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

Zoom: https://us06web.zoom.us/j/82203802613?pwd=ZVlucDZoVGhnOU1rR3RhYkpxdXVJQT09
Meeting ID: 822 0380 2613 **Passcode:** 298996 **Dial in #:** (301) 715-8592

September 19, 2023
10:30 am – 12:30 pm

AGENDA

1. Call to Order	Chair Rudolph
2. Approval of July 28 meeting minutes	Chair Rudolph
3. Presentation on the Future of Behavioral Health Services in Maryland	Secretary Laura Herrera Scott
4. Update since last Consortium meeting	Mark Luckner and Tammy Fraley
5. Framework Subcommittee recommendations for Hubs-only RFP	Sadiya Muqueeth
6. Discussion of Hubs-only RFP	Consortium members
7. Discussion of service provider applicant questions	Mark Luckner
8. Review Committee and other next steps	Chair Rudolph, Mark Luckner
9. Adjournment	Chair Rudolph

Meeting of the
Maryland Consortium on Coordinated Community Supports

Wednesday, July 28, 2023
In-Person and Virtual Meeting
45 Calvert Street, Annapolis MD 21401

10:00 AM – 11:00 AM

CONSORTIUM MEMBERS IN ATTENDANCE

1. David D. Rudolph, Chair, Maryland Consortium on Coordinated Community Supports
2. Erin McMullen, Maryland Department of Health | Chief of Staff
3. Emily Bauer, Maryland Department of Human Services | Two-Generation Program Officer
4. Edward Kasemeyer, Maryland Community Health Resources Commission | Chair
5. Mary Gable, Director of Community Schools | Assistant Superintendent, Division of Student Support, Academic Enrichment, & Educational Policy, Maryland State Department of Education
6. Dr. Derek Simmons, Public School Superintendents Association of Maryland | Superintendent, Caroline County Public Schools
7. Dr. Donna Christy, Maryland State Education Association | School Psychologist, Prince George's County Public Schools
8. Gail Martin, Former Baltimore County Public Schools Team Leader, School of Social Work
9. Sadiya Muqueeth, DrPH, Baltimore City Health Department | Member, Maryland Community Health Resources Commission
10. Larry Epp, Ed.D, representative of the community behavioral health community with telehealth expertise | Director of Outcomes and Innovation, Families and Communities Service Line, Sheppard Pratt Health System
11. Gloria Brown Burnett, local Department of Social Services | Director, Prince George's County Department of Social Services
12. Michael A. Trader II, representative of local departments of health | Director of Planning, Quality, and Core Services, Worcester County Health Department
13. The Honorable Katie Fry Hester, Maryland Senate
14. The Honorable Eric Ebersole, Maryland House of Delegates

Also in attendance were: Sharon Hoover and Nancy Lever co-Directors, National Center for School Mental Health, University of Maryland School of Medicine; CHRC Executive Director Mark Luckner; other staff; and members of the public. Consortium members Tammy Fraley and Christina Bartz attempted to join the meeting virtually, but were unable due to technical issues related to Zoom.

WELCOME

Chair Rudolph welcomed the group.

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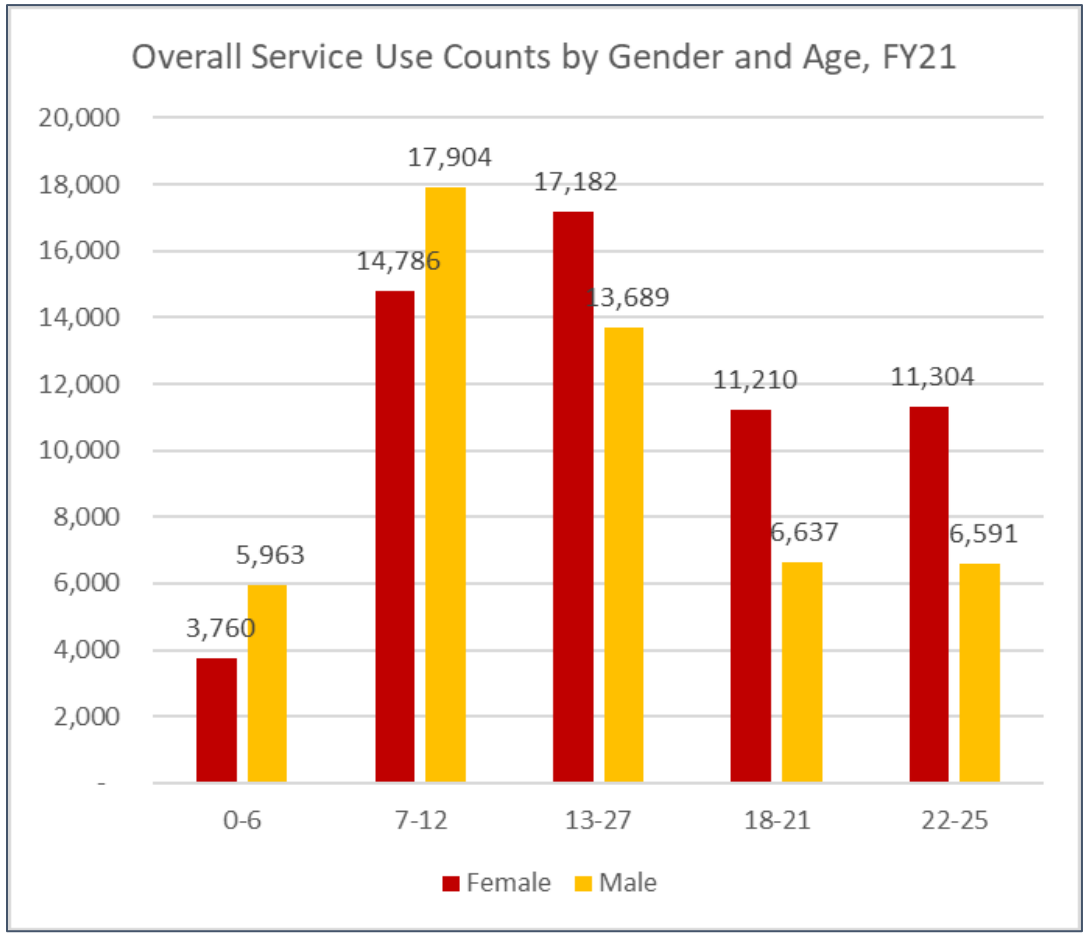
Children's Behavioral Health Strategy

Consortium on Coordinated Community Supports
September 19, 2023

Overview

- Children's behavioral health utilization
- Continuum of Care
- Call to Action

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 (58.3%) of child and young adult service users were between the ages of 7 to 17 years, while 41.7% 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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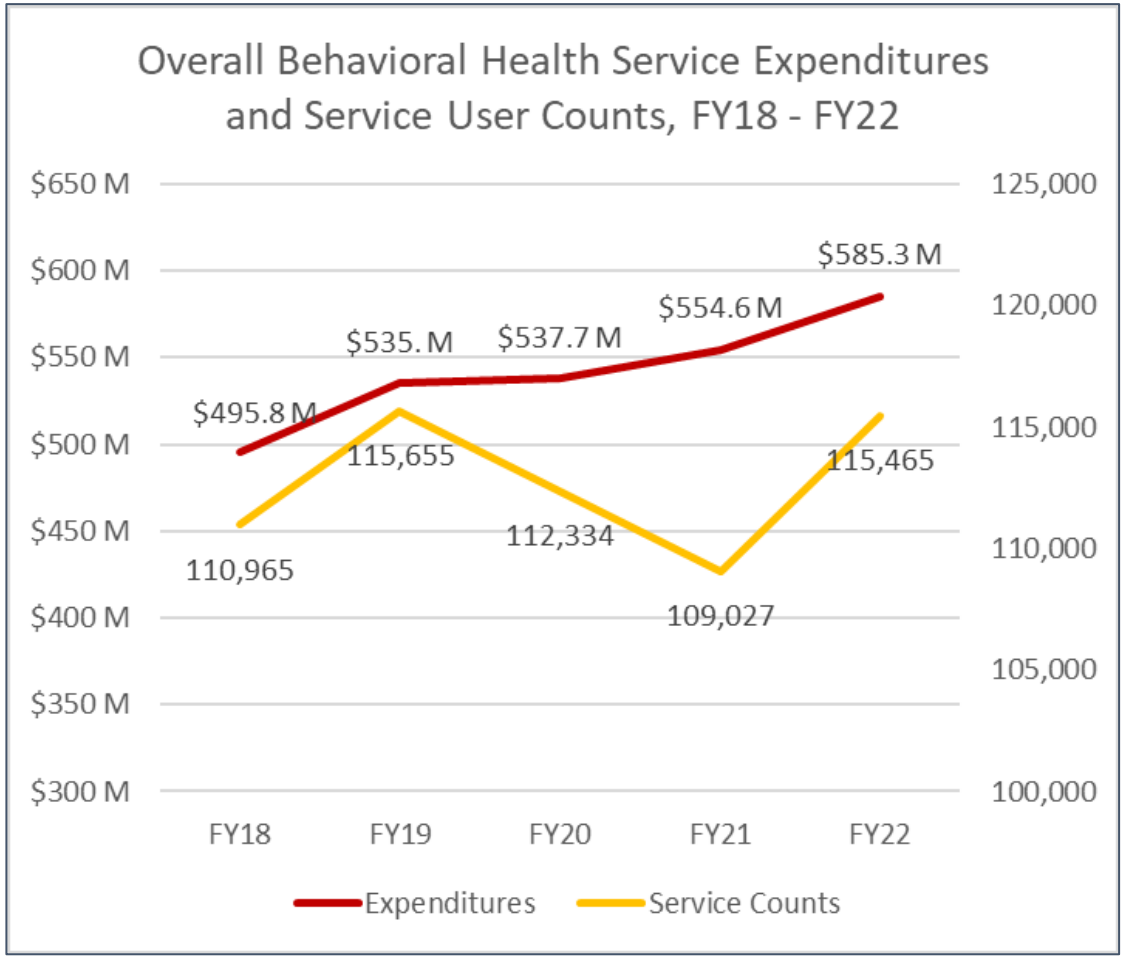
Youth and Young Adult Public Behavioral Health Service Use and Expenditures



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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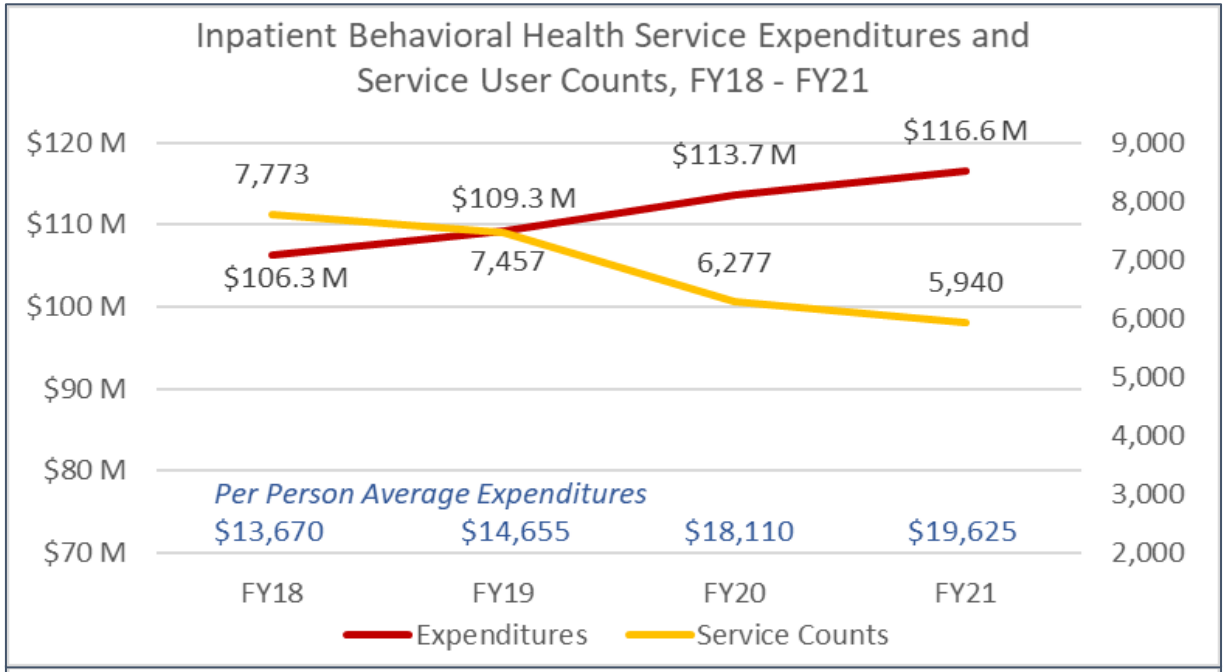
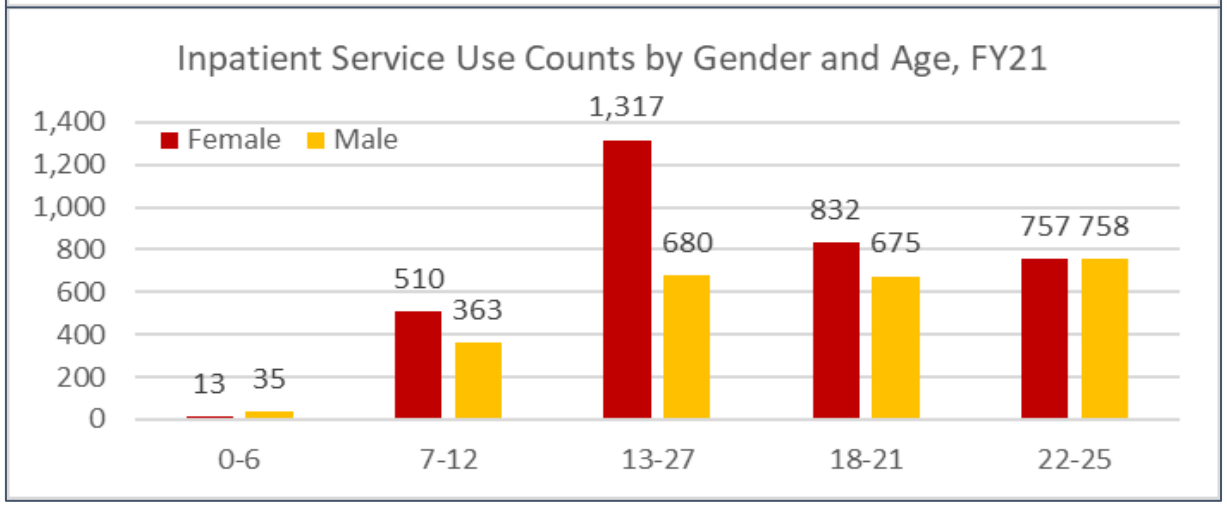
Hospital Inpatient Use and Expenditures





- In FY21, 5,940 (5.4%) children and young adults 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

- 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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Continuum of Care

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Behavior is the language of trauma. Children will show you before they tell you that they are in distress. – Micere Keels

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Behavioral Health Continuum of Care for Children and Adolescents

Draft - 9.5.23

Prevention/Promotion				Primary Behavioral Health			Urgent/Acute Care		Treatment / Recovery	
Promotion	Universal Prevention	Selective Prevention	Indicated Prevention	Outpatient Care	Intermediate Community Care	Intensive Community Based Care	Urgent/ Crisis Care	Acute Treatment	Sub-Acute Intervention	Recovery Supports
• General Outreach • Pop Specific Outreach • Comms Campaigns	• ACE Awareness • Social and Emotional Learning modules • School-Based Services (Tier 1)	• Good behavior game • SBIRT • Harm Reduction • Early childhood MH consultations w/ brief treatment	• SBIRT • Home Visiting • Mental Health First Aid • TAY • Early childhood MH consultations w/ brief treatment • DHS Prevention	• Community-Based Services • Case Mgmt • MH Client Support Services • Drug Court • Outpatient Detox • MAT • Brief intervention - PCP • School-based care	• Youth PRP • Youth TBS • DDA Youth Community Supports Services	• Partial Hospitalization • Intensive outpatient (IOP) • Intensive in home supports (EBPs) under 1915i	• 988 Hotline • Urgent Care Services • Crisis Stabilization Centers • Mobile Crisis Teams • Res Crisis • STOP • Resipte	• ED • Inpatient • Inpatient Detox (ASAM 4.0, 3.7-D)	• ASAM 3.5/3.7 • Intensive in-home supports (EBPs) under 1915i • MAT	• State Care Coor. • MDRN • START • Family Peers • Adolescent Clubhouse • Recovery schools
			• SATS (TCA) • Targeted Case Management			• ACT • MHSS / MRSS • Safe Stations		• Targeted Case Management • Res. Treatment		
			• BHIPP • EPSDT • EMR embedded screening • FEP							

Promotion and Universal Prevention

Vision: Encourage and increase protective factors and healthy behaviors to promote healthy mental, emotional, and behavioral development. Prevent and address trauma, and build resilience.

Current Activities:

- Public awareness campaigns, including 9-8-8 campaign targeted at youth, Good Samaritan Law back to school campaign, and fentanyl awareness campaign
- ACE training, including ACE screening tools and cross agency workgroup

Opportunities:

- Identify additional early intervention opportunities
- Create referral pathways for follow up of ACE screening
- Further collaboration with the Opioid Operational Command Center for public awareness campaigns
- Partnership with the Consortium on expansion of Tier 1 (universal prevention) services

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Selective & Indicated Prevention

Vision: Children and youth exhibiting early signs of substance use and mental health conditions will be identified and appropriate referrals to treatment will be made. Risk factors associated with behavioral health conditions will be addressed to promote resilience and recovery.

Current Activities:

- Training for screening tools, including Screening, Brief Intervention, and Referral to Treatment (SBIRT)
- Local Harm Reduction education strategies
- Services targeting Transitioning Age Youth (TAY)
- Youth Mental Health First Aid
- Home visiting services, including Medicaid pilot

Opportunities:

- Examine opportunities to expand SBIRT services for children and youth
- Identify additional harm reduction resources for at-risk youth, including overdose prevention training
- Promote USPSTF recommended screenings for depression, anxiety, and other behavioral health conditions

Primary Behavioral Health

Vision: From infancy to young adulthood, behavioral health conditions will be assessed, identified early, and managed in primary care settings. Referral to specialty treatment will occur for those identified as needing more extensive treatment.

Current Activities:

- Maryland Behavioral Health Integration in Pediatric Primary Care
- First Episode Psychosis (FEP) intervention pilots
- Collaborative Care pilot moving statewide

Opportunities:

- Alignment across MDPCP and Medicaid and continued partnership with MCOs to increase investments in behavioral health supports and outcomes
- Explore additional models to support primary care practices, including telehealth and co-location of services
- Evaluate programming related to antipsychotic prescribing in children and adolescents, including foster care youth

Primary Behavioral Health: School Services

Vision: In partnership with the Consortium on Coordinated Community Supports, implement a multi-tiered system of behavioral health supports in all public schools.

Current Activities:

- Preschool mental health consultation services in partnership with University of Maryland, Baltimore
- Partnerships with preschool programming (e.g., Lourie Center, and PACT)
- Partnership with UMB on Center for School Mental Health
- MDH School Based Health Center (SBHC) development of enhanced service standards

Opportunities:

- Maximize Medicaid funding to support school based behavioral health services, including payment for non-IEP related services.

Intermediate and Intensive Community Care

Vision: Specialty behavioral health care will be accessible to children and youth. Intensive community based care will promote psychological health, healing, and resiliency.

Current Activities:

- Youth psychiatric rehabilitation programs
- Youth Therapeutic Behavioral Services
- Partial hospitalization and intensive outpatient (IOP)
- Intensive in home supports covered via Medicaid but underutilized

Opportunities:

- Evaluate criteria for intensive in home supports and restructure benefits to reduce barriers to treatment
- Seek planning fund opportunities for certified community behavioral health clicnis; evaluate other federal demonstration opportunities.

Urgent and Acute Care

Vision: Provide timely access to behavioral health crisis services to support youth and their families in their homes, schools, and communities. Inpatient behavioral health care will be readily accessible for those with acute needs.

Current Activities:

- Grant funding supporting Mobile Response and Stabilization Services (MRSS) via Mobile Crisis Teams
- Mental Health Stabilization Services to youth involved with the Department of Social Services
- Scheduled respite services available to a limited number of families
- Expanding Residential treatment centers (RTC) state capacity to serve complex and hard to place youth

Urgent and Acute Care, cont.

Opportunities:

- Explore additional partnerships with private hospitals to improve access to care for children and youth
- Procure a bed registry & care traffic control platform to triage behavioral health crisis calls and track real-time bed availability
- Explore Medicaid reimbursement for MRSS services and other services to support ED diversion
- Identify providers to increase access to residential substance youth treatment
- Explore feasibility of reimbursement for therapeutic, on-demand crisis respite services
- Examine RTC rates and services
- Exploring possible service expansion for children and adolescents on the Upper Shore

Treatment and Recovery

Vision: Person-centered behavioral health services will be available at the right time, at the appropriate level of care, in the least restrictive setting.

Current Activities:

- Adolescent Clubhouses
- Recovery Schools
- Targeted Case Management

Opportunities:

- Identify opportunities to improve step down capacity for children and youth leaving inpatient and residential settings
- Explore expansion of family peer support services
- Examine targeted case management services to ensure individuals and families are informed, and able to access services across the continuum

Call to Action

- Addressing childhood poverty
  - Poverty is both a cause and a consequence of unmet behavioral health needs
- Continued interagency coordination is necessary to ensure a continuum of care is available for all children and youth.
  - This includes MDH, the Community Health Resources Commission and the Consortium of Coordinated Community Supports, DHS, DJS, and MSDE
- Partnering with community and faith based organizations to strengthen access to care
- Leverage and improve upon existing behavioral health infrastructure to ensure we are maximizing funding
- Ensure that we are building trauma informed systems of care

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Maryland Consortium on Coordinated Community Supports

September 19, 2023

Update on RFP #1 Services Only

- CHRC issued first Coordinated Community Supports RFP (services only) – August 18
- FAQ call with over 400 participants – August 29
- Written response to FAQs posted on website
- CHRC staff responding to questions from potential applicants – ongoing
- Applications will be due **October 11 at NOON**
- Awards will be made in December 2023
- Grant period will be December 2023 – June 2025

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Outreach update

- Significant outreach with stakeholders throughout the State - more than 100 meetings and presentations to date
- 20 of 24 Jurisdictions have held meetings with Consortium staff to discuss RFP and local priorities
  - meetings involved LEA, LHD, LHBA, LMB, service providers, etc.
- Upcoming meetings:
  - Baltimore City, September 21 (Hybrid)
- September 7 - Meeting with local Directors of Student Services to discuss strategies for letters of support (MSDE)
- Follow-up meetings with other groups

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Maryland Consortium on Coordinated Community Supports Framework, Design & RFP Subcommittee Update

Superintendent Mohammed Choudhury and Dr. Sadiya Muqueeth
Co-Chairs

September 19, 2023

Objectives

1. Overview of meetings
2. Consensus recommendations
3. Topics for discussion by full Consortium

Meeting Status

- On **July 28**, the full Consortium adopted MDH recommendation to remove Hubs from first RFP in order to ensure any future Hubs are built on, and do not duplicate, existing structures for behavioral health care coordination.
- The Framework Subcommittee met on **August 17** to hear presentations from Local Behavioral Health Authorities and Local Management Boards.
- The Framework Subcommittee met on **August 31** to develop consensus on consider key aspects of the Hub RFP.

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Consensus Recommendations

1. Pilot 5-8 Hubs to test the model before it is implemented statewide
2. Pilots will be selected through a competitive RFP
3. Consider regional diversity, different types of entities
4. Issue first RFP in September/October 2023, applications due in December 2023, awards in January/February 2024

Consensus Recommendations, ctd.

5. Hub pilot will be limited to LBHAs and LMBs only
6. Regional Hubs could apply
   - ➢ Existing regional entities (e.x., Mid Shore Behavioral Health) or
   - ➢ Coalitions of existing entities (e.x., a partnership involving two or more LMBs or LBHAs)
7. Grant period of approximately 18 months (January 2024-June 2025) to align with service provider RFP
8. Future RFP issued in February 2025 for Community Supports Partnerships, i.e., Hubs with Spokes

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Recommended selection criteria and application requirements (slide 1 of 2)

Criteria	Application requirements
1. Experience coordinating broad array of behavioral health services in schools	• Describe experience coordinating • Describe commitment to evidence-based approaches and innovation • Submit current MOU with school (if any) • Submit a list and brief description of programs currently supported, including any Tier 1 interventions • Submit existing community needs assessment prepared by the organization
2. Experience as a fiduciary	• Describe experience • Submit overall organizational budget including all sources of funding • Provide a list of all current grants received and grants issued • Describe procurement timeline – how quickly can they move funds?

Recommended selection criteria and application requirements (slide 1 of 2)

Criteria	Application requirements
3. Experience with data	• Describe current data system • Provide examples of measures currently collected and reported
4. Collaboration and community consensus	• Describe clear roles in the proposed Hub for the LBHA, LMB, and LEA, including current and proposed contractual relationships • **Required**: Provide letter of support from LEA • Optional: Provide letter of support from the other entity (LMB or LBHA)

What is being tested in Hub pilot?

The pilot will test key features in the deign of Community Support Partnership before the model is rolled out statewide.

A. Roles for LBHA, LMB, schools, others within each Partnership?

B. Legal issues, including data-sharing and MOU development?

C. Referral processes – what should be the role of the Hub?

D. What staffing is required?

E. Are certain types of organizations better suited to be Hubs than others? (e.g., non-profit versus government, etc.)

F. Ability of Hubs to support best practices and monitor implementation

G. Ability of Hubs to support success for spokes

H. Does the presence of a Hub improve service delivery outcomes for students?

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Activities/deliverables during pilot grant period

Activities:

A. Hire staff
B. Develop referral processes
C. Develop governance structure
D. Engage and coordinate with the community, school system, and providers
E. Develop MOUs
F. Plan for data sharing and reporting
G. Collective Impact model training
H. Participate in statewide community of practice led by National Center
I. Support accountability, best practices, and outcomes of service providers

Deliverables:

A. Asset Map
B. Needs Assessment
C. Community Supports Partnership contracts and proposal

CHRC/National Center will sponsor a Technical Assistance program to support these activities and deliverables

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Permissible uses of grant funds

1. Staff salaries – Recommend 2-3 dedicated FTE for pilot
2. IT systems for on-going monitoring and evaluation
3. Contractual
4. Expenses related to convening meetings
5. Indirect – 10%

Hub applicant budget requests

Budget for the Hub Pilot RFP. Options:

A. Provide a number, range, or a sample budget – up to $500,00 per year per Hub ($750,000 over 18 months)?

B. No guidance – like service provider grants (reservations by Chair and staff)

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Revisit for a future Hub RFP

1. Allow additional types of entities to apply, and/or allow new entities to be formed?
2. Timing – when should the second Hub RFP be issued, at the end of the 18-month pilot, or sooner?
3. Overall budget for future Community Supports Partnerships – long term, develop a formula based on a percentage of the total funding available in the RFP, service population, and other factors?

Potential Timeline for Consortium RFPs

	2023		2024				2025				2026	
	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2
Services RFP #1 – proposals due October 11												
Hub RFP #1 - pilot 5-8 Hubs												
Services RFP #2 -- additional service grants, if needed												
Hub RFP #2 -- Hubs for the rest of the state												
CSPs RFP (Hubs + Spokes, statewide)												

	RFP issued, applicants develop proposals
	Grant period

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Questions from applicants

- On August 29, CHRC held a FAQ call with over 400 participants, lasting 2.5 hours.
- CHRC staff posted a written FAQ document summarizing the questions and answers from the call, as well as other questions we have received. 17 pages long, more than 130 questions. We will continue to update this document.
- CHRC staff continues to receive questions from potential applicants. **Four** of these questions are discussed in the next slides, for the consideration of the full Consortium.

RFP Applicant Questions for Consideration by the full Consortium

1. Can grant funds be used for assistance with hiring?

CHRC staff recommends against using funds for hiring incentives, because competition for staff could disrupt the strained behavioral health workforce. However, grants funds could be used for advertisements for hiring, workforce pipeline initiatives, etc.

RFP Applicant Questions for Consideration by the full Consortium

2. Can a for-profit provider apply for grant funds at their usual rate, i.e. including "profit?"

CHRC staff recommends that proposals reflect actual costs and not include "profit." To the extent that services have a Medicaid rate, that rate should be used. Requested grant funds should not be excessive, should be appropriate, and should be in line with other reimbursement rates, i.e. Medicaid.

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RFP Applicant Questions for Consideration by the full Consortium

3. Can funds be used to supplement or add to existing Medicaid or commercial reimbursement rates?

CHRC staff recommends against using funds for this purpose. Adding to existing rates seems to run afoul of legislative intent that funds not supplant or duplicate existing funding. However, funds can be used for co-pays and for activities that are not reimbursable.

RFP Applicant Questions for Consideration by the full Consortium

4. Should the CHRC fund services in this RFP that will not have a formal MOU in place?

For example, if an LEA provides a letter of support for the proposal, but indicates an MOU with the applicant/service provider is not necessary and will not be forthcoming, should the program be funded? CHRC staff has reservations about funding services that will not have a formal MOU or traditional written approval.

Review of Incoming Applications – RFP #1 Services Only

October 11 – proposals due

October 16 - November 6 – review period (three weeks)

November 7 – submit reviews to CHRC staff

Mid-November – potential review committee meeting

Early December – grant award decisions made

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Review of Incoming Applications – RFP #1 Services Only

- Every proposal will receive three levels of review: National Center, CHRC staff, Consortium/CHRC.
- Consortium members are invited to volunteer to review approximately 10-12 proposals, depending on the number of proposals received, over a three-week period.
- Reviewers may be asked to attend a review committee meeting in mid-November.

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