experience as a Consumer of Behavioral Health Services
  - **Dr. Paula Anne Smith-Benson,** Individual with Experience as a Consumer of Behavioral Health Services
  - **Kathleen Birrane,** Maryland Insurance Commissioner
  - **Matthew Eisenberg,** Individual with Expertise in Health Economics
  - **Shannon Hall,** Representative of the Community Behavioral Health Association of Maryland
  - **Mark Luckner,** Executive Director of the Maryland Community Health Resources Commission
  - **Oleg Tarkovsky,** Representative of a Health Insurance Carrier
  - **Sheena Patel,** Designee for the Executive Director of the State Designated Health Information Exchange
  - **Kathryn Dilley,** Representative of a Local Behavioral Health Authority
  - **Ben Steffen ,** Executive Director of the Maryland Health Care Commission

Next Steps

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Workgroup Timeline

- **November 9th**, first meeting of the full Commission.
- **Between November 13th and December 8th** each workgroup will meet once.
- **Week of December 8th**, each workgroup will prepare a report to submit to the Commission.
- **December 18th**, second meeting of the full Commission.

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Workgroup Responsibilities

- During the first workgroup meeting, members are charged with:
  - **Prior recommendations:** Each workgroup will delve deeper into prior recommendations made. A list of relevant reports and recommendations will be shared with workgroup members.
  - **Needs assessment:** Each workgroup, where relevant, will examine data included in the needs assessment shared today. Workgroup staff will help identify other data sources.

Questions

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BEHAVIORAL HEALTH COMMISSION INITIAL NEEDS ASSESSMENT

Sara Barra, Chief of Staff, Behavioral Health Administration

November 9, 2023

Agenda

- Behavioral Health Continuum of Care
- Morbidity, Mortality and Behavioral Health
- Service Utilization Analysis
- Assessment of Currently Funded Services by Jurisdiction
- Next Steps

Behavioral Health Continuum of Care

Prevention/Promotion				Primary Behavioral Health/ Early Intervention		Urgent/Acute Care		Treatment / Recovery	
Promotion	Universal Prevention	Selective Prevention	Indicated Prevention	Outpatient Care	Intermediate Care	Urgent/ Crisis Care	Acute Treatment	Long-Term Treatment	Recovery Supports

Data / Quality / Health Equity / Workforce Initiatives

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Morbidity, Mortality and Behavioral Health

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National Context

- Untreated behavioral health conditions have serious consequences, including reduced life expectancy
    - Americans with a major mental illness die 14 to 32 years earlier than the general population
- Comorbid medical conditions are often cited as the main factor contributing to shortened life expectancy for those with mental illness
- Suicide is one of the most widely acknowledged contributors to premature mortality among individuals with mental illness
    - Suicide is the 10th leading cause of death for all ages in the United States, and the second leading cause of death for individuals age 10–34
- Mortality is also impacted by overdose deaths
    - In 2021 life expectancy in the US declined, primarily due to increases in COVID-19 and drug overdose deaths.

Sources: Centers for Disease Control and Prevention, Medicaid and CHIP Payment and Access Commission

Maryland Mortality Data

Overdose Data:

- In 2022, there were 7.6% fewer fatal overdoses in Maryland compared to 2021 (decreasing from 2,800 to 2,586).
- There were 2,581 fatal overdoses in the 12 months ending in May 2023. This was a 2.9% decrease compared to the 12 months ending in May 2022, when there were 2,659 fatal overdoses in Maryland.

Suicide Data:

- There were 627 deaths due to intentional self-harm (suicide) in 2021.
- The age-adjusted mortality rate for suicide was 9.8 per 100,000 population in 2021, 5.4% higher than the 2020 rate of 9.2 per 100,000 population.

Data from the Opioid Operational Coordination Center Data Dashboard and the Vital Statistics Administration 2021 Annual Report

Adult Service Utilization Analysis

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National Landscape: Access to Behavioral Health Services in Medicaid

- Nationally, Medicaid is the largest payer of behavioral health services
- When compared to privately insured peers, Medicaid beneficiaries age 18–64 with a mental health condition are:
  - nearly four times as likely to receive inpatient treatment for their mental health condition
  - more likely to report that they needed but did not receive mental health treatment in the past year
- Need for specialty mental health treatment facilities offering supportive services, such as peer support, supported employment, as well as crisis services, including emergency walk-in services

Sources: Medicaid and CHIP Payment and Access Commission

About Public Behavioral Health System Data

Data Source and Time Period

- The data are for all **"active" billing Maryland Public Behavioral Health System (PBHS) providers who submitted a claim for services** rendered for more than $0 in **Fiscal Year 2021.**
- The data are based on ASO-OPTUM claims paid through 01/31/2023.
- Data are un-duplicated within each provider for the number served-by service category.

Data Details

- The data are presented in 2 overarching treatment service categories **1) Substance Use Disorder Services** and **2) Mental Health Services**
- Number of providers billed for SUD and MH services by County and by Service Sub-categories in FY 21
- Number of individuals receiving SUD and MH Treatment by Service Category in FY 21
- Total expenditures by treatment Service Category

Limitations

- **One provider can offer both SUD and MH services** hence data can not be summed to get total providers in both categories, the total would be an overcount
- **An individual may have been served by more than one provider** hence data can not be summed by service type to get total service utilization for a particular service category, the total would be an overcount.
- Some **out of State providers have rendered services** and been reimbursed for services rendered by Maryland Medicaid recipients.

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Active Billing providers under PBHS for FY 2021 reporting period

During FY 21, **973** distinct providers submitted Substance Use Disorder claims and **2,600** distinct providers submitted Mental Health Services claims.

There were approximately **3,000** distinct behavioral health treatment providers submitting claims in FY 21.

Approx **43%** of MH and SUD providers who submitted claims were from Baltimore City and Baltimore County

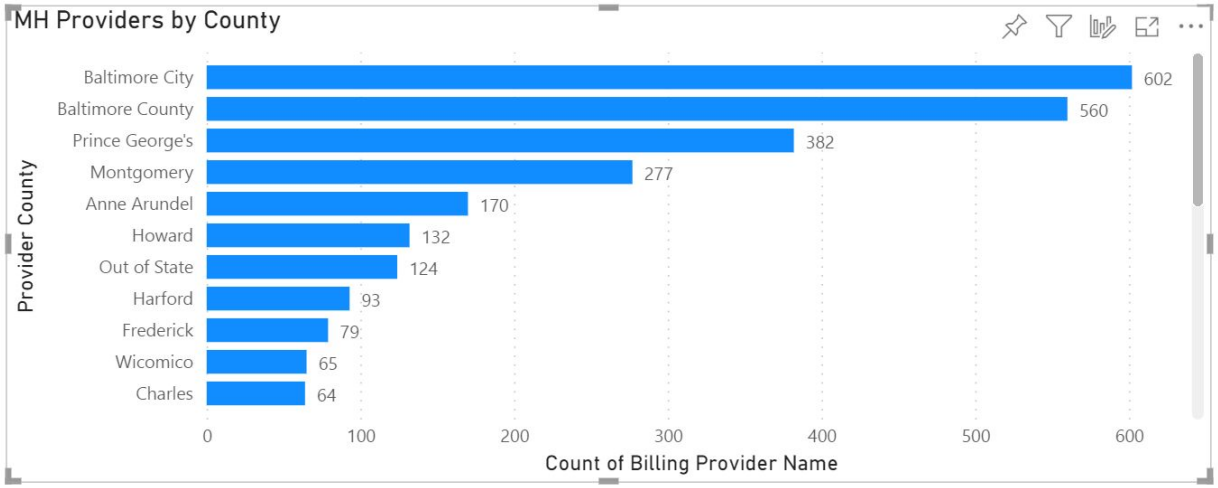
Note: One provider can offer both SUD and MH services hence data can not be summed to get total providers in both categories, the total would be an overcount

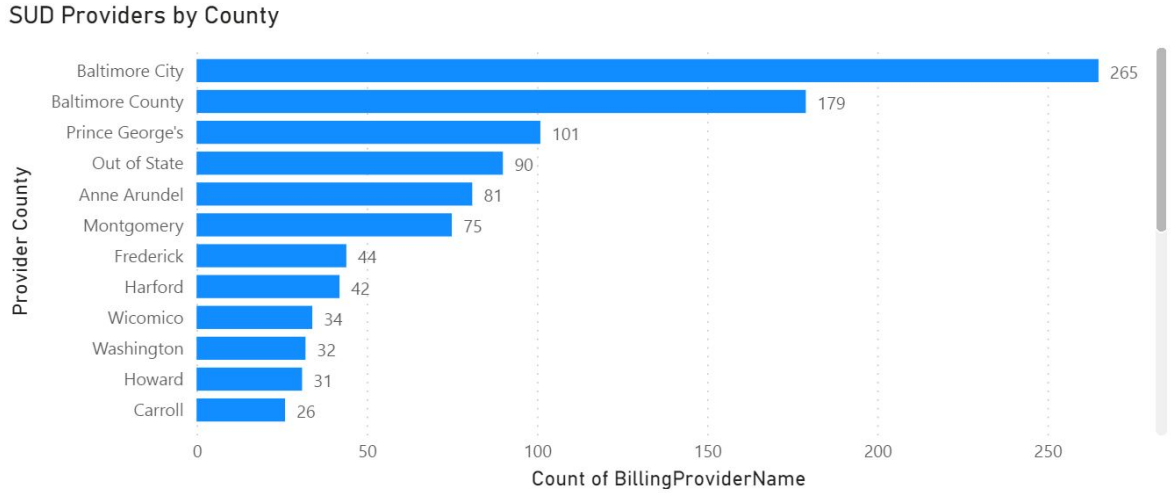
 # Billing Providers for SUD Services

973

 # Billing Providers for MH Services

2,600





Substance Use Disorder (SUD) Treatment Services FY 2021

During FY 21, SUD services claims were submitted by **973** providers across **2,042** locations.

The expenditures for SUD service claims amounted to **$406.58 million**, attributed to the **104,200** individuals who received these services.

Outpatient services were the most commonly used among various SUD services, with approximately 47,000 individuals, representing **45%** of all SUD service users.

The total claims submitted for Opioid Maintenance Treatment were the highest, representing **29%** of the total claims submitted.

Note: An individual may have been served by more than one provider hence data can not be summed by service type to get total service utilization for a particular service category, the total would be an overcount.

 # Billing Providers for SUD Services

973

 # Provider Locations for SUD Services

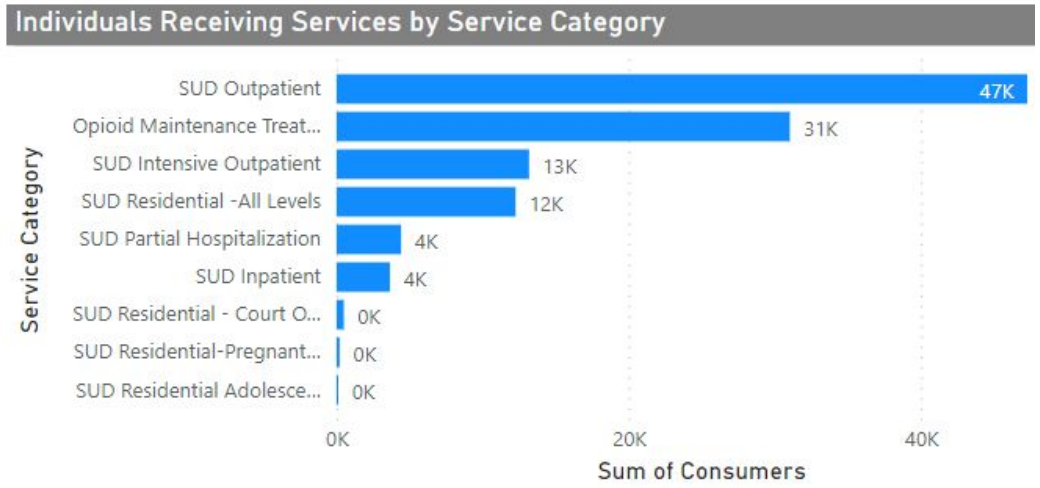
2,042

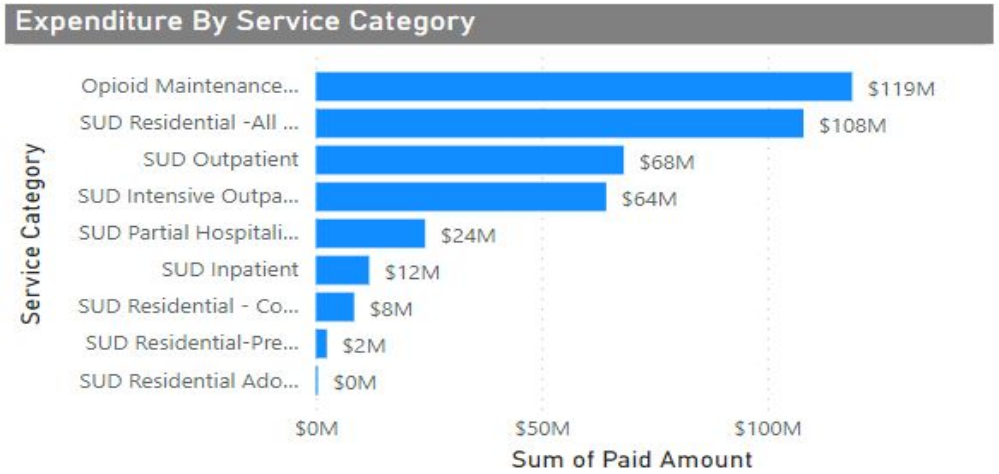
 # Individuals Received SUD Services

104.2K

SUD Service Claims

$406.58M





Mental Health (MH) Services FY 21

 # Billing Providers for MH Services

2,600

 # Provider Locations for MH Services

4,481

 # Individuals Received MH Services

233.9K

MH Service Claims

$1.2B

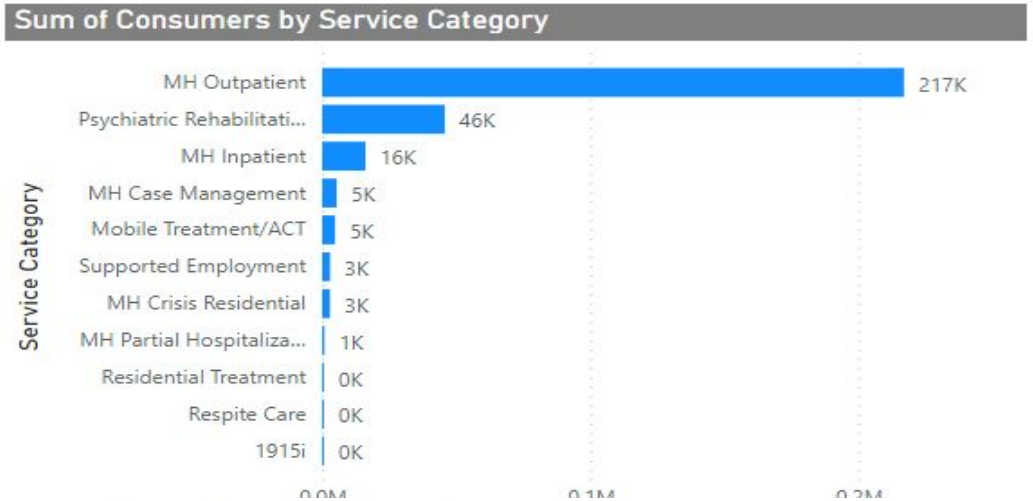
During FY 21, MH services claims were submitted by **2,600** providers across **4,481** locations.

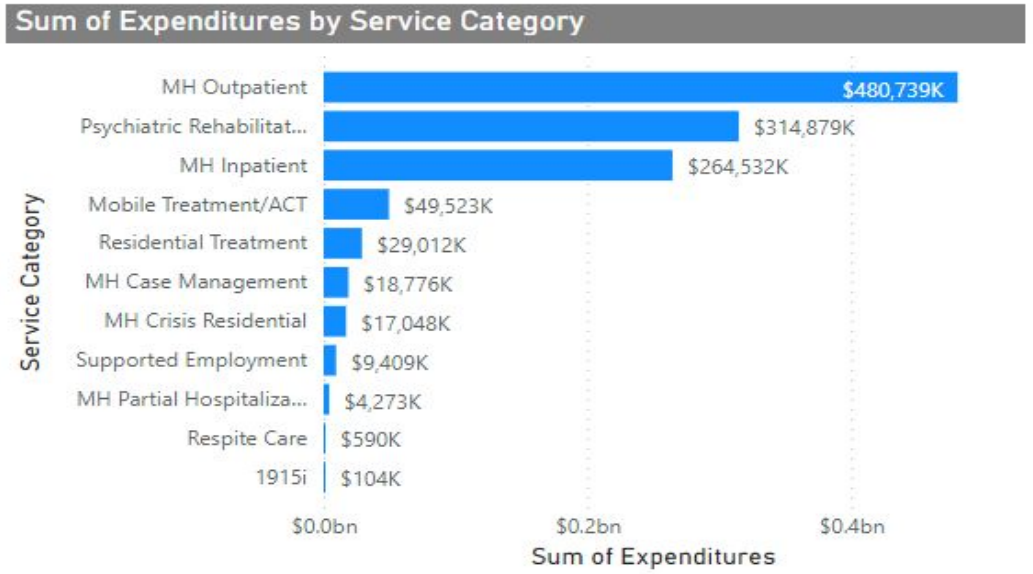
The expenditures for MH service claims amounted to **$1.2B**, attributed to the **233,900** individuals who received these services.

Outpatient services were the most commonly used among various MH services, with approximately **217,000** individuals, representing **93%** of all MH service users.

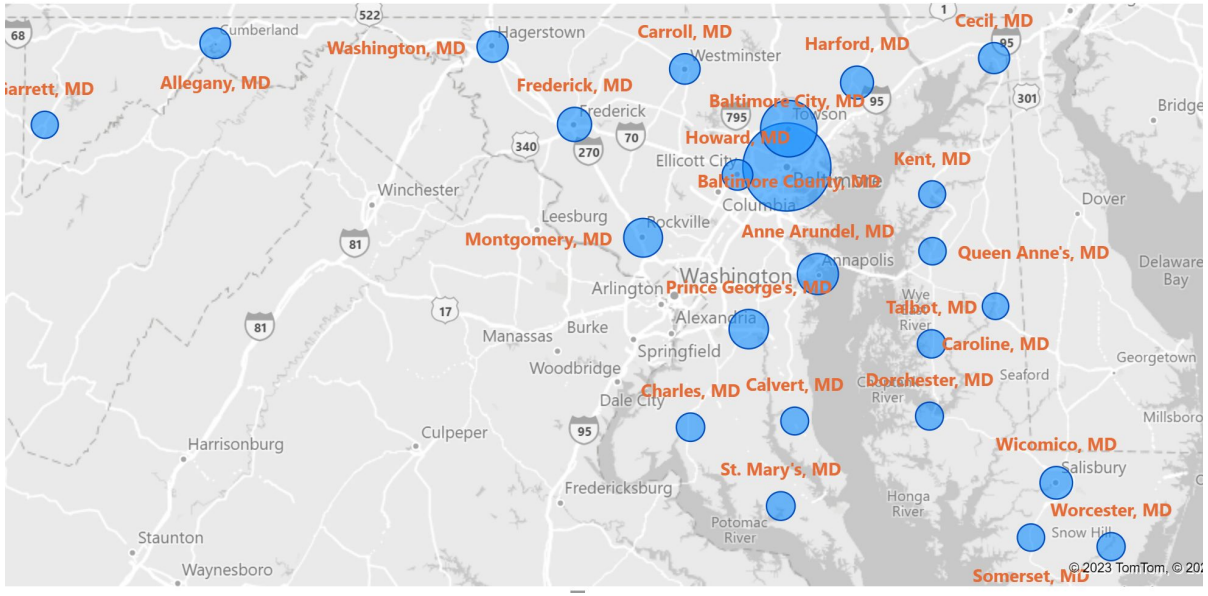
The total claims submitted for **Outpatient Treatment** were the highest, representing **40%** of the total claims submitted.

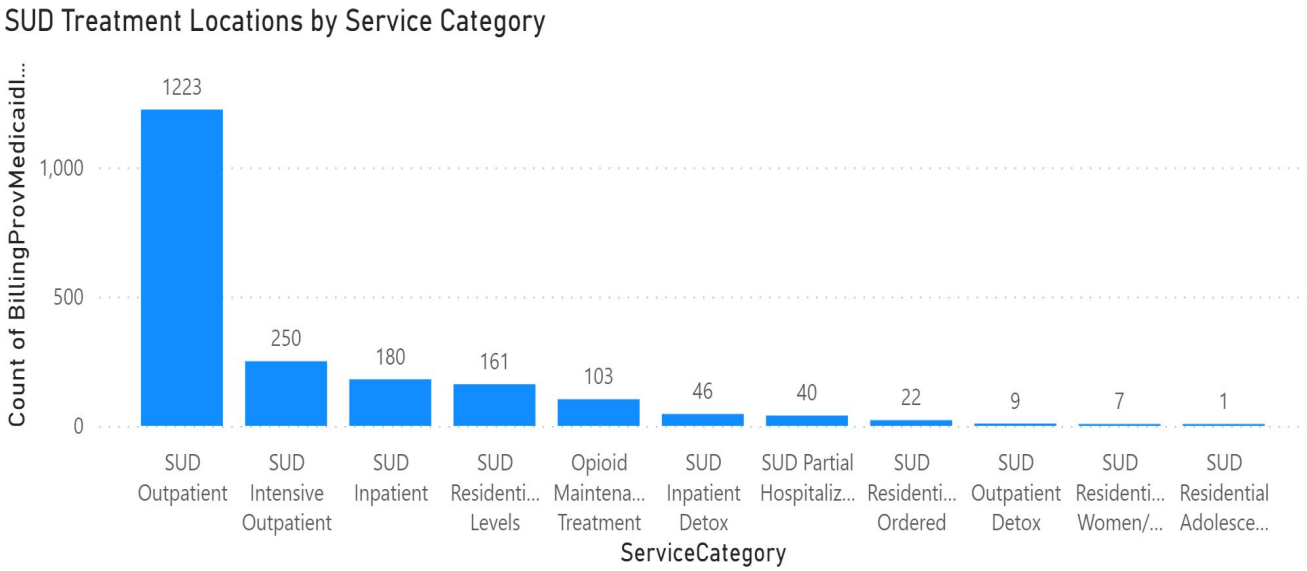
Note: An individual may have been served by more than one provider hence data can not be summed by service type to get total service utilization for a particular service category, the total would be an overcount.





SUD Treatment Service Provider Location Highlights





For Substance Use Disorder Treatment services, Baltimore City has the highest number of treatment locations (609 or 30%) and Baltimore County has the second highest number of substance use disorder treatment locations (298 or 15%).

During FY 21, there were 90 Out of State* providers across 136 locations that rendered SUD treatment services to Marylanders.

The top two Service Categories were Outpatient Services (1223 or 60%) and Intensive Outpatient Services (250 or 12%).

*Out of State covers approximately 15 states and the District of Columbia.

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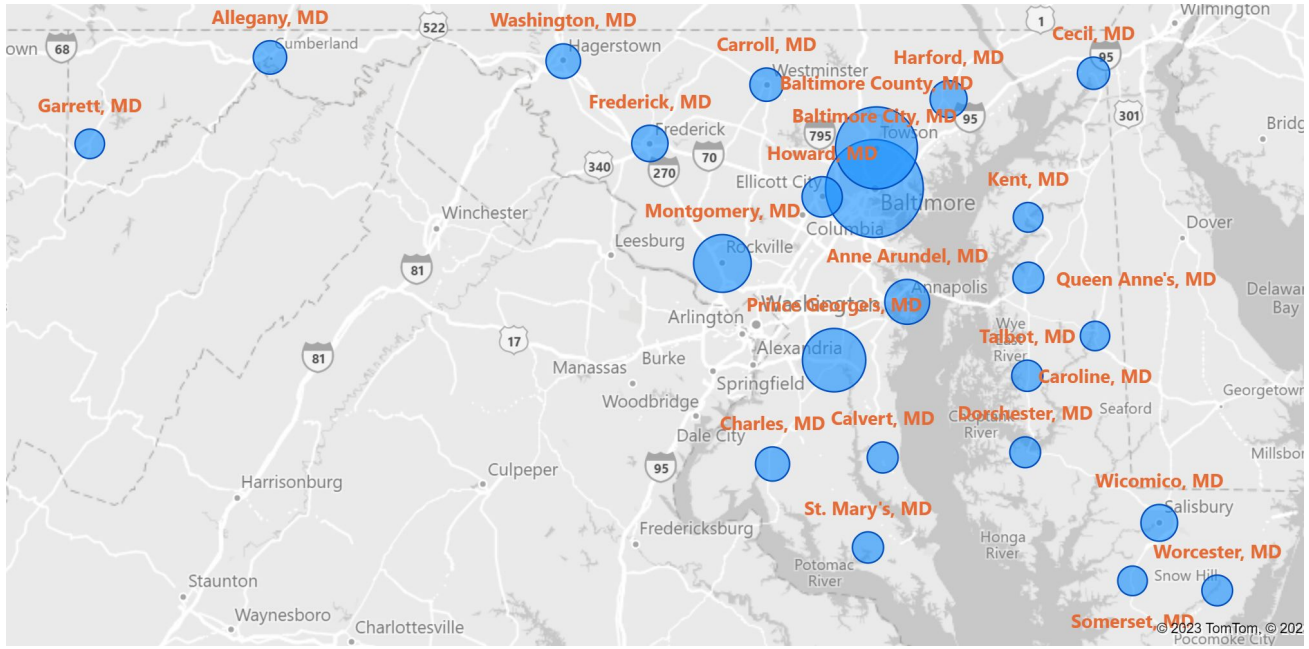
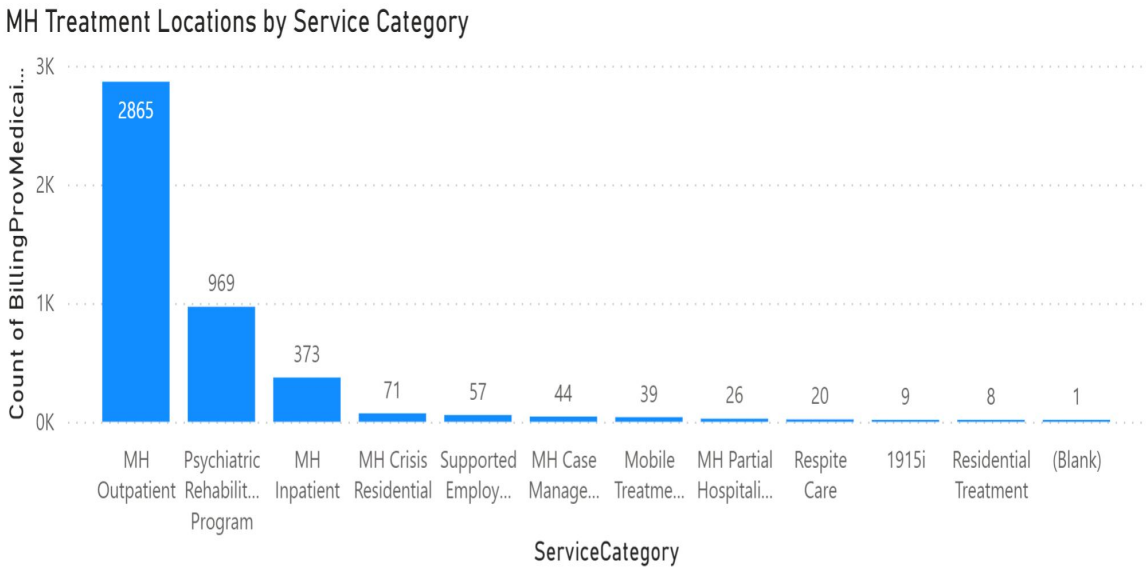
MH Treatment Service Provider Location Highlights





For Mental Health Treatment services, Baltimore City has the highest number of treatment locations (1,035 or 23%) and Baltimore County has the second highest number of all mental health treatment locations (799 or 18%).

During FY 21, there were 124 Out of State* providers across 189 locations that rendered MH treatment services to Marylanders.

The top two Service Categories were Outpatient Services (2,865 or 64%) and Psychiatric Rehabilitation Program Services (969 or 22%).

*Out of State covers approximately 20 states and the District of Columbia.

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Children and Youth Service Utilization Analysis

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National Landscape: Access to Behavioral Health Services for Children in Medicaid

- Behavioral health needs of children and youth often go unmet
- National data shows 54.1 percent of non-institutionalized youth enrolled in Medicaid or CHIP who experienced a major depressive episode received mental health treatment.
  - These adolescents were more likely than those with private coverage to receive treatment in institutional settings, as opposed to outpatient care.
- In 2018, there were nearly 12,000 specialty mental health treatment facilities in the United States, but many did not accept children or youth or offer tailored programming for adolescents with serious emotional disturbance.
  - Only one-third (32 percent) of these facilities offered such programming and participated in Medicaid. (In Maryland, 2018 data indicates only 30% of facilities offers this type of programming.)

Source: Medicaid and CHIP Payment and Access Commission

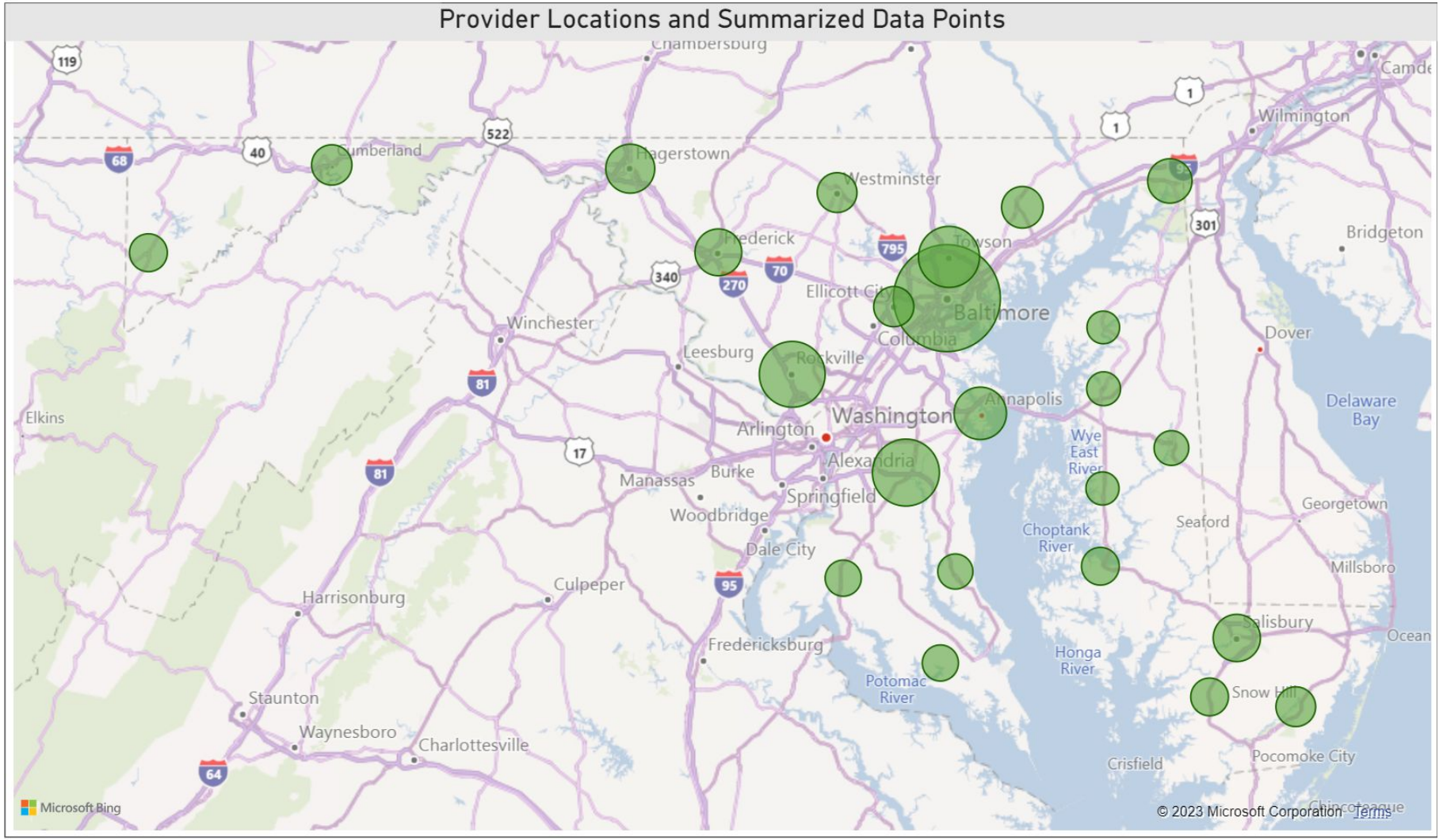
SUD Services Utilization Under 18 population By County of Service Locations: FY21

* 2,397

Customers Served

$2,479,363

Total Expenditure



* Please note that Individuals can have more than one service and could have moved within the FY hence the customer served counts includes duplicates. The max claims paid date is '6/30/2023'.

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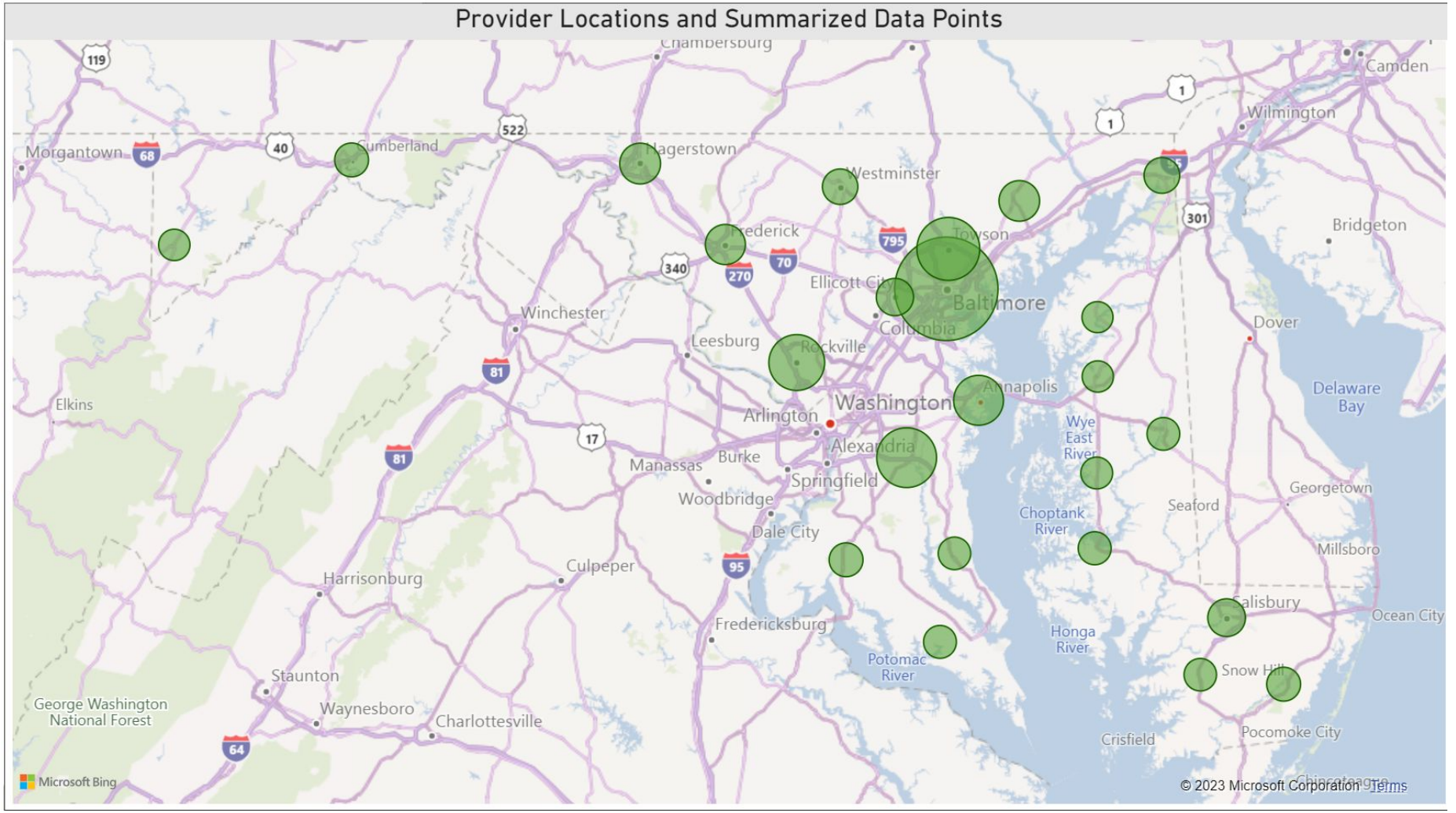
Mental Health Services Utilization By Children Under 18 by County of Service: FY21

* 71,922
Customers Served

$378,743,809
Total Expenditure



* Please note that Individuals can have more than one service and could have moved within the FY hence the customer served counts includes duplicates. The max claims paid date is '6/30/2023'.

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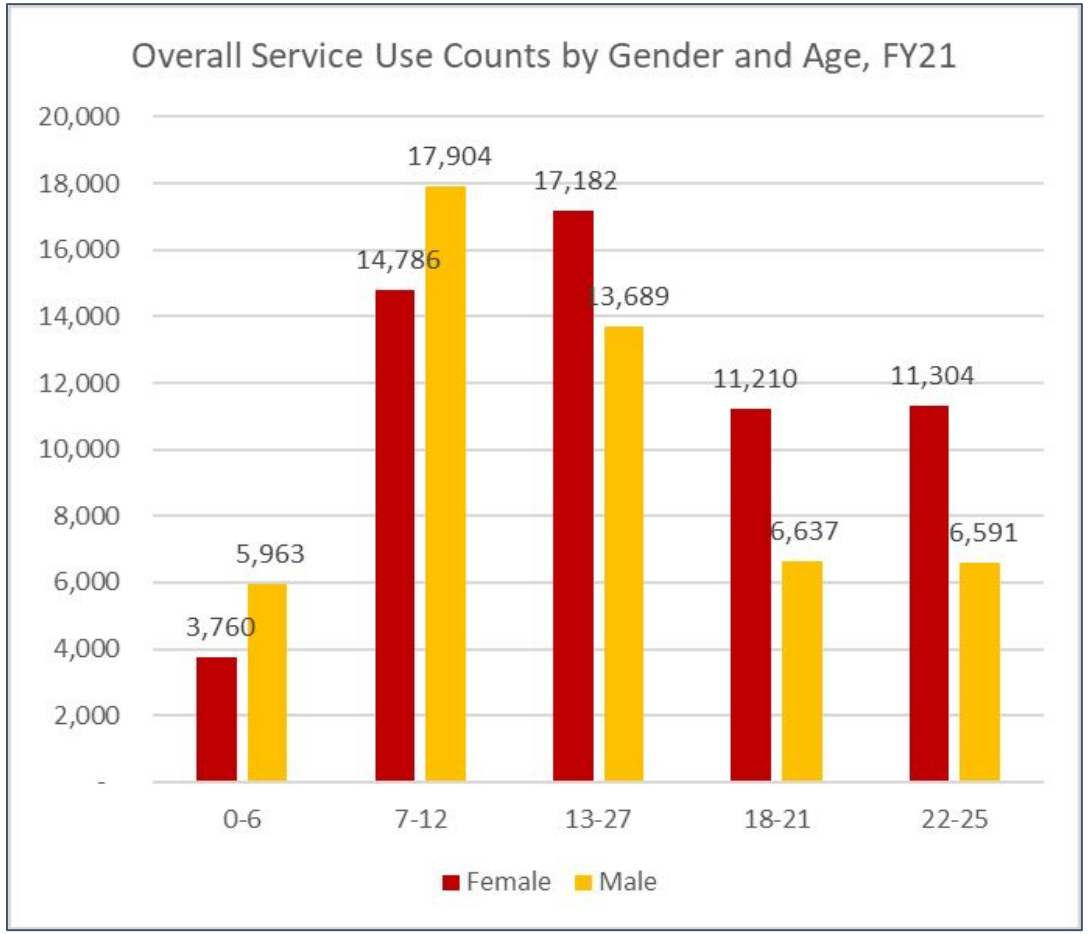
Child and Young Adult Service User Demographics



- Children and young adults (birth to 25 years) represent one-third of the Maryland population (1.9M).
- More than one-half (67.2%) of child and young adult service users were between the ages of 0 to 17 years, while 32.8% were young adults between the ages of 18 to 25 years.
- Males were more likely to enter services at a younger age (birth - 12 years), while females enter services in their teen and young adulthood years and are more likely to use intensive inpatient hospital and Emergency Department Services.

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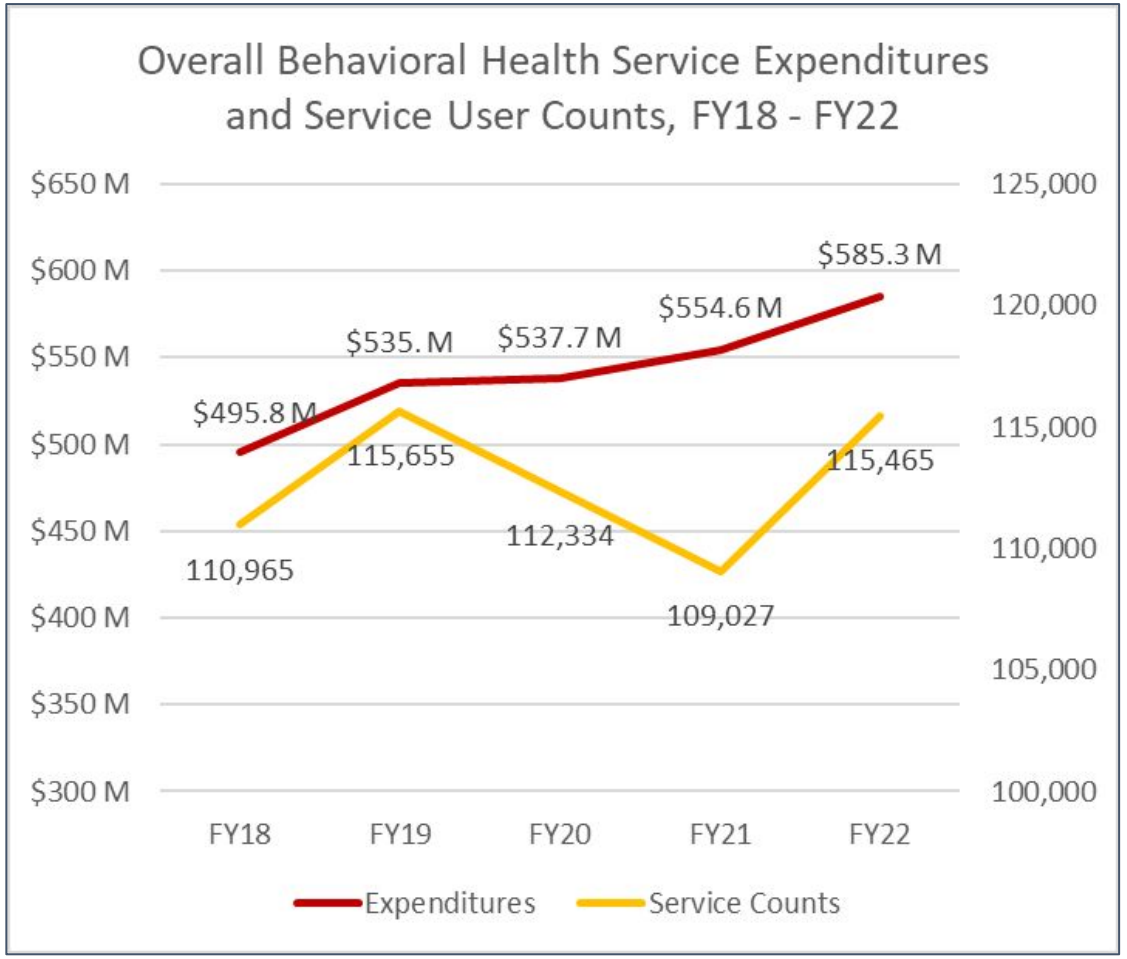
Youth and Young Adult Public Behavioral Health Service Use and Expenditures



Data Source: PBHS Service Claims data FY2018 - FY2021

- In FY 21, a total of 109,027 children and young adults received one or more behavioral health services within the PBHS system statewide with a total expenditure of $554.6M.
- Service use among children and young adults decreased by 5.7% between FY20 and FY21, while expenditures increased over the same period by 3.1%.
- The increase in expenditures was largely driven by increased spending on Inpatient Hospital (9.7% increase); and PRP (42.0% increase)

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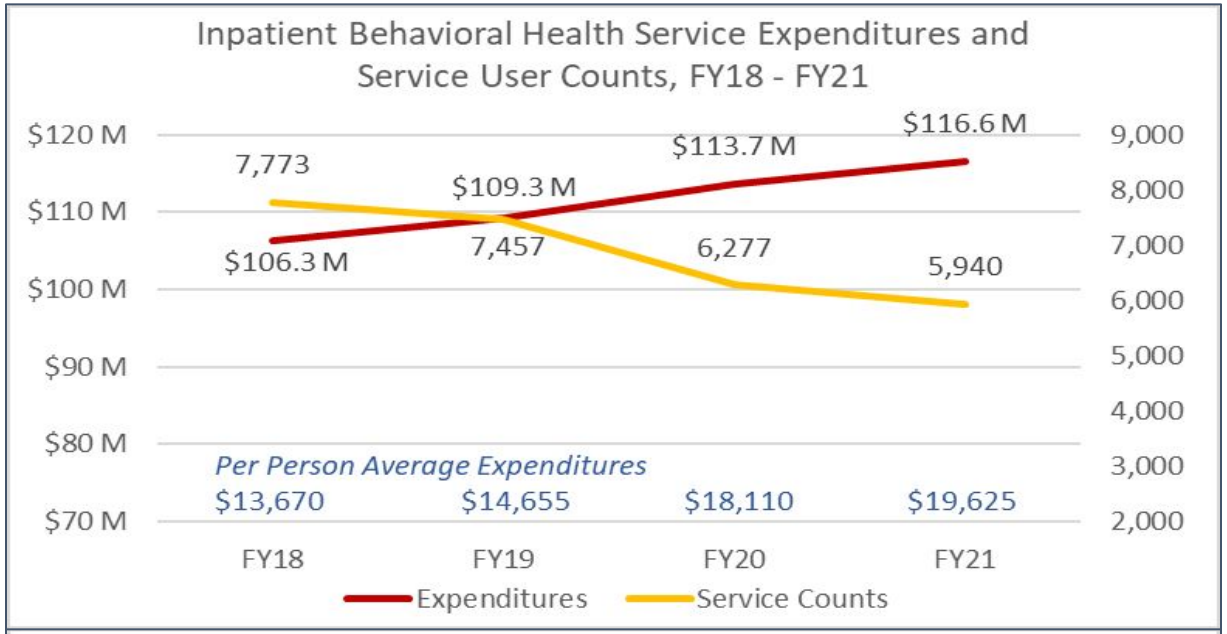
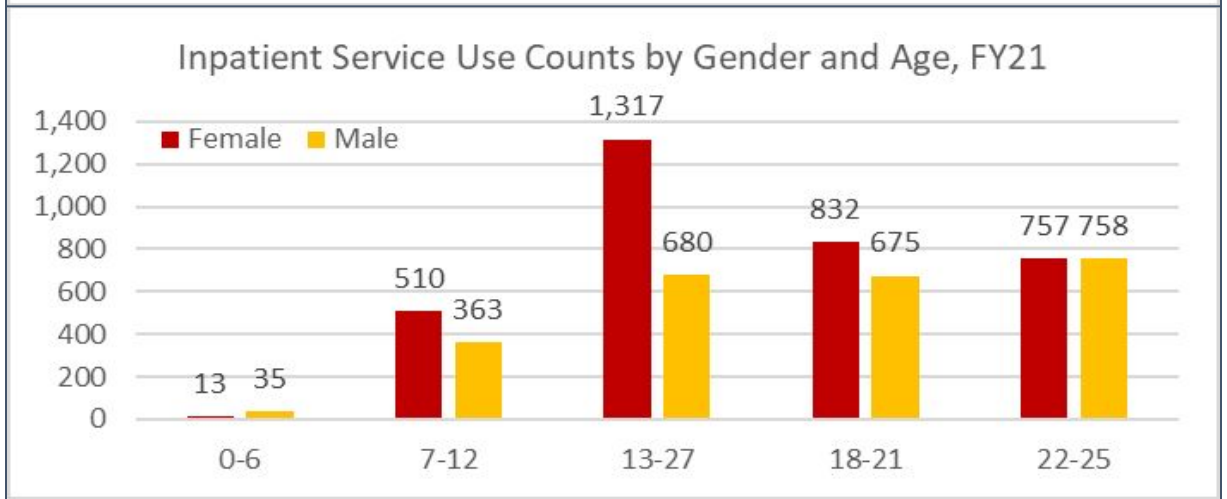
Hospital Inpatient Use and Expenditures





- In FY21, 5,940 (5.4%) children and young adult PBHS recipients used behavioral health inpatient hospital services at a rate of 7.0 per 1,000 Medicaid eligible individuals and represented nearly one quarter (21.0%; $116.6M) of annual public behavioral health expenditures.
- Reduction in inpatient hospital use and overall expenditures in the past year, annual per person expenditures have increased (8.4%). This is consistent with other data demonstrating increased length of stay, and an increase in the intensity of needs of individuals served.
- Females were more likely to use inpatient hospital and ED services with use increasing in this group during the teen years (13 to 17 years) where females were nearly twice as likely to be hospitalized or use ED services than males.

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Additional Key Findings on Children and Youth

- Among services studied, psychiatric rehabilitation services, which provide rehabilitation and support services to aid in the development and enhancement of independent living skills, were the most utilized services.

- Few children and youth with intensive behavioral and emotional challenges are accessing community-based behavioral health services, including intensive care coordination and in-home programs.

- Differences in utilization exist between boys and girls accessing services. Findings show that compared to males, females are more likely to enter services in the teen and young adult years and are more likely to use inpatient hospital and Emergency Department services.

- Spending on substance use disorder treatment was significantly lower than spending on mental health services for youth.

- Disparities in access to key services exist across the state, in part due to provider availability, and social determinants of health that disconnect certain populations from care. Examples of disparities include:
    - All jurisdictions, except Charles, Howard, Montgomery, Prince George's and St. Mary's had PBHS service use rates that were higher than the state average of 128.6 per 1,000 eligible.
    - Three jurisdictions, including Charles, Montgomery and Prince George's Counties had utilization rates of less than 100 per 1,000 eligible.

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Assessment of Currently Funded Services by Jurisdiction

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Assessment of Currently Funded Services

Jurisdiction	Assertive Community Treatment	Adolescent Clubhouse	Assisted Living/ ALU	Buprenorphine Initiative	Care Traffic Control	Case Management (MH)	Children in Need of Assistance (SB 512) Assessments	Client Support Services (MH)	Court / DJS Initiatives	Crisis Intervention Team	Crisis Walk-In / Beds / Stabilization / Urgent Care	Crisis Residential	988 Crisis Hotline	Deaf/Hard of Hearing Interpreter Services	Detox (Inpatient/Outpatient)	Detention / Jail-Based Services	Drug Court	ED / Hospital Diversion Initiatives	First Episode Psychosis	Harm Reduction Services	Housing Supports (CoC, PATH)	Inpatient Services (MH)	Inpatient Services (SUD)	LEAD	MCCJTP	Maryland Recovery Net	MH Stabilization Services (Youth)	Mobile Crisis Response	Mobile Response Stabilization Services (MRSS)	Opioid Maintenance Treatment
Allegany	G			G		ASO		G		G	G	ASO	G		ASO		G			G	G	ASO	ASO		G	G	G			ASO
Anne Arundel	G/ASO	G	G	G		ASO		G		G	G	ASO	G	G	ASO	G	R/G		G	G	G	ASO	ASO	O	G	G/ASO	G	G		ASO
Baltimore City	G/ASO	G	G	G	HSCRC	ASO	G	G	G	G	G	ASO	G	G	ASO	G	R		G	G	G	ASO	ASO	G		G/ASO		G	G	ASO
Baltimore County	G/ASO	G		G	HSCRC	ASO		G		G	G	ASO	G		ASO	G	R		G	G	G	ASO	ASO		G	G/ASO		G		ASO
Calvert	G	G		G		ASO		G	G	G	G		G			G	G	G		G	G	ASO	ASO		G	G/ASO		G	G	ASO
Caroline		G	G	G	G			G	G	G	G	ASO	G	G			G	G			G	ASO	ASO		G	G/ASO	G	G		
Carroll	ASO			G	HSCRC	ASO		G		G	G	ASO	G	G	ASO	G	G			G	G	ASO	ASO	OOCC	G	G/ASO		G		ASO
Cecil	ASO	G		G	G	ASO		G		G	G		G	G	ASO		G	G		G	G	ASO	ASO		G	G/ASO		G	G	ASO
Charles	G/ASO					ASO		G		G	G		G	G	ASO	G	G			G	G	ASO	ASO		G	G/ASO		G	G	ASO
Dorchester	ASO	G	G	G	G			G	G	G	G		G	G	ASO		G	G		G	G	ASO	ASO		G	G/ASO	G	G	G	
Frederick	ASO	G		G		ASO		G		G	G	ASO	G	G		G	G	G		G	G	ASO	ASO	G	G	G/ASO		G	G	ASO
Garrett	G			G		ASO		G	G	G	G	ASO	G			G		G		G	G	ASO	ASO		G	G				
Harford	G/ASO	G				ASO				G	G	ASO	G		ASO		G			G	G	ASO	ASO	O	G	G/ASO	G	G	G	ASO
Howard	ASO			G	HSCRC	ASO		G		G	G	ASO	G		ASO	G	G			G	G	ASO	ASO	O	G	G/ASO	G	G		ASO
Kent		G	G	G	G			G	G	G	G		G	G				G			G				G	G/ASO	G	G	G	
Montgomery	ASO	G	G	G		ASO		G	G	G	G	ASO	G	G	ASO	G	G		G	G	G	ASO	ASO			ASO				ASO
Prince George's	ASO	G	G	G	HSCRC	ASO	G		G	G		ASO	G	G	ASO	G	R/G	G	G	G	G	ASO	ASO		G	G/ASO		G		ASO
Queen Anne's	ASO	G	G	G	G	ASO		G	G	G	G		G	G				G			G	ASO	ASO		G	G/ASO	G	G	G	
Somerset		G			G			G				ASO	G	G			R/G	G		G	G	ASO	ASO	OOCC	G	G		G	G	
St. Mary's	G	G	G	G		ASO		G		G	G		G			G	G			G	G	ASO	ASO	O	G	G/ASO	G	G	G	ASO
Talbot		G	G	G	G			G	G	G	G		G	G			G	G			G	ASO	ASO		G	G/ASO	G	G		ASO
Washington	G/ASO	G	G			ASO	G	G		G	G	ASO	G	G		G	G			G	G	ASO	ASO	O	G	G/ASO	G	G	G	ASO
Wicomico	ASO	G		G	G	ASO		G	G	G		ASO	G	G		G	G	G		G	G	ASO	ASO	O	G	G/ASO		G	G	ASO
Worcester		G		G		ASO	G	G	G	G	G	ASO	G	G			R/G	G		G	G	ASO	ASO	G	G	G/ASO		G		ASO

Jurisdiction	Outpatient Services (MH)	Outpatient Services (SUD)	Overdose Response Program	Partial Hospitalization (MH)	Partial Hospitalization (SUD)	Peer to Peer Support / Peer Recovery	Psych Rehab Program	Recovery Support Preg Women / Children	Residential Rehabilitation Program	Residential Treatment Center	Residential Treatment (MH)	Residential Treatment (SUD)	Respite Care	Safe Station	SBIRT	School / Preschool Programs	Senior Outreach	SOAR	Spanish-Speaking Therapeutic Services	State Care Coordination	START - Sobriety Treatment and Recovery Teams	STOP - Substance Abuse Treatment Outcomes Partnership	Supportive Employment	Syringe Services Program	TAMAR	Targeted Case Management / 1915i	TAY	Temporary Cash Assistance	Teen Diversion	Older Adult Behavioral Health PASRR	Wellness/ Recovery Centers
Allegany	ASO	ASO	G			G	ASO		ASO			ASO	ASO							G		G	ASO	G				R		G	G
Anne Arundel	ASO	ASO	G	ASO	ASO	G	ASO		ASO			ASO		G					G	G	R	G	ASO	G	G	G	G	R		G	G
Baltimore City	ASO	ASO	G	ASO	ASO	G	ASO	G	ASO	SF/ASO	ASO	ASO	G/ASO		G	G		G	G	G			ASO	G			G	R		G	G
Baltimore County	ASO	ASO	G	ASO	ASO	G	ASO	G	ASO	ASO	ASO	ASO				G	G	G		G		G	ASO	G	G	ASO		R		G	G
Calvert	ASO	ASO	G	ASO		G	ASO		ASO			ASO				G	G			G		G	ASO	G			G	R		G	G
Caroline	ASO	ASO	G				ASO		ASO				G	G		G		G	G	G	R	G	ASO				G	R		G	G
Carroll	ASO	ASO	G		ASO	G	ASO		ASO			ASO								G	R	G	ASO				G	R		G	G
Cecil	ASO	ASO	G		ASO	G	ASO	G	ASO			ASO				G				G	R	G	ASO	G				R		G	G
Charles	ASO	ASO	G			G	ASO		ASO			ASO								G		G	ASO		G	ASO	G	R		G	G
Dorchester	ASO	ASO	G		ASO	G	ASO		ASO			ASO	G/ASO					G	G	G			ASO		G		G	R		G	G
Frederick	ASO	ASO	G	ASO	ASO	G	ASO		ASO		ASO	ASO	G/ASO			G	G	G		G	R	G	ASO	G	G	ASO		R		G	G
Garrett	ASO	ASO	G			G	ASO		ASO				ASO			G	G	G		G		G	ASO				G	R		G	G
Harford	ASO	ASO	G		ASO	G	ASO		ASO			ASO	G			G		G		G		G	ASO	G	G	G		R	G	G	G
Howard	ASO	ASO	G	ASO		G	ASO		ASO			ASO	ASO		OOCC		G		G	G		G	ASO	G			G	R		G	G
Kent	ASO	ASO	G				ASO		ASO			ASO	G/ASO					G	G	G	R		ASO				G	R		G	G
Montgomery	ASO	ASO	G	ASO	ASO		ASO		ASO	SF		ASO	G		G	G	G	G		G		G	ASO	G			G	R		G	G
Prince George's	ASO	ASO	G	ASO		G	ASO	G	ASO			ASO				G	G			G		G	ASO	G	G	ASO	G	R		G	G
Queen Anne's	ASO	ASO	G			G	ASO		ASO				G/ASO					G	G	G			ASO				G	R		G	G
Somerset	ASO	ASO	G	ASO		G	ASO		ASO			ASO								G	R	G	ASO					R		G	G
St. Mary's	ASO	ASO	G			G	ASO		ASO			ASO						G		G		G	ASO	G			G	R		G	G
Talbot	ASO	ASO	G			G	ASO	G	ASO				G					G	G	G	R	G	ASO				G	R		G	G
Washington	ASO	ASO	G	ASO		G	ASO	G	ASO			ASO	ASO			G		G		G	R	G	ASO	G	G		G	R		G	G
Wicomico	ASO	ASO	G	ASO	ASO	G	ASO		ASO			ASO	ASO	G		G				G		G	ASO	G		ASO		R		G	G
Worcester	ASO	ASO	G			G	ASO	G	ASO				G	G		G				G		G	ASO				G	R	G	G	G

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Assessment of Currently Funded Services - Analysis

- There are a number of services covered by Medicaid - some with good jurisdictional representation and others with limited availability (meaning clients have to travel for care)
- There are many services/resources that are grant funded through the Department and other partners
- There are services/resources that not available in all jurisdictions (i.e. the “white space”)
  - ASO services such as detoxification, Partial Hospitalization, and mental health Residential Treatment
  - Children’s services, such as Targeted Case Management, Residential Treatment Centers, Respite, and Inpatient SUD Services

Next Steps

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Next Steps

- This analysis is Phase 1 - MDH continues to analyze data and trends
- Questions for future discussion:
  - What additional information/analysis is needed to drive workgroup discussion and recommendations?
  - How can we better capture unmet need and demand for services/resources?

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Thank you!

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Review of Prior Recommendations Related to Behavioral Health

Jordan Fisher, Chief of Staff, MDH Operations & Healthcare System

Commission Requirements

Among other things, HB1148/SB 582 of 2023 requires the Commission to:

- Review recommendations and reports of state commissions, workgroups, or task forces related to behavioral health care

A multidisciplinary team at MDH reviewed reports issued from 2011 - 2022, **65 reports were identified, reviewed, and summarized.**

- MDH sought guidance from Librarians at the Department of Legislative Services to ensure that the reports included in its review were comprehensive
- Recommendations highlighted in today's presentation are framed around notable gaps in Maryland

Commission Requirements

- Reports and recommendations presented here are summarized first by the Behavioral Health Advisory Council, and then by topics for the workgroups established under the Commission's authorizing statute:
  - Geriatric Behavioral Health
  - Youth Behavioral Health, and Intellectual and Developmental Disabilities
  - Individuals with Complex Behavioral Health Needs
  - Criminal Justice Involved Individuals
  - Behavioral Health Workforce Development, Infrastructure, and Coordination
  - Behavioral Healthcare Financing
- Workgroups will be charged with taking a deeper look at these prior recommendations at their first meeting.

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Behavioral Health Advisory Council

Background: Behavioral Health Advisory Council

- Pursuant to the Annotated Code of Maryland, Health General 7.5 - 305, and federal Public Law (PL) 102-321, the State of Maryland established the Maryland Behavioral Health Advisory Council (BHAC) in 2016 to:
  - Promote and advocate for planning, policy, workforce development, and services to ensure a coordinated, quality system of care that is outcome-guided and that integrates prevention, recovery, evidence–based practices, and cost-effective strategies that enhance behavioral health services across the state; and
  - A culturally competent and comprehensive approach to publicly-funded prevention, early intervention, treatment and recovery services that support and foster wellness, recovery, resiliency, and health for individuals who have behavioral health disorders and their family members.
- **The BHAC consists of 28 In-Statute Ex-Officio Members (or designees) representing state and local government, the Judiciary, and the Legislature:**
  - 13 members, appointed by the Secretary of Health, representing behavioral health provider and consumer advocacy groups; and
  - 14 representatives that include a diverse range of individuals who are consumers, family members, professionals, and involved community members.

BHAC Report Findings & Recommendations

- BHAC reports have documented findings and/or action areas on:
  - **Examining the crisis response system in the State,** including gaps in coverage and disparities between urban and rural programs.
  - Advocating for expansion of a **continuum of care in Maryland,** including focusing on recovery housing and recovery services
  - Online support and training, and waivers to allow out of State providers to offer **telehealth services** to patients in State
- Key recommendations made by the BHAC include:
  - **Expanding rehabilitation services,** including working on improvements in sustainability of programs, placement flow, and aftercare opportunities, and developing and expanding recovery housing/halfway housing services for rehabilitation, and address competency admission delays in providing service (2021)
  - Establishing **crisis walk-in and mobile crisis teams models** for each jurisdiction (2019)
  - **Address workforce shortages,** funding and accountability, transportation accessibility, and public awareness (2018)

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Geriatric Behavioral Health

Geriatric Behavioral Health Reports

- **4** reports related to geriatric behavioral health were identified as part of MDH review:
  - *Bed Registry Workgroup Accomplishments (2022)*
  - *JCR on Cognitive Health Plan for Maryland (2022)*
  - *JCR on Pre-Admission Screening and Resident Review Program (PASRR) (2021)*
  - *JCR on Individuals with Serious Mental Illness and Aging in Place (2013)*

- These reports focus on:
  - **Examining and evaluating crisis services for older adults,** including policy, operational, and other requirements necessary to promote and deliver crisis services in Maryland.
  - **Examining appropriate long term care placement** in Medicaid for older adults
  - Identifying the **current cognitive and behavioral health needs of Maryland's aging population** and the challenges facing the State to address these needs

Key Recommendations on Geriatric Behavioral Health

- **Pre-Admission Screening and Resident Review Program (PASRR) Recommendations (2022)**
  - **Strengthen evaluation tools for aging individuals:** Explore opportunities for updating the Level II Evaluation tool. Currently, MDH uses the STEPS assessment for the PASRR Level II Evaluation that has benefited from local knowledge of the target population for the past 30 years. With more information available today, this tool can be strengthened.
  - **Enhance PASRR management systems:** Review opportunities to improve the PASRR data management system by strengthening communications on timeliness, accuracy, and completeness of information between the parties who manage the screenings and evaluations.
- **Recommendations related to Aging (2021)**
  - Establishment of internal interagency coordinating process,
  - Identify existing groups to assist,
  - Engage a review of the Alzheimer's 2022-2026 plan.
- **Serious Mental Illness and Aging in Place (2013)**
  - **Consideration of an enhanced Residential Rehabilitation Program (RRP) model:** The state should explore an RRP model that incorporates further integration of somatic care into RRP settings

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Youth Behavioral Health, and Intellectual and Developmental Disabilities

Youth Behavioral Health & I/DD Reports

- **9 reports** related to youth behavioral health were identified as part of MDH review, including:
  - *JCR on Youth-Centered BH Intervention and Prevention (2022)*
  - *Out of home Placement and Family Preservation Resource Plan (2022)*
  - *JCR on Voluntary Placement Agreements Review and Access to Intensive BH Services (2021)*
  - *JCR on Increased Capacity for Psychiatric Care for Youth (2020)*
  - *JCR on Treatment Options for Youth with Heroin-Related SUDs (2014)*
  - *JCR on Mental Health Services for Transitional Age Youth (2013)*
  - *JCR on Residential Treatment Center Outcomes (2013)*

- No reports were identified that were specific to behavioral health and Intellectual and Developmental Disabilities

- Among other things, these reports focus on:
  - The role of **youth-centered** behavioral health intervention and preventative programs
  - Evidence-informed models to **reduce and prevent juvenile justice system involvement**
  - Documenting the State's capacity for and **utilization of out-of-home placements**, including analyzing the costs associated with out-of-home placements. It also identifies areas of need across Maryland and strategies each child-serving agency will employ in FY 2023 to develop those resources.
  - Reviewing processes in other states for assisting families in accessing high intensity behavioral health services for their children, including states that **do not require custody relinquishment**
  - **Limited treatment options** for youth that use heroin
  - **Best practices** for mental health services for transitional aged youth

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Key Recommendations on Youth Behavioral Health & I/DD

- **Integrated behavioral health models for juveniles (2022)**
  - Consider creating a multi-layered group to start the planning process for developing a pilot program in Maryland that would utilize the co-design model.
  - **Note: HB 1155 of 2023 was introduced, but did not pass.** This bill would have implemented recommendations made on this topic.
- **Programs designed for transitional aged youth (TAY) (2013)**
  - Additional Programs to support transitional age youth should offer coordinated and consistent transition services, stronger linkages and collaboration, and services for TAY with mild or moderate mental health conditions.
- **Expanding capacity for children and youth (2021, 2020)**
  - Increase residential treatment center capacity, in partnership with DHS
  - Continuing efforts to increase the number of providers who administer these services under the Medicaid 1915i/1915(b)(4) waiver.

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Individuals with Complex Behavioral Health Needs

Reports on Complex Behavioral Health Needs

- **19** reports related to complex behavioral health were identified as part of MDH review, including:
  - *Data-Informed Overdose Risk Mitigation (DORM) Annual Reports (2020, 2021)*
  - *Opioid Operational Command Center Annual Reports (2018 - present)*
  - *JCR on Medication Adherence for Severe and Persistent Mental Illness Patients (SPMI) (2019)*
  - *JCR on Family-centered Substance Use Disorder Residential Treatment (2019)*
  - *JCR on Affordable Housing for People with Serious Mental Illness (2016)*
  - ***Outpatient Services Programs Stakeholder Workgroup (2014)***
  - ***Continuity of Care Advisory Panel Report (2013)***

- Among other things, these reports focus on:
  - Identifying and coordinating overdose datasets and documenting **disparities related to overdose deaths in our state,** examining statewide and jurisdictional specific plans to reduce opioid overdoses
  - **Examining expenses and expenditures for individuals with SPMIs** such as schizophrenia, bipolar disorder, or major depression, including dually eligibles such as expenses related to treating this population, impact on expenditures due to nonadherence to medication, and potential patient benefits and cost savings from use of advanced medication adherence technology
  - **Summarizing** affordable housing options, and efforts to increase affordable housing resources.
  - Developing model legislation for an **assisted outpatient treatment** (also known as outpatient civil commitment);
  - Evaluating the dangerousness standard for involuntary admissions and emergency evaluations.

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Key Recommendations on Complex Behavioral Health

- **Increase data collection and analysis surrounding the overdose crisis and expand resources to reduce overdose (2020, 2021)**
  - Expand access to buprenorphine for treatment of opioid use disorder
  - Expand targeted naloxone distribution
  - Identify culturally competent strategies to address increasing overdose death rates among older adults (55+).
  - Bolster targeted outreach and care coordination for medicaid-eligible populations.
- **Evaluate strategies related to medication adherence (2019)**
  - Technology, long acting injectables, and clinical approaches need more research to determine efficacy and cost savings.
- **Increase treatment resources (2019, 2020)**
  - Make overdose education and naloxone distribution available to individuals who at high-risk
  - Increase access to naloxone and other harm reduction services for active opioid users.
  - Expand access to recovery support services, enhance data collection, sharing, and analysis to improve understanding of and response to the opioid epidemic.
  - Build capacity of healthcare system to identify opioid use disorders and link patients to speciality care.
- **Increase awareness and decrease stigma** (2018)
  - Reduce stigma and improve education around opioid addiction.
  - Increase patient, youth, public safety, and general public knowledge of opioid risk and benefits.
  - Reduce illicit opioid supply, and inappropriate/unnecessary opioid prescribing and dispensing.

Key Recommendations, Continuity of Care Advisory Panel, 2013

- The Continuity of Care Advisory Panel was convened in Fall 2013 to explore the barriers to continuity of care – economic, social, legal and clinical – for individuals with serious mental illness, and make recommendations to strengthen the public behavioral health service delivery system, improve health outcomes, and address deficiencies that lead to interruptions of care.
- Panel put forth 25 recommendations to address deficiencies in continuity of care in the following areas:
  - Accessibility of mental health records;
  - Services to address the needs of individuals with serious mental illness;
  - Workforce training;
  - Mental health literacy;
  - Additional areas for research;
  - Delegated decision making;
  - Services for court-involved individuals; and
  - Involuntary commitment.
- This Panel recommended that the **Secretary should convene a workgroup to further examine the implementation of an outpatient civil commitment program in Maryland**

Key Recommendations, Outpatient Services Programs Stakeholder Workgroup, 2014

- Senate Bill 882/House Bill 1267 of the 2014 legislative session required the Secretary of Health and Mental Hygiene to convene a stakeholder workgroup to:
  - Examine the development of assisted outpatient treatment (also known as outpatient civil commitment) programs, assertive community treatment programs, and other outpatient services in the state;
  - Develop a proposal for a program in the State; and
  - Evaluate the dangerousness standard for involuntary admissions and emergency evaluations.

- Building upon the Continuity of Care Advisory Panel's work, the Outpatient Services Programs Stakeholder Workgroup, developed three proposals, in line with its statutory mandate.

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Criminal Justice Involved Individuals

Reports on Criminal Justice Involved Individuals

- **16** Reports on criminal justice involved individuals, including state facilities which largely serve court-involved individuals:
  - *Annual Report - Commission to Study Mental and Behavioral Health in Maryland (2019 - 2020)*
  - *Opioid Operational Command Center Annual Reports (2018 - present)*
  - *JCR Report detailing direct care staffing issues, recruitment and retention (2018 - 2019)*
  - *JCR on Inpatient Psychiatric Bed Capacity Across All Sectors (2018)*
  - *JCR on Appropriate Staffing Levels for Direct Care Employees and Associated Data in BHA-Administered Facilities (2018)*
  - *Forensic Services Workgroup Reports (2016 - 2017)*
  - *JCR on Security Recommendations for State Psychiatric Facilities (2016)*
  - *JCR on Alternatives to Residential Treatment for Commitments Under Section 8-507 (2016)*
  - *JCR on Treatment and Service Options for Certain Court-involved Individuals (2014)*
- Among other things, these reports focus on:
  - improving the continuum of mental health services, including a statewide crisis response system
  - access to substance use treatment for court-involved individuals
  - improving access to care for those leaving jail and prison
  - ensuring parity of resources to meet mental health needs
  - staffing concerns, increasing bed capacity, and forensic services capacity for MDH facilities

Key Recommendations on Criminal Justice Involved Individuals

- **Increase treatment resources for those leaving jail and prison (2019, 2020)**
  - Identify and connect patients to treatment and recovery services.
  - Implement law enforcement diversion programs to connect low-level drug-involved offenders with treatment services.
  - Improve access and quality of opioid addiction treatment in communities.
  - Enhance criminal justice services for opioid-addicted offenders to prevent re-entry and recidivism.
  - Expand access to treatment and recovery services for inmates with SUDs in correctional facilities.
  - Transition inmates with SUDs leaving incarceration to outpatient treatment services.
- **Forensic Services recommendations (2016 - 2017)**
  - Increase bed capacity within MDH.
  - Increase availability of Community Crisis Services.
  - Expand the capacity of the Office of Forensic Services.
  - Increase outpatient capacity to meet the needs of forensic patients.
  - Centralize MDH Forensic Processes. Increased education to reduce stigma in both the general public and mental health treatment community
- **Serving individuals in the least restrictive setting (8-507 placements) (2014).**
  - Evaluate and place individuals in the least restrictive alternative setting whenever the evaluation does not require a residential treatment placement, including outpatient treatment combined with recovery housing or other supportive housing.

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Behavioral Health Workforce Development, Infrastructure, and Coordination

Reports on Behavioral Health Workforce Development, Infrastructure, & Coordination

- **12** Reports identified on these topics,, including:
  - *JCR on Occupational Therapy in Behavioral Health Services (2019)*
  - *JCRs on Behavioral Health Workforce and Infrastructure (2018, 2019)*
  - *JCR on Feasibility and Potential Impact of Merging Core Service Agencies with Local Addiction Authorities (2017)*
  - *JCR on Specialty Behavioral Health Information Sharing (2015)*
- Among other things, these reports:
  - note that reimbursement of occupational therapy services are limited to children under age 21 in an FQHC or OMHC and adults in hospital settings;
  - advise that gaps still remain in acute care services, outpatient and residential treatment services as well as other support and community-based services; there are unmet needs in each area
  - note that a shortage of behavioral health workforce and transportation are two of the major barriers to access to behavioral health services
  - merging CSAs and LAAs would support the PBHS, as long as mergers allow for local flexibility
  - document consent sharing needs under the behavioral health carve-out

Note: Reports with duplicative recommendations and/or no recommendations were not included on this slide

Recommendations on Behavioral Health Workforce, Infrastructure, and Coordination

- **Capacity of public behavioral health workforce of the local PBHS (2019).**
  A review of local behavioral health plans identified gaps in current capabilities and capacity of the behavioral health workforce of the local PBHS. These include:
  - hiring and retention of psychiatrists, especially in rural areas, which affect MAT services;
  - hiring and retention of nurses throughout the system;
  - lack of providers trained in co-occurring disorders, licensed social workers, counselors, SUD providers, and culturally and linguistically competent providers and interpreters; and
  - high turnover of the behavioral health workforce related to burnout and non-competitive salaries offered by the PBHS.

  Addressing transportation, culturally appropriate services, and outreach and engagement were also noted
- **Integration of CSAs and LAAs (2017)**
  - Use guiding principles to motivate greater integration
  - Increase clarity from State BHA to support Local Systems Management
  - Take an integrated approach to behavioral health policy and funding
  - Develop multi---year plan to support local behavioral health integration

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Behavioral Health Financing

Reports on Behavioral Health Financing

- 6 reports identified on behavioral health financing:
  - *JCR on Increases in Psychiatric Rehabilitation Program (PRP) Expenditures (2021)*
  - *JCR on SUD Residential Treatment Practices and 1115 Waiver*
  - *Report on Delivery and Payment Systems (2019)*
  - *JCR on Expenses and Use of Behavioral Health Services by Medicaid and ACA Eligibility (2015)*
  - *JCR on Local Treatment Grants (2013)*
  - *JCR on Specialty Physician Rate Increase (2013)*
- Among other things, reports focus on:
  - outlining increased spending in certain areas of the public behavioral health system, namely (PRP) and new residential substance use benefits under the state's Section 1115 waiver
  - a history of rate setting in the PBHS, an overview of the delivery system, including accreditation and licensure, and behavioral health integration
  - both fee for service and grants based expenditures on behavioral health

Behavioral Health Financing Recommendations

- **PRP expenditures (2021)**
  - Develop cost containment strategies
  - Develop quality management systems for PRP programs
  - Offer training and capacity building for PRP programs
- **Rate related recommendations (2019)**
  - All providers participating in the PBHS should act within the scope of practice of their license or certificate to receive reimbursement.
  - Community-based behavioral health services should be provided at the local level by providers who are licensed at the independent practice level to provide treatment, or by programs with accreditation-based licensing through BHA's Licensing Unit to do so. DUI education should continue to be licensed through BHA's Licensing Unit.
  - Rate increases for federally funded grant programs and specialized pilot programs should be contingent on increases in federal funding, and within federal requirements (funds are not used to supplant other funding).
  - A rate study should include an evaluation of the job classifications and salary of direct care and licensed clinicians working in the public sector in comparison to those working in the private market.
  - Value-based payment mechanisms should be explored to improve the quality of services

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Commission on Behavioral Health Care Treatment & Access

December 18, 2023

Agenda

- Call to Order
  - Attendance
- Approval of minutes
- Workgroup meeting updates
- Workgroup participation updates
- Commission reporting requirements
- Future scheduling
- Closing and Public Comment

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Approval of Minutes

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Geriatric Behavioral Health

- Chair: **Ben Steffen**, Executive Director of the Maryland Health Care Commission.
- Meeting held on November 30, 2023.
- Members:
  - **Megan Renfrew,** Designee for the Executive Director of the Health Services Cost Review Commission.
  - **Renard Brooks**, Designee for the Secretary of the Department of Public Safety and Correctional Services.
  - **Lawanda Williams**, Representative of a Federally Qualified Health Center.
  - **Delegate Bonnie Cullison**, Member from the Maryland House of Delegates.
  - **Linda Raines**, Representative of the Mental Health Association of Maryland.

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Discussion

Among other things, the meeting focused on:

- The need for additional healthcare facilities, and workforce needs, **especially licensed occupations**, and reimbursement for behavioral health services (public and private).
- **Incarcerated individuals** who have served long sentences, are now elderly, eligible for release, and do not have **any resources**.
- The **lack of behavioral health providers who take Medicare and/or have geriatric expertise**.
- Over the last three years, there has been an **increase in the number of people 55 and older presenting for substance use treatment**.
  - There are logistical and somatic considerations to treating an older population.
  - After residential treatment, **safe and affordable permanent housing** is needed. This is key to recovery.

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Recommendations

The Workgroup discussed the following areas and deemed further investigation and research is necessary:

- Increase **specialized workforce** needs:
  - Including increasing Geropsychiatry, cross training for physicians, and a geriatric specialty workforce.
- Opportunities for 50+ who are unemployed to fill some of the workforce gaps.
  - Specifically those who are **entering the workforce after prison sentences and substance use treatments**.
- Service needs including geriatric substance use disorder and **services for those transitioning from institutional settings**.
  - Jails & prisons, hospitals, nursing facilities, and inpatient substance use disorder facilities.
- There is a need for **affordable, supported, and permanent housing**.
- Supports and interventions that **decrease loneliness**, which has a negative impact on somatic and behavioral health.
- A focus on transitional aged adults who need help **preparing for late life**.

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Youth Behavioral Health, Individuals with Developmental Disabilities, and Individuals with Complex Behavioral Health Needs

- Chair: **Alyssa Lord**, Deputy Secretary for the Behavioral Health Administration.
- Meeting held on December 4, 2023.
- Members:
  - **Tamar Rodney,** Individual with Expertise in Social Determinants of Health.
  - **Stephen Liggett-Creel**, Designee for the Department of Human Services.
  - **Stacey Garnett,** Representative of an Inpatient Psychiatric Hospital.
  - **Mercia Cummings,** Representative of a Provider of Substance Use Treatment Services.
  - **Rachel London,** Representative of the Developmental Disability Coalition.
  - **Leslie Seid Margolis,** Representative of Disability Rights Maryland.
  - **Carol Beatty,** Secretary of the Maryland Department of Disabilities.
  - **Dr. Arlene Tyler,** Representative of a School-Based Health Center.
  - **Senator Malcolm Augustine,** Member from the Senate of Maryland.
  - **Linda Dietsch,** Representative of a Managed Care Organization.
  - **Clara Baker,** Individual with an Intellectual Disability who uses Self-Directed Behavioral Health Services.

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Discussion

- Overview of current efforts including, but not limited to, the Behavioral Health Continuum of Care and MDH's Children, Youth, and Family Strategy with **emphasis on suicide prevention, 988 crisis support, mobile crisis teams, and new 1115 waiver opportunities.**
- Youth
  - The importance of **support services for parents/guardians** of youths with complex behavioral health needs, **timely management of patients** stepping down from acute care, and **utilization** of the Center for School Safety & Judy Centers.
  - Key functions needed in a crisis is a **clear roadmap** of where to look for services.
  - **Workforce concerns** related to improving education/training, increasing pay, improving career advancement opportunities, and decreasing turnover and knowledge loss for DSPs and providers.
  - Importance of braiding and blending grants and insurance payor (especially Medicaid) funding, **to provide a sustainable funding stream** over multiple years.

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Discussion, continued

- Co-Occurring I/DD
  - A focus on **community-based services, wrap-around supports, and the importance of specialized training** for DSPs, providers, law enforcement, and other emergency services related to this population.
  - **Need for training/resources** for I/DD-BH dual diagnosis youth to expand outside of school.
  - Training and resources related to **non-pharmacological interventions.**
  - Trauma-informed care and support systems.
- Complex Behavioral Health Needs
  - The importance of a **comprehensive resource listing** for providers, guardians, youth, and others, and an **increase in community-based treatment** with a decrease facility-based treatment.
  - Improving services for complex behavioral health is a very long-term commitment, and requires **engaging as many MH providers as possible** - most efforts are directed toward psychiatrists only.
  - There has been **expanded funding for community health workers** that could include a greater focus on supporting the population being discussed. These trainings provide relatively rapid increases in the workforce.
    - The state has also increased/facilitated access to funding for these community-based health workers.

Recommendations

The Workgroup discussed the following areas and deemed further investigation and research is necessary:

Youth

- A need for more crisis centers, help to identify long-term pathways.
- Comprehensive statewide resource for stakeholders to determine the correct path for accessing appropriate services based on their needs, including school connections.
- **Expanding career development ladders**, including adequate pay.
- Colleges, universities, and pre-professional programs in Maryland need to **train students and extend opportunities** to focus on youth populations long-term.
- **Braiding and blending Medicaid and grant funding to improve the sustainability of all Medicaid expansion efforts.**
- Increase of **in-home behavioral health services** for youth with autism spectrum disorder.

Recommendations, continued

Co-occurring I/DD

- Improving the availability of **non-pharmacological interventions** and **trauma-informed care and support systems**.
- **Providers must be rewarded** when they seek training, expertise, and appropriate qualifications to interact productively with I/DD patients (e.g., higher reimbursement for dual diagnosis patients).
- Colleges and universities that are training Maryland's behavioral health workforce must develop **specialized training opportunities** for students interested in serving this population.
- Training on **de-escalation and specialized communication for emergency services** is essential to ensure safe and effective interactions with individuals in this population.

Complex Needs

- **Expanding provider capacity** and the provider workforce, and increasing Medicaid reimbursement through a tiered system related to quality of care.
- In particular, workforce discussions in all three focus areas focused on **earlier exposure for pre-professional students related to specialized populations,** tiered funding for providers in the public mental health system to **increase competitiveness and quality**, and **adequate support for non-medical staff,** including Direct Support Personnel (DSP) and Community Health Workers (CHWs).

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Criminal Justice-Involved Behavioral Health

- Chair: **Dr. Aliya Jones**, Representative of an Acute Care Hospital.
- Meeting held on December 8, 2023.
- Members:
  - **Kevin Amado Sr.,** Representative of the Maryland Chapter of The National Council on Alcoholism and Drug Dependence.
  - **Emily Keller,** Special Secretary of Opioid Response.
  - **Kathryn Spencer Farinholt,** Representative of the National Alliance on Mental Illness.
  - **Stephanie Wolf,** Representative of the Maryland Psychological Association.
  - **James Rhoden,** Designee for the Executive Director of the Governor's Office of Crime Prevention, Youth, and Victim Services.
  - **Jonathan Davis,** Representative of a Provider of Residential Behavioral Health Services.
  - **Alexa Herzog,** Designee for the Department of Juvenile Services.
  - **Benjamin Charlton,** Representative from the Office of the Public Defender.

Maryland
DEPARTMENT OF HEALTH

Discussion

- The data surrounding existing State Court-Ordered Psychiatric Infrastructure was consistent over time as it demonstrated a need for the Maryland Department of Health (MDH) to **increase staffing and bed capacity for the adult psychiatric hospitals** to align with the increase in commitment and evaluation orders from the Maryland Judiciary.
  - To guide recommendations, current data would be required including **an analysis of patient days by sector and average wait time**.
- **State employee retention** in the MDH adult psychiatric hospitals was also explored.
- The MDH Facilities Master Plan was discussed along with the **need for capacity planning for Spring Grove Hospital Center** due to the recent land transfer to the University of Maryland Baltimore County.
- Review of behavioral health crisis services, the Workgroup identified the **need for standardized high quality measures for crisis stabilization.**
- The need to **review the current landscape of recovery housing and the need to develop additional housing.**
  - Explore whether there is adequate housing available to meet the needs of this community and to devise a measure to gauge the outcomes for those who use the Maryland Recovery Net Program.

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DEPARTMENT OF HEALTH

Recommendations

The Workgroup discussed the following areas and deemed further investigation and research is necessary:

- Current data is required including **an analysis of patient days by sector and average wait time.**
- Additional data points of interest include: **Average length of stay, quality of care, location of providers, level of transitional care, success rates, and any standardization across providers**.
- Need to review the current landscape of **recovery housing and the need to develop additional housing**.
  - Specifically, the Workgroup would like to explore whether there is **adequate housing** available to meet the needs of this community and to **devise a measure to gauge the outcomes for those who use the Maryland Recovery Net Program**.
- Evaluating **the needs of employees caring for individuals in adult psychiatric hospitals** and updated data regarding the State's Apprenticeship Program.

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DEPARTMENT OF HEALTH

Behavioral Health Workforce Development, Infrastructure, Coordination, and Financing

- Chair: **Commissioner Kathleen Birrane**, Maryland Insurance Commissioner.
- Meeting held on December 5, 2023.
- Members:
  - **Debra Bennett**, Family Member of an Individual with Experience as a Consumer of Behavioral Health Services.
  - **Dr. Paula Anne Smith-Benson**, Individual with Experience as a Consumer of Behavioral Health Services.
  - **Matthew Eisenberg**, Individual with Expertise in Health Economics.
  - **Shannon Hall**, Representative of the Community Behavioral Health Association of Maryland.
  - **Mark Luckner**, Executive Director of the Maryland Community Health Resources Commission.
  - **Oleg Tarkovsky**, Representative of a Health Insurance Carrier.
  - **Sheena Patel**, Designee for the Executive Director of the State Designated Health Information Exchange.
  - **Kathryn Dilley**, Representative of a Local Behavioral Health Authority.

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DEPARTMENT OF HEALTH

Discussion

- **Workforce is being defined broadly**, all occupations considered, para professionals, and peers.
- Review trends and best practices from other states regarding **policy and reimbursement strategies that support access to a comprehensive array of services and ensure quality of care.**
- Identified **Community Care Behavioral Health and Federally Qualified Health Centers**.
- Reimbursement structures:
  - **Third-party and state reimbursement structures.**
  - New York - CHAMP program, focus on insurance-reimbursed care.
- **Essential health plans** and what they provide/ cover.
- The impact of external events on our ability to deliver services:
  - Particularly behavioral health services.
- Integration of **telehealth** and its usefulness.
- **Crisis stabilization** resources.
- Defined **complex behavioral health needs and specialty behavioral health needs.**

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DEPARTMENT OF HEALTH

Recommendations

The Workgroup discussed the following areas and deemed further investigation and research is necessary:

- Workforce surveys in order to evaluate **the needs of the State's behavioral health care workforce**.
- **Reimbursement strategies and practices** used in other states that support access to comprehensive services and ensure quality of care.
- **Action plans for the system's** ability to prepare and respond to future challenges that impact the state as a whole or specific geographic areas and populations.
- Diverting behavioral health patients from emergency departments through the **Maryland Mental Health and Substance Use Disorder Registry and Referral System, and 2-1-1**.
- **Harm reduction strategies**; the exploration of harm reduction strategies to facilitate access to care.
- Methods which can be used to **support consumers in evaluating behavioral health services**.

Update on Workgroup Participation & Commission Reporting Requiremen

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DEPARTMENT OF HEALTH

Public Workgroup Participation

- The Commission's webpage has been updated to include an application where non-commission members can apply to serve on a Workgroup.
  - Please check the right hand side directly under where the meeting link is listed
- When evaluating applications, the Commission is looking for perspectives that are not already represented in each Workgroup to allow diversification.
- Applications will close on **December 29th, 2023 at 5 pm.**
- The Commission has also created a listserv for non-commission members who wish to be provided with updates.
  - Please email mdh.behavioralhealthcommission@maryland.gov to be added

Maryland DEPARTMENT OF HEALTH

Mandated Report

- The Commission is statutorily required to submit a report to the Maryland General Assembly and the Governor.
- The Report will contain:
  - A summary of materials presented at the Commission's first meeting (needs assessment and review of prior reports);
  - Details about commission meetings held in November and December of 2023;
  - Establishment of the Workgroups;
  - Workgroup progress (detailed from the Workgroup reports); and
  - The goals and objectives for the Commission moving forward.
- A draft report will be circulated to Commission members this week. Commissioner feedback on the draft is requested by COB on January 5th.

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DEPARTMENT OF HEALTH

Future Scheduling

- The Commission is required to meet at least three times per year.
- The Next Full Meeting will take place after Session with two additional meetings to follow by the end of 2024.
  - Discussion to include items or topics that are germane to all Workgroups.
- Workgroups are required to meet at least two times per year, but may meet quarterly.

Closing and Public Comment

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