11/14/2017

2018 Legislative Priorities

Behavioral Health Coalition of the Mid Shore

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Closure of Adventist Behavioral Health Eastern Shore

Problem: Since the closure of Adventist Behavioral Health Eastern Shore, November 30, 2016, there has been no introduction of new services on the entire Eastern Shore. In addition, several other residential treatment centers including Good Shepherd Services of Baltimore County and Advoserve of Delaware have recently closed. The Lois E. Jackson Unit of Cumberland Maryland converted their inpatient adolescent substance abuse treatment into adult programming.

Over the course of the last 10 months, 18 mid-shore youth requiring residential level of care have been placed on the western shore to receive services. The burden of seeking treatment for their child continues to impact the family's ability to work and the overall wellness of the family.

In spring of 2017, the Governor's Office of Children (GOC), Maryland Department of Health (MDH) and Department of Human Services (DHS) began collaboration on the return of Maryland children in out of state placements. The goal: to bring 38 Maryland youth back into local residential treatment centers and group homes is to be completed by Labor Day; this further impacts capacity on an increasingly limited system of care.

There were hopes that Adventist Behavioral Health at Peninsula Regional Medical Center would expand inpatient services to children and adolescents. However, services remain outpatient exclusively. Mid Shore Behavioral Health recently experienced a termination of services by the current Care Coordination Organization, Choices Coordinated Care Solutions and had to reissue a request for proposals to which no proposals were received. The entire continuum of care for children and adolescents is at risk. MSBH is currently in negotiations with an approved regional provider for service provision.

Families with children with severe behavioral health needs have often exhausted community resources, as well as their own financial, physical and emotional resources. These families will now have no option for Residential Treatment or Level V schooling for their children and youth on the Eastern Shore, thus increasing the disconnection of children and youth from their families and community.

Update: As of October 1, 2017 MSBH contracted with Wraparound Maryland, Inc. to provide Child and Adolescent Mental Health Case Management Services to youth and families of the Mid-Shore. MSBH is currently in discussions with an Intensive In-home Services (IIHS) provider to contract for service provisions for 1915i eligible children, which would also open access to respite, expressive and experiential therapies through the fee for service system.

Representatives from the Behavioral Health Administration announced that Woodbourne, a Residential Treatment Center located in Baltimore County is considering opening a 45-bed treatment facility which would be located in Dorchester County (at the previous Adventist location). There has been no time frame outlined for the implementation of this service nor are any plans finalized.

While there is hope for increased community based services and the possibility of access to local inpatient treatment, the current reality is there still is an extreme shortage of behavioral health treatment options for children and adolescents statewide. A shortage of inpatient beds has left children waiting in the emergency rooms for days and weeks at a time. Access to behavioral health services continue to be a hardship for Maryland youth and families.

Solution/Support: The priority for families living on the Eastern Shore of Maryland who have children and youth with intense behavioral health needs, should be to treat the children, youth and families close to home, in their rural setting where staff understand the culture of these families. In order to accomplish this, we need quality programs on the Eastern Shore; such as high quality evidence-based programming at all levels- Residential, Acute, Intensive Outpatient, Partial Hospitalization and Level V Non-Public Schools. In order to accomplish this, it will take additional funding to fill the gaps that are being created by the closure of Adventist Behavioral Health Eastern Shore. Statewide initiatives to provide supports in the community, such as the 1915i waiver, are not currently accessible to children and youth on the Eastern Shore due to the lack of in-home providers and the lack of 24 hour crisis response services.

As the Behavioral Health Coalition, we ask that you educate yourself on the impact this closure has had on your constituents, families and children from the Eastern Shore, and seek additional funding to re-open the facility based centrally on the Eastern Shore and/or provide additional funding, including start-up funds, to increase community-based services available to treat children and youth on the Eastern Shore.

Behavioral Health Integration in the Mid-Shore Region

"Integration is the strategic alignement and coordination of systems management resources at the local juristiction level, to ensure quality of services and support for individuals with behavioral health conditions and increase the effeciveness and efficiency of behavioral health system, without comprimising the integrity of local programs' missions or objectives. This is not a "one size fits all" as there are many ways to envision, structure, approach and achieve integration". (Maryland Behavioral Health Integration Project, Principles for Local Systems Management Infomration, September 2017 DRAFT).

In July of 2014, the Mental Hygiene Administration and Alcohol and Drug Abuse Administration merged to become the Behavioral Health Administration (BHA). Since then, the work to support and encourage integration on a local level has been a priority of BHA. Integration has been required to our provider community, with our mental health and substance use providers, and now our local authorities are facing on the same expectations. The task of the management of our fee-for-service system and grants based programming/services has been a collaborative effort in the mid-shore. In our mid-shore region, we have made attempts to integrate independent of any guidance or mandate on a state level. As you can see from the graphic below, we have experienced our own challenges with the identification of what is the "best model" for our region.

County	FY2015	FY2016	FY2017	FY2018
Caroline	Partial Integration	Partial Integration	LDAAC Support Only	LDAAC Support Only
Dorchester	Partial Integration	Partial Integration	Partial Integration	Partial Integration
Kent	Partial Integration	Partial Integration	No Integration	No Integration
Queen Anne's (Not a provider)	Partial Integration	Partial Integration	No Integration	Partial Integration
Talbot (Not a provider)	Partial Integration	Partial Integration	Partial Integration	No Integration

Mid Shore Behavioral Health, Inc. serving as the Core Service Agency for the five mid-shore counties, and the Local Addictions Authorities (5) have worked to maintain the focus of our work in the community to support BHA's five (5) established priority areas and support the development of a service delivery system of care that provides opportunity for individuals across the lifespan to access needed service regardless of the system point of entry. The five priority areas are as follows:

- *Moving toward an integrated system of care;*
- *Improving access and quality of service throughout the continuum of care;*
- *Building infrastructure to support system capacity to collect, analyze, and track data to improve service delivery outcomes;*
- *Developing and implementing population-based efforts to promote wellness;*
- *Reviewing the array of services provided to individuals requiring inpatient care to develop specific strategies to address hospital capacity.*

Our mid-shore region finds ourselves in the midst of uncertainty as it relates to the Maryland Behavioral Health Integration Project report. As systems planners, managers, and in the case of some of our Local Addictions Authorities, that are providers, we are uncertain as to how our makeup will look in the future following the recommendations of the Legislative Report on Integration Planning for Behavioral Health.

Additional information from the Talbot County Health Department on Integration:

Traditionally, the Local Addictions Authorities through the local Health Departments have collaborated with Maryland Department of Health (MDH) Behavioral Health Administration (BHA) to integrate systems planning and management of the Public Behavioral Health System (PBHS) including planning, managing, and monitoring publicly funded substance use disorder services in each of the Mid-Shore counties. The Health Departments and Local Addictions Authorities (LAA) of each jurisdiction oversee some combination of the following:
Prevention programming, participation in recovery activities, recovery and wellness centers, client linkage to services and systems navigation, consultation/case management, screening and assessment for grant funded services, recovery housing, and developing and implementing integrated behavioral health treatment services and recovery supports in collaboration with other health authorities, public and private service providers, human services agencies and somatic care providers.

- Prevention/Education
- Narcan Trainings and Distribution
- Tobacco Cessation
- Peer Support
- Care Coordination
- Prevention, behavioral health treatment, and recovery support services for women and women with children
- Addiction Specialist in the local Department of Social Services
- Adult Drug Court (Circuit Problem Solving Court)
- 8-505 court ordered evaluations
- Substance use disorder treatment in local Detention Center through STOP Grant
- Safe Streets Initiative
- Mid-Shore Opioid Misuse Prevention Program
- Opioid Operational Command Center/Opioid Intervention Team
- Opioid Task Force

- Local Drug and Alcohol Abuse Council (LDAAC)
- Peers in the hospital/ED
- Wellness and Recovery Centers
- Opioid Treatment Programs (OTPs)

As of January 1, 2017, grant funds for ambulatory substance-related disorder services have been removed from the annual jurisdictional awards and moved to the Administrative Service Organization (ASO), Beacon Health Options. For some mid-shore counties, the focus has shifted from delivering direct outpatient services to organizing patient care activities in the community and planning for the jurisdiction's needs, including addressing gaps in the service delivery system. Dorchester and Caroline counties continue to provide direct care for outpatient addictions in addition to partial LAA functions. Each jurisdiction must also meet new requirements under COMAR 10.63 for accreditation and/or licensure to continue to provide grant funded or outpatient treatment services.

The Mid Shore region is unique in its geographic coverage, widely dispersed population and differentiated service funding. Behavioral Health Integration for system managers must estimate impacts in other state agencies that invest in behavioral health programs such as the Courts, Parole and Probation, local Departments of Social Services and correctional facilities, as well as the impact on the provider stakeholder networks. We are hopeful that systems integration may maximize patient access while reducing duplication of services with enhanced information systems for data sharing, collection and analysis including submission of categorical grants and All Hazards Plans for each jurisdiction. Separate processes currently exist between authorities for developing and disseminating public and consumer education and information, coordinating care of high risk and high cost patients in need of multiple ancillary services, uninsured exception requests, and the monitoring function of those entering Levels 3.3, 3.5, and 3.7 with public funding. Separate councils also exist within each jurisdiction to coordinate efforts for preventing, intervening with, and treating alcohol and drug abuse, and strategies to deliver and fund mental health prevention programs, intervention and treatment services.

Mid Shore Behavioral Health, Inc. and Local Addictions Authorities recognize that each has separate responsibilities and perspectives and that, to be successful in integrating behavioral health systems customized to regional and local factors, we must proceed jointly in the provision and integration of services, ensuring adequate supply and quality of services, and in compliance with federal, state and organizational requirements. Behavioral Health Integration of the authorities at the local level needs to be complimentary of each jurisdiction's design as it relates to SRD and co-occurring capable services and the organizations that provide critical programs for our most vulnerable residents. It should allow for greater collaboration between providers so that individuals may access the level of care needed at the time needed. Systems integration may also allow for the development of new approaches to care delivery and holistic patient management, as there is an equal need to link physical and behavioral health, and to build bridges to housing, transportation and other complex social needs.

We need your support to keep the Behavioral Health Integration Project a priority in the upcoming session, as the recommendations from BHA's Integration Consultant/Project Lead, Diane Stollenwerk, MPP, will be a priority for us on a local level to strategize our next steps with ensuring a system of care and management that is a best fit for our rural region.

Private Insurance Credentialing

Recommendations to Streamline the Credentialing Process

Problem: The State of Maryland is in the midst of a shortage of licensed Behavioral Health professionals that negatively impacts client access to care. This situation is further impacted by a lengthy credentialing process that all too often results in the insurance company denying otherwise eligible staff from providing services. Therefore, clients who are paying premiums to the insurance company for behavioral health are prevented from accessing those services.

The insurance companies limit otherwise eligible practitioners within a geographic area. There appears to be no consideration for rural areas where transportation can present a barrier for clients, who in order to access care, would need to travel up to 50 miles from their residence and perhaps be required to obtain services at an agency or from a counselor they do not wish to utilize.

When credentialed staff leave, the agency typically cannot replace that staff person with another qualified staff in order to maintain (never mind increase) its capacity to continue services for clients of that insurance company or serve others that may be on the agency waiting list. This is counterintuitive to the "any willing provider" approach that Maryland purports to provide. Some insurance companies require submitting written vs. online applications and/or rarely respond to an application within their own processing timeline(s). With CareFirst, it takes 120 days for it to credential the agency and then another 120 days for the behavioral health staff to be credentialed by Magellan. That delays the agency staff (assuming the application is not denied) for 6+ months before they could provide services to a CareFirst insured client.

Private insurance companies do not recognize the LGPC or LGSW credential. This even more severely limits the Workforce Capacity for the 2 years it takes for someone to obtain the LCPC or LGSW-C credential the insurance company recognizes. Medicare has the same limitation except that it does not even recognize the LCPC credential!

If the agency is not accredited, some insurance companies require a site visit before it will credential the agency or its staff.

Solution/Support: For true parity for client access and client choice, require all private insurance companies to credential the agency vs. every individual provider within the agency. The agency could report on its internal credentialing process to ensure its staff meet the necessary requirements. **For example, Cigna now has a contract in effect with Corsica River as an agency that is expediting paneling individual staff. The credentialing of an agency with the agency ensuring the credentialing of individual staff is a more efficient process.**

It appears advantageous for the insurance companies to stretch out the credentialing process and/or ultimately deny the application to credential the agency or its staff. Whereas, the agency is motivated to credential staff to provide the needed services.

Another option: Once a licensed professional is credentialed with the insurance company, allow that provider to retain that credential, as long as they maintain their license, and use it wherever they work. This would allow the agency to recruit credentialed staff to maintain the capacity needed to avoid or minimize wait listing clients with that type of insurance and not incur all the time, expense and delay it currently takes to try to get each individual staff credentialed (which could just end in a denial anyway).

Behavioral Health Service Delivery Expansion to Meet Increased Demand

Recommendations to streamline Program Licensure for new services and/or new locations.

The Eastern Shore is in the midst of an opiate epidemic and a rising demand for behavioral health services. At the same time, local Health Departments, in response to the transition from grants to fee-for-service, have or are planning to discontinue or severely limit their provision of SUD (Substance Use Disorder) treatment services as of Jan 2017.

Problem: Per the attached Beacon Health Options (BHO) Provider Alert, it takes about 6 months for a new program and/or a new site to go from application to operational.

There is no time frame listed for obtaining an NPI (National Provider Identification) number which can take anywhere from 1 day to 1 month.

The process implies a provider must incur the start-up costs related to securing a site to be inspected for at least 6 months prior to being able to provide billable services. This places a fiscal burden/disincentive on the provider.

The application is to include the resumes of staff who will provide services about 6 months out. This implies the provider has staff employed or waiting to be employed for 6 months prior to being able to provide billable services. This is another fiscal burden/disincentive.

The process is totally sequential – no steps can be accomplished simultaneously. Subsequent parties in the process must receive written verification from the prior party before the provider can start the next step in the process. This could be streamlined as indicated below.

Both OHCQ (Office of Health Care Quality) and Medicaid send different people to visit the same site. Depending on the number and timing of applications a provider submits, these two site visits could potentially occur in the same week.

The attached chronology of 1 provider's efforts to develop new services and service locations illustrates the process.

Solution/Support: The OHCQ time frame is half the total amount of time to begin service provision. This extended period of time seems to be due to the small number of staff available to make site visits statewide. This time lag could be eliminated if currently approved providers have the site visit waived, especially if the new services will be provided at currently approved locations.

The Medicaid site visit appears to replicate the OHCQ site visit. If OHCQ & Medicaid could coordinate site visits, and/or if OHCQ & Medicaid could accept electronic (followed by written) verification from each other that the site meets criteria, this step in the process could be accomplished faster.

If the site visit(s) are waived, or at least completed more timely, the NPI number can be obtained faster. Additionally, if the NPI number could be requested at the time of application & approved upon OHCQ/Medicaid approval, the process could be further streamlined.

Once the OHCQ approval, NPI number & Medicaid approval is obtained, which BHO is awaiting, BHO can register the provider.

It seems the overall timeframe could be reduced by at least 50% thus saving the provider at least 50% in potential start-up costs.

Providers could be incentivized to expand services by BHA/CSA's providing start-up funds. This has recently occurred for SUD service expansion.

UPDATE: The new vendor is in place and conducting webinars. All Outpatient Mental Health Clinic's need to register the NPI# for every provider of services and keep the list updated.

This in addition to having a NPI# for every site and every service.

There is an indication that all PRP providers will need to enter all staff and keep the list updated.

We hope that once all the information is entered maybe they can figure out how to streamline all this data entry.

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Behavioral Health Workforce Crisis

Recommendations to Streamline the Professional Counselor Licensing Process

Problem: The Eastern Shore is in the midst of an opiate epidemic thus facing increased demand for behavioral health services. Normally there is an urgent need to increase the workforce to treat mental health and substance use disorders. The need becomes critical given the reduction in the SUD (Substance Use Disorder) treatment workforce through retirement and the transition of SUD services from grants to fee-for-service.

While Maryland's Board of Social work can turn around a Master's student's licensing application within 1 month of graduation, the Board of Professional Counselors often takes 6 months or more.

The following timeline outlines the LGPC licensing process:

- **April** – Master's internship ends – student can no longer see clients until licensed.
- **May** – Student graduates.
- **June/July** – Student begins application process - must obtain official college transcripts to submit with the application. If course titles are not exactly as stated on application, student must also include college catalog course descriptions or course syllabi.
- **July/August** – After the application is submitted, the student learns they need to also submit a Criminal Background check. This requirement is not listed on the Board website or application. The Board does not meet in July or August. Although a Committee that meets in July & August could apparently approve a flawless application, it appears that applications are typically held until the Board meets in September.
- **September** – The application must be approved by the Board of Professional Counselors prior to it notifying the NBCC (National Board of Certified Counselors) that the student is eligible to take the NCE (National Counselor Exam) – which is offered on-line the first week of the month. Timing of this process can delay access to the NCE test.
- **October** – The student needs to pass the NCE to be eligible to take the MD Law Test which is offered only at the Board office and only twice per month. If the maximum number testing is reached, the student will have to wait until the next available testing date. Again, timing can delay access to the test.
- **November** – The student fulfills all obligations and waits for the license to be issued. This takes about 3 weeks.
- **November/December** – An employer can now hire the student who finished interning in April to provide billable services.

UPDATE: Progress has been made with the Board of Professional Counselors Interim Director, Kimberly Link. After a meeting held on November 1st with several agency directors, state associations and Ms. Link, we were very encouraged by her grasp of the issues, her strategies, to address them, and her determination to resolve them. All present at the meeting pledged to support her and her efforts any way we can.

Ms. Link will make a presentation at the Forum

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24/7 Crisis Services

Crisis Services Expansion Summary

In response to SB551/Ch. 405(2015 and House Bill 682/Ch. 406 (2015) a collaborative crisis expansion was submitted to the Behavioral Health Administration at their request in late August. Below is a summary. The final report is due to Governor Hogan 12/17 where it is hoped to be a legislative priority for the 2018 Session.

24/7 Crisis Stabilization Center in Elkton

- Collaborative partnership with crisis beds, assessment, and stabilization with Union Hospital, Upper Chesapeake, Mobile Crisis, Upper Bay, Ashley Treatment Centers, Behavioral Health Administration, Law Enforcement
- Set to open in 2018

Crisis Intervention Team (CIT) Programming Expansion

- Hire Full-Time CIT Officer Liaison to cover the 6 Counties
- 7 - 40 hour Mid Shore and 1 - 40 hour Cecil Training each year
- 3 - 24 hour Mid Shore and 2 - 24 hour Cecil Dispatcher Trainings each year
- Multiple law enforcement/community trainings of various topics in the Mid Shore and Cecil in Brown Bag/Lunch and Learn format as well as in 3 and 6 hour update formats with P#s, C#s, and CEUs attached.
- Peer to Peer Trainings to enhance Peer to Peer Support Program

Eastern Shore Crisis Response Line Expansion

- Increase capacity to meet growing demand
- Dedicated line for law enforcement – Calls for Service and Support
- Additional Call Center staff hired to meet current capacity needs and expanding capacity when additional 4 teams are added with same parameters

Mobile Crisis Expansion

- Staffing of all Teams with 2 person shifts
    - Person with Lived Experience
        - Certified Peer Specialists
        - Persons in Recovery (Behavioral Health) with AA/BSW/etc
    - Expansion of Intern Program to include AA and Bachelor level for workforce development
- When teams go to 24/7/365, by 12/31/18, 30 hours of coverage will be provided
    - 12-6 - High volume shift based on current data
    - Staff will be based in Safe Space locations/Co-located with Law Enforcement to enhance partnership and enhance communities' feelings of safety in going to the locations
- Add 4 additional Mobile Crisis Teams with same parameters as existing teams
- Average cost in the Mid Shore for Incarcerated Individual with Behavioral Health needs $170 versus $114 without
    - Diverted - 198 in FY14; 193 in FY15; 434 in FY16; 359 in FY17 **Total 1184**

    - Potential Savings $201,280
- Average cost according to the Health Care Blue Book for an ER visit in the Mid Shore is $2189
    - Diverted – 516 in FY14; 912 in FY15; 1221 in FY16; 1229 in FY17 Total 3878
    - Potential Savings $8,488,942

Safe Stations/Specialized Addictions Programming

- Community collaborations with law enforcement, EMS, providers, hospital, and crisis to address the opioid and other community addictions needs
- County/community specific programming

Specialized Services

- Enhanced funding for individuals who are deaf and hard of hearing
- Enhanced funding for consumer support funds

Wellness, Recovery and Peer Support for Individuals and Families across the Region

- Expansion of Chesapeake Voyagers serving the 5 Mid Shore Counties, with location in Talbot
- Expansion of DRI-Dock Wellness and Recovery Center in Dorchester
- Expansion of Family Peer Support through Maryland Coalition of Families
- Expansion of Recovery in Motion in Kent

Urgent Care

- Expansion of Urgent Care Appointments for On Demand availability
- Expansion of Urgent Care Appointments for Substance Use

The Behavioral Health Coalition of the Mid Shore is a partnership of regional mental health and substance use disorder agencies including Affiliated Santé Group's Eastern Shore Crisis Response, Channel Marker, Inc., Chesapeake Voyagers, Inc., Corsica River Mental Health Services, Crossroads Community, Inc., Eastern Shore Psychological Services, For All Seasons, Inc., Maryland Coalition of Families, Mental Health Association of the Eastern Shore, Mid Shore Behavioral Health, Inc., University of Maryland Medical System – Recovery For Shore, and local health departments.

Contact Laura Pollard at lpollard@midshorebehavioralhealth.org *for more information or visit: www.midshorebehavioralhealth.org/advocacy.*