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Maryland Consortium on Coordinated Community Supports

Presentation to
Maryland Association of Behavioral Health Authorities

Mark Luckner, Executive Director

Maryland Community Health Resources Commission

March 23, 2023

Objectives for today's presentation

- Statutory objectives of the Consortium
- Overview of Collective Impact model to establish Community Support Partnerships
- Overview of first RFP to be issued spring/summer 2023
- Discussion about potential role of Local Behavioral Health Authorities

Community Health Resources Commission

Created by the Maryland General Assembly in 2005.

Current statutory responsibilities:

1. Expand access to health care in underserved communities;
2. Support projects that serve low-income Marylanders, regardless of insurance status;
3. Build capacity of safety-net providers;
4. Council on Advancement of School-Based Health Centers;
5. Implement the Maryland Health Equity Resource Act; and
6. **Maryland Consortium on Coordinated Community Supports**.

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Maryland Consortium on Coordinated Community Supports

- Added as an amendment to HB 1300 of 2020, Blueprint for Maryland's Future
  - Legislators wanted to do more to address student behavioral health
  - "Housed" at CHRC
- A new state agency to expand access to student behavioral health services and related "wraparound" needs
- Former Del. David D. Rudolph appointed chair in July 2022
- National Center for School Mental Health provides technical assistance

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Consortium Membership – 24 total

David D. Rudolph, Chair

Maria Rodowski-Stanco, Dir, Child, Adolescent and Young Adult Services, Behavioral Health Administration, MDH

Emily Bauer, Two-Generation Pgm Ofcr, Dept of Human Services

Mohammed Choudhury, Superintendent, MD State Dept of Education

Edward Kasemeyer, Chair, CHRC

Cory Fink, Dep Sec for Community Ops, Dept of Juvenile Services

Mary Gable, Asst Superintendent, Div of Student Support, Academic Enrichment, & Educational Policy, MD State Dept of Education

Christina Bartz, Dir of Community Based Programs, Choptank Community Health Sys

Dr. Derek Simmons, Superintendent, Caroline County Public Schools

Tammy Fraley, Allegany Co. Board of Education

Dr. Donna Christy, School Psychologist, Prince George's Co. Public Schools (MSEA rep)

Gail Martin, former Baltimore Co. Public Schools Team Leader, School Social Work

D'Andrea Jacobs, School Psychologist, Baltimore Co. Public Schools

Dr. John Campo, MD, Dir of Mental Health, Johns Hopkins Children's Center, JHU Hospital

Sadiya Muqueeth, DrPH, Dir of Community Health, National Programs, Trust for Public Lands, and member, CHRC

Linda Rittelmann, Senior Manager, Medicaid Behavioral Health ASO, Maryland Dept of Health

Larry Epp, Ed.D., Dir of Outcomes and Innovation, Families and Communities Service Line, Sheppard Pratt

Gloria Brown Burnett, Dir, Prince George's Co. Dept of Soc Svcs

Michael A. Trader, II, Asst Dir of Behavioral Health, Worcester Cty Health Dept

Dr. Kandice Taylor, School Safety Manager, Baltimore Co. Public Schools

Senator Katie Fry Hester

Delegate Eric Ebersole

The Consortium currently has two vacancies.

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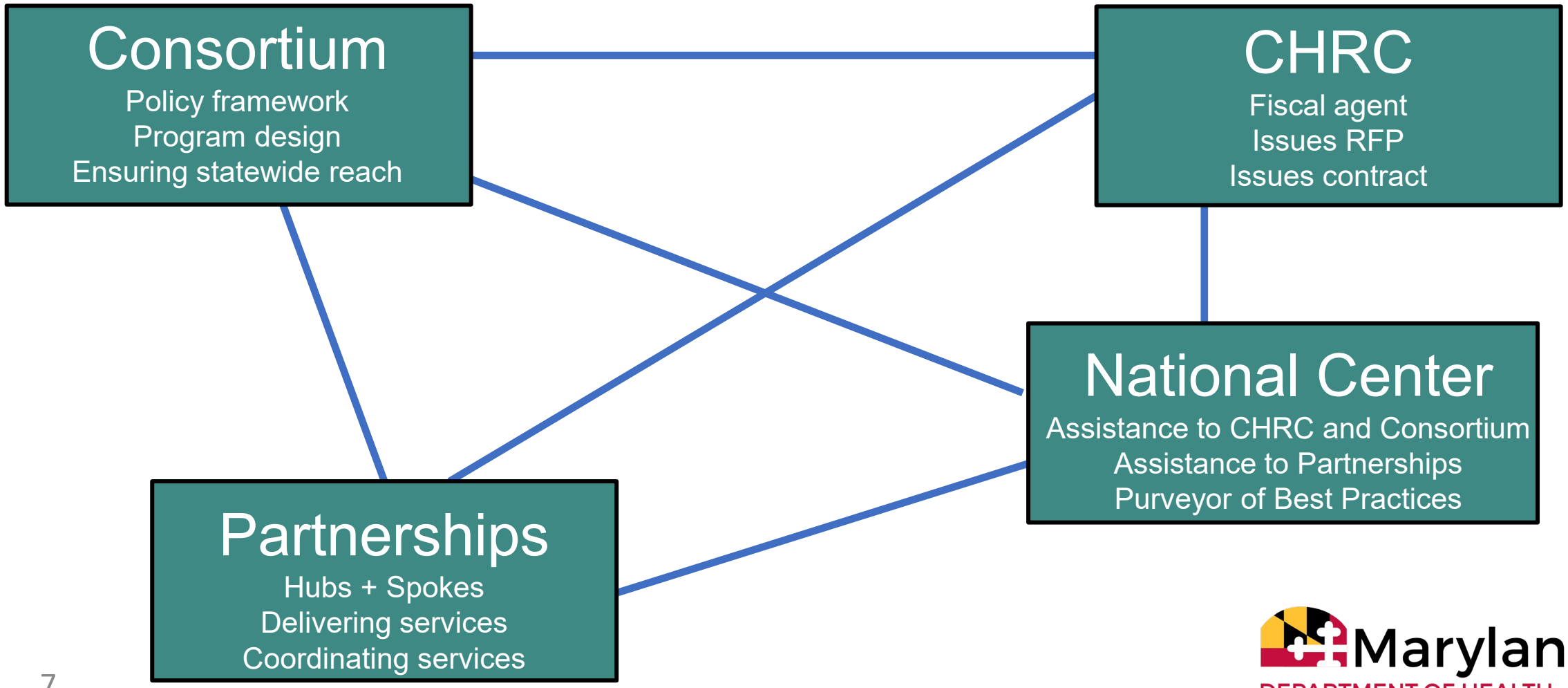
Consortium Subcommittees

1. **Framework, Design, & RFP** – Superintendent Mohammed Choudhury and Dr. Sadiya Muqueeth
2. **Data Collection/Analysis & Program Evaluation** – Dr. Larry Epp
3. **Outreach and Community Engagement** – Tammy Fraley
4. **Best Practices** – Dr. John Campo and Dr. Derek Simmons

Organizational Chart



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Legislative requirements for Partnerships

- Blueprint bill (Md. Code, Educ. § 7-447.1) requires the Consortium to "develop a statewide framework for the creation of Coordinated Community Supports Partnerships" to "meet student behavioral health and other needs."
- Legislation requires Partnerships to be "community-based, family driven, and youth-guided," serve an "area," and provide "holistic and coordinated services and supports" including both "behavioral health and other wraparound needs."
- Partnerships should be "formed," should involve many different kinds of organizations and people, and may include "partnership coordinators."
- Partnership grants may include "reasonable administrative costs."

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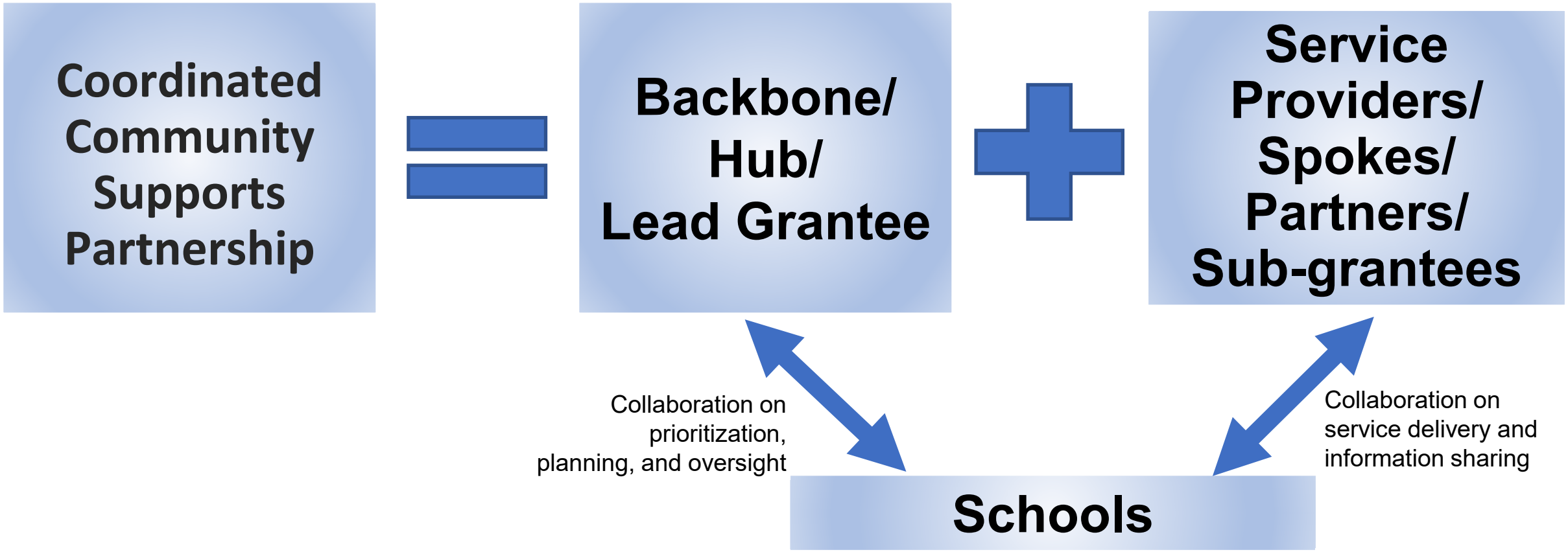
Operationalizing the Collective Impact model



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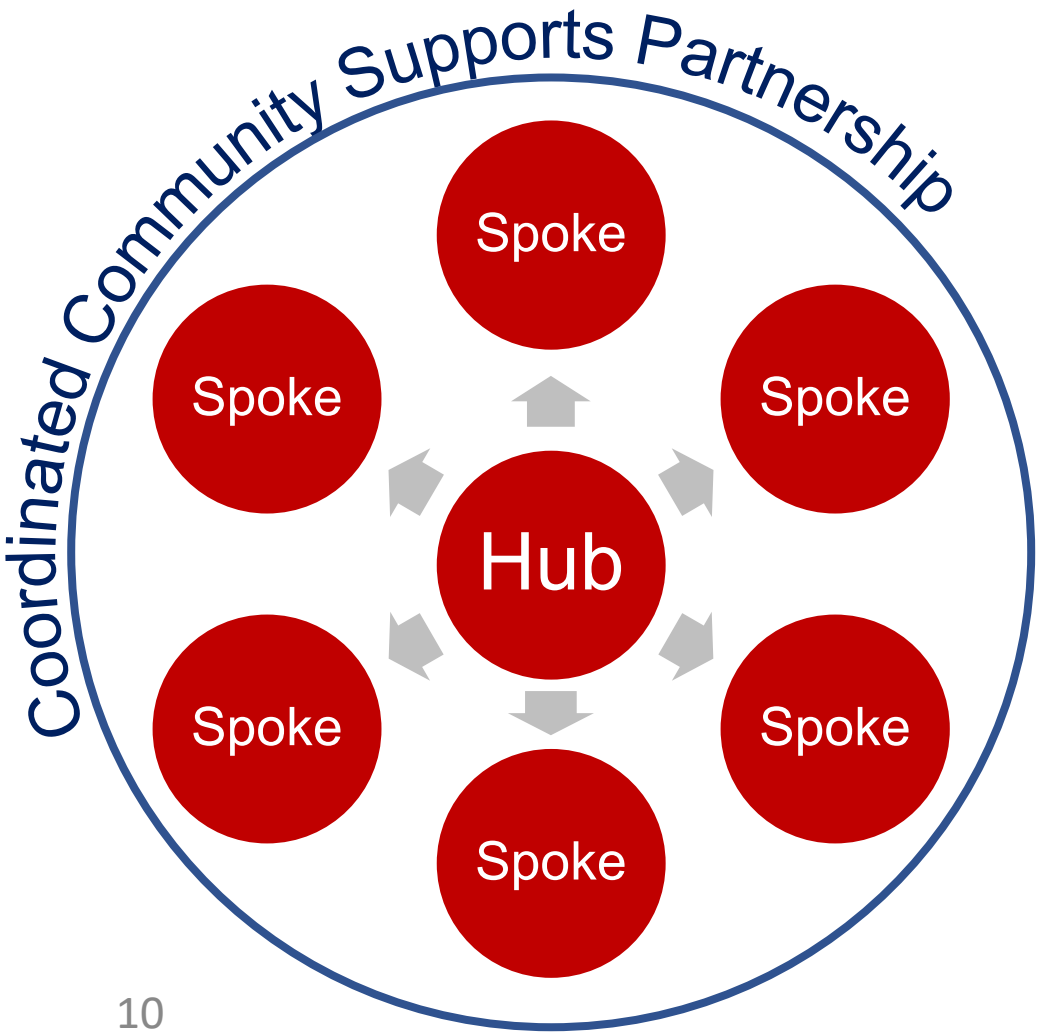
Partnerships and the Collective Impact Model



- "Hub" = "backbone" of Collective Impact model = "lead grantee."
- "Spokes" = "partners" of Collective Impact model = service providers = "sub-grantees."
- "Coordinated Community Supports Partnership" is all of these together.
- Close coordination and MOU with the schools.
- Hubs coordinate the activities of spokes, manage financial and data responsibilities.
- Geographic – more or less at school district level

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Landscape in 2023

- Students need services now. Funds must expand access to services immediately.
- Need to build capacity for future Partnerships – Hubs + Spokes.
- Engage key stakeholders and receive feedback on the model.

For first RFP (issued spring/summer 2023), grants will be provided to BOTH Hubs and Spokes directly.

- *Future* grants will go to Hubs only, who will distribute funding to Spokes as subgrantees.

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First RFP (spring/summer2023)

Two tracks:

- Service Delivery (Spokes) – *majority of funding*
- Capacity Building (Hubs)

Utilizes funding from both FY 2023 ($50 million) and FY 2024 ($85 million)

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Who can be a Hub?

Hubs may be existing organizations such as **Local Behavioral Health Authorities**, Local Management Boards, universities – or new entities. Several different kinds of organizations could be Hubs, so long as they ultimately can do the following:

Service Delivery	• coordinate many partners • all MTSS tiers • ensure fidelity to best practices
Fiduciary	• receipt of grant dollars • accountability for grant funds • maximize third party billing including Medicaid if possible • leverage funds from other sources • distribute funds to Spokes
Data	• collect data from Spokes • report data to Consortium and CHRC

Where do Hubs go?

- Each Partnership has a Hub. Each Hub serves one Partnership.
- Hubs may not overlap.
- At full implementation, every school is covered by a Partnership.
  - The jurisdiction level is the most natural “fit” for a Partnership.
  - Larger jurisdictions could potentially have more than one Partnership.
  - Smaller jurisdictions could have a regional Partnership with a single Hub.
- Hub applicants must have a letter of support demonstrating collaboration with the LEA.

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Potential Hub staffing model

A Hub could have 2-3 dedicated staff. Could also budget for supplies and office space.

Example 1 - $395,000/yr

1. Executive Director
2. Program Manager
3. Operations/Data/Fiscal Specialist

Example 2 - $200,000/yr

1. Executive Director/Program Manager
2. Operations/Data/Fiscal Specialist

For 20-30 Hubs at full implementation, salaries and expenses could range from $4 million to $12 million total per year.

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First RFP:
Hub capacity building grant requirements

TA Program Activities

1. Governance
2. Community engagement
3. Partner relations
4. Vision and mission statement
5. Planning and organizing services and providers
6. Communications
7. Financial planning/budgeting
8. Data collection, analysis, utilization

Key Deliverables

1. MOU with the LEA
2. Asset Map
3. Needs Assessment (including use of SHAPE system)
4. Partnership Grant application, including plan for services and partners

National Center to provide Technical Assistance

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Other key activities of Hubs

1. Hiring **staff** (approximately 2-3 dedicated FTE – executive director, program manager, data analyst)
2. Identifying an **advisory council** that includes key stakeholders including students and families, community-based organizations, providers, and others
3. Identifying a **steering committee** that includes leadership from: LEA, Local Behavioral Health Authority (LBHA), Local Management Board (LMB), Local Health Department (LHD), Local Departments of Social Services (DSS), and others
4. Engaging **provider organizations**/partners
5. Mapping and **coordinating** existing programs; assessing strengths, weaknesses, and opportunities for Spokes and potential Spokes; utilizing Community School Needs Assessments
6. Participating in **statewide Technical Assistance program** with other Hubs

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First RFP: Service delivery grants (Spokes)

Service delivery grant funds should be used to expand access to the following:

- Individual, group, and family therapy
- Case management/wraparound services
- Substance Use Disorder services
- Behavioral health education and support for families
- Crisis planning and services
- Telehealth services
- Support groups
- School-wide preventative and mental health literacy programming

Service providers must bill Medicaid to the maximum extent, and use grant funds to fill in the "gaps."

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Tentative timeline for RFP

March-July 2023	Outreach to engage with local communities and potential applicants
May/June 2023	RFP is released by CHRC
July/August 2023	Applications are due
August/September 2023	Award decisions are made
Fall 2023 – Fall 2025	First grant period; services begin for 2023-2024 school year

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Consortium goals and indicators

Goals	Indicators
1. Expand access to high-quality behavioral health and related services for students and families	# of students and families served, # of schools, # of services, wait time for services, improvements in quality and array of services (SHAPE system)
2. Improve student wellbeing and readiness to learn	% of students receiving Tier 2/3 service who demonstrate improvement in social, emotional, behavioral, or academic functioning using a validated assessment tool; % of students demonstrating reduction in substance use **
3. Foster positive classroom environments	Increased use of positive classroom strategies, SHAPE system measures of improvements in school climate
4. Expand revenues from Medicaid, commercial insurance, hospital community benefits, and other sources	Medicaid revenues, other revenues

** Grantees will choose assessment tools that align with the conditions of individual students, such as: PSC-17, PHQ-9, GAD-7, CAGE-AID, SNAP-IV, CATS, etc.

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Discussion questions re: potential role of LBHAs

1. How do LBHAs interact with schools currently?
2. How are LBHAs staffed? Would there be capacity/desire to add 2-3 dedicated, funded Hub staff?
3. How do LBHAs feel about governance, ie. steering committees, advisory boards?
4. What sources of funding do LBHAs currently have? How would Consortium dollars fit?
5. Could LBHAs serve as Hubs for a regional Partnership involving more than one jurisdiction?
6. Would an LBHA want to serve as *both* a Hub and a service provider (Spoke)?
7. What barriers to subcontracting should be considered?
8. If selected as a Partnership Hub, how would a CSA manage SUD services?
9. How do LBHAs interact with LMBs?

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Staff contact information & website

Mark Luckner, CHRC Executive Director

mark.luckner@maryland.gov

Lorianne Moss, Policy Analyst

Lorianne.moss@maryland.gov

Consortium website:

https://health.maryland.gov/mchrc/Pages/Maryland-Consortium-on-Consolidated-Community-Supports.aspx

Consortium mailing list

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