

I: State Information

State Information

Plan Year

Start Year:

2014

End Year:

2015

State DUNS Number

Number

135218621

Expiration Date

I. State Agency to be the Grantee for the Block Grant

Agency Name

Department of Health and Mental Hygiene

Organizational Unit

Mental Hygiene Administration

Mailing Address

Spring Grove Hospital Center 55 Wade Avenue – Dix Building

City

Catonsville

Zip Code

21228

II. Contact Person for the Grantee of the Block Grant

First Name

Joshua

Last Name

Sharfstein

Agency Name

Department of Health and Mental Hygiene

Mailing Address

201 W. Preston Street, 5th Floor, Baltimore, MD 21201

City

Baltimore

Zip Code

21201

Telephone

410-767-6505

Fax

410-767-6489

Email Address

Joshua.Sharfstein@maryland.gov

III. State Expenditure Period (Most recent State expenditure period that is closed out)

From

To

IV. Date Submitted

NOTE: this field will be automatically populated when the application is submitted.

Submission Date

8/29/2013 5:19:32 PM

Revision Date

1/16/2014 10:14:50 AM

V. Contact Person Responsible for Application Submission

First Name

Cynthia

Last Name

Petion

Telephone

410-402-8468

Fax

410-402-8309

Email Address

Cynthia.Petion@maryland.gov

Footnotes:



MARTIN O'MALLEY
GOVERNOR

STATE HOUSE
100 STATE CIRCLE
ANNAPOLIS, MARYLAND 21401-1925
(410) 974-3901
(TOLL FREE) 1-800-811-8336

TTY USERS CALL VIA MD RELAY

July 20, 2011

Grant Management Officers
Division of Grants and Contracts Management
Department of Health and Human Services
5600 Fishers Lane
Rockville, MD 20857

Dear Grant Management Officers:

Several federal government agencies routinely require that the Chief Executive Officer of a State or his designee sign official grant documents. In order to expedite the processing of federal grants, on my behalf, I designate the Secretary of Maryland's Department of Health and Mental Hygiene (DHMH), Joshua M. Sharfstein, M.D., to make future assurances, sign applications and agreements, and perform any similar acts relevant to the Department of Health and Mental Hygiene.

Sincerely,

A handwritten signature in black ink, appearing to read "Martin O'Malley".

Governor

cc: Joshua M. Sharfstein, M.D., DHMH



I: State Information

Assurance - Non-Construction Programs

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0040), Washington, DC 20503.

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.

Note: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is \$10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).
12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).

14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

Name	<input type="text" value="Joshua M. Sharfstein, M.D."/>
Title	<input type="text" value="Secretary"/>
Organization	<input type="text" value="Department of Health and Mental Hygiene"/>

Signature: _____ Date: _____

Footnotes:

I: State Information

Assurance - Non-Construction Programs

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As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award, and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
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15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
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17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

Name: Joshua M. Sharfstein, M.D.
Title: Secretary
Organization: Department of Health and Mental Hygiene

Signature: *Joshua M. Sharfstein*

Date: 8/15/13

Footnotes:

I: State Information

Certifications

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 45 CFR Part 76, and its principals:

- a. are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;
- b. have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
- c. are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and
- d. have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause titled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion--Lower Tier Covered Transactions" in all lower tier covered transactions (i.e., transactions with subgrantees and/or contractors) and in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 45 CFR Part 76 by:

- a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
- b. Establishing an ongoing drug-free awareness program to inform employees about--
 1. The dangers of drug abuse in the workplace;
 2. The grantee's policy of maintaining a drug-free workplace;
 3. Any available drug counseling, rehabilitation, and employee assistance programs; and
 4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
- c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
- d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
 1. Abide by the terms of the statement; and
 2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
- e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
- f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
 1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
 2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
- g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

For purposes of paragraph (f) regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Office of Grants and Acquisition Management
Office of Grants Management
Office of the Assistant Secretary for Management and Budget

3. Certifications Regarding Lobbying

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING \$100,000 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that:

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to \$1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

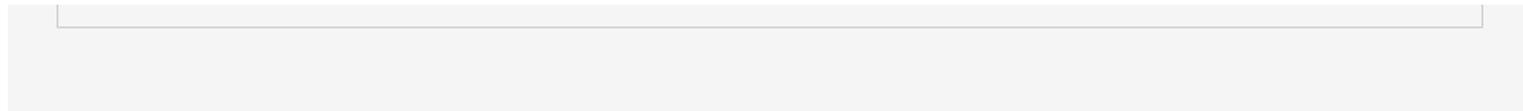
The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

Name	Joshua M. Sharfstein, M.D.
Title	Secretary
Organization	Department of Health and Mental Hygiene

Signature: _____ Date: _____

Footnotes:



I: State Information

Certifications

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 45 CFR Part 76, and its principals:

- a. are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;
- b. have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
- c. are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and
- d. have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause titled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion--Lower Tier Covered Transactions" in all lower tier covered transactions (i.e., transactions with subgrantees and/or contractors) and in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 45 CFR Part 76 by:

- a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
- b. Establishing an ongoing drug-free awareness program to inform employees about--
 1. The dangers of drug abuse in the workplace;
 2. The grantee's policy of maintaining a drug-free workplace;
 3. Any available drug counseling, rehabilitation, and employee assistance programs; and
 4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
- c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
- d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
 1. Abide by the terms of the statement; and
 2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
- e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
- f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
 1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
 2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
- g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

For purposes of paragraph 7 regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Office of Grants and Acquisition Management
Office of Grants Management
Office of the Assistant Secretary for Management and Budget

3. Certifications Regarding Lobbying

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING \$100,000 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that:

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

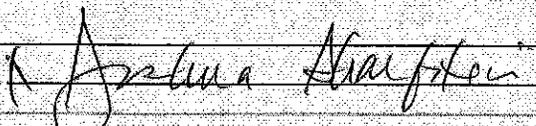
Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to \$1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

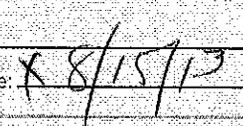
By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

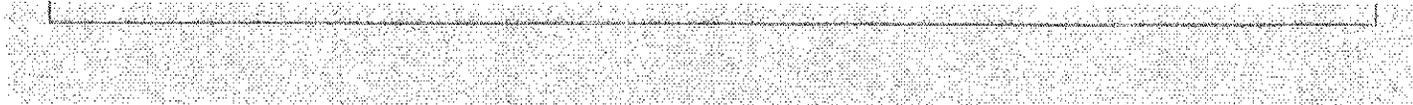
The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

Name	Joshua M. Sharfstein, M.D.
Title	Secretary
Organization	Department of Health and Mental Hygiene

Signature: 

Date: 

Footnotes:



I: State Information

Chief Executive Officer's Funding Agreements (Form 3) - Fiscal Year 2014

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
Community Mental Health Services Block Grant Program
as authorized by
Title XIX, Part B, Subpart I and Subpart III of the Public Health Service Act
and
Title 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart I of the Public Health Service Act

Section	Title	Chapter
Section 1911	Formula Grants to States	42 USC § 300x
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	42 USC § 300x-1
Section 1913	Certain Agreements	42 USC § 300x-2
Section 1914	State Mental Health Planning Council	42 USC § 300x-3
Section 1915	Additional Provisions	42 USC § 300x-4
Section 1916	Restrictions on Use of Payments	42 USC § 300x-5
Section 1917	Application for Grant	42 USC § 300x-6

Title XIX, Part B, Subpart III of the Public Health Service Act

Section 1941	Opportunity for Public Comment on State Plans	42 USC § 300x-51
Section 1942	Requirement of Reports and Audits by States	42 USC § 300x-52
Section 1943	Additional Requirements	42 USC § 300x-53
Section 1946	Prohibition Regarding Receipt of Funds	42 USC § 300x-56
Section 1947	Nondiscrimination	42 USC § 300x-57
Section 1953	Continuation of Certain Programs	42 USC § 300x-63
Section 1955	Services Provided by Nongovernmental Organizations	42 USC § 300x-65
Section 1956	Services for Individuals with Co-Occurring Disorders	42 USC § 300x-66

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart I and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

Name of Chief Executive Officer (CEO) or Designee

Joshua M. Sharfstein, M.D.

Title

Secretary

Signature of CEO or Designee¹: _____ Date: _____

¹ If the agreement is signed by an authorized designee, a copy of the designation must be attached.

Footnotes:

I: State Information

Chief Executive Officer's Funding Agreements (Form 3) - Fiscal Year 2014

U.S. Department of Health and Human Services
 Substance Abuse and Mental Health Services Administrations
 Funding Agreements
 as required by
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Name of Chief Executive Officer (CEO) or Designee

Joshua M. Sharfstein, M.D.

Title

Secretary

Signature of CEO or Designee:

Joshua M. Sharfstein

Date:

8/15/13

¹ If the agreement is signed by an authorized designee, a copy of the designation must be attached.

Footnotes:

I: State Information

Disclosure of Lobbying Activities

To View Standard Form LLL, Click the link below (This form is OPTIONAL)

[Standard Form LLL \(click here\)](#)

Name	<input type="text" value="Joshua M. Sharfstein, M.D."/>
Title	<input type="text" value="Secretary"/>
Organization	<input type="text" value="Department of Health and Mental Hygiene"/>

Signature: _____ Date: _____

Footnotes:

I: State Information

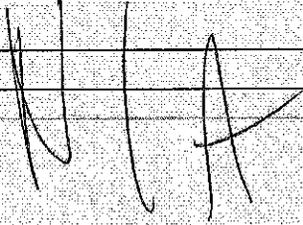
Disclosure of Lobbying Activities

To View Standard Form LLL, Click the link below (This form is OPTIONAL)

Standard Form LLL (click here)

Name:
Title:
Organization:

Signature: _____ Date: _____



Footnotes:

II: Planning Steps

Step 1: Assess the strengths and needs of the service system to address the specific populations.

Narrative Question:

Provide an overview of the State's behavioral health prevention, early identification, treatment, and recovery support systems. Describe how the public behavioral health system is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SSA, the SMHA and other state agencies with respect to the delivery of behavioral health services. States should also include a description of regional, county, tribal, and local entities that provide behavioral health services or contribute resources that assist in providing the services. The description should also include how these systems address the needs of diverse racial, ethnic and sexual gender minorities.

Footnotes:

FY 2014 – 2015 MARYLAND MENTAL HEALTH BLOCK GRANT

Section II-B: Planning Steps

EXECUTIVE SUMMARY

Through the Affordable Care Act (ACA), Maryland has begun implementation of Health Care Reform and several activities are underway which include integrating the care of individuals with behavioral health disorders. Under the leadership of Governor Martin O’Malley and Lt. Governor Anthony Brown, Maryland has established the Maryland Health Benefit Exchange (MHBE). In 2014 Marylanders who need health insurance will be able to get it through a new HBE known as the Maryland Health Connection.

Maryland has begun implementation of the behavioral health integration process. In 2011, under the leadership of the Department of Health and Mental Hygiene (DHMH) Secretary Joshua Sharfstein, M.D., the Department engaged an experienced consultant to examine the current system, consider integration options, and provide recommendations regarding financing structures to best support integrated care. As part of the FY 2012 budget, the Maryland General Assembly asked the DHMH, to convene a workgroup and provide recommendations “to develop a system of integrated care for individuals with co-occurring serious mental illness and substance abuse issues”. The Department established a planning team led by the Deputy Secretary of Health Care Financing. The process included a consultant’s report, followed by the Secretary’s development of seven principles of behavioral health integration and series of stakeholders’ workgroups to inform the recommendations of a financing model.

Under the leadership of the DHMH Secretary and Deputy Secretary for Behavioral Health and Disabilities, MHA and ADAA continue efforts that support the mission to foster an integrated process for planning and collaboration to ensure a quality system of care is available to individuals with behavioral health conditions. The two administrations continue to work collaboratively to address the needs of individual with co-occurring disorders.

FY 2014 – 2015 MARYLAND MENTAL HEALTH BLOCK GRANT

Introduction

Maryland is providing separate applications for the FY 2014-2015 Mental Health Block Grant and Substance Abuse Block application; however, there are common areas in which the Mental Hygiene Administration (MHA) and the Alcohol and Drug Abuse Administration (ADAA) are providing joint responses. In 2011 the Department of Health and Mental Hygiene (DHMH) which oversees Mental Hygiene (MHA), Alcohol and Drug Abuse (ADAA) and Developmental Disabilities (DDA) administrations, initiated the process of exploring recommendations of a model that improves the integration of Medicaid-financed behavioral health services. This process involved a series of stakeholder meetings and workgroups.

Under the leadership of the Deputy Secretary of Behavioral Health and Disabilities, includes the merger of the mental health agency (Mental Hygiene Administration, MHA) and the substance use agency (Alcohol and Drug Abuse Administration, ADAA). The MHA and ADAA continue efforts that support the mission to foster an integrated process for planning and collaboration to ensure a quality system of care is available to individuals with behavioral health conditions.

Additionally, the Advisory Councils for the MHA and ADAA, the Maryland Advisory Council on Mental Hygiene/P.L. 102-321 Planning Council (Joint Council) and the State Drug and Alcohol Abuse Council (SDAAC), each, chose representatives to form a Behavioral Health Council Workgroup with the intended purpose of clarifying what a Behavioral Health Council should look like and defining a model to present to both councils. The Workgroup is receiving technical assistance through Advocates for Human Potential, a contractor for SAMHSA's Center for Mental Health Services, that is leading the selected states in the National Learning Community Technical Assistance Project.

FY 2014 – 2015 MARYLAND MENTAL HEALTH BLOCK GRANT

Section II-B: Planning Steps

STEP 1 - ASSESS THE STRENGTHS AND NEEDS OF THE SERVICE SYSTEM TO ADDRESS THE SPECIFIC POPULATIONS:

Overview of the State's Current Behavioral Health System:

The Mental Hygiene Administration (MHA) is the State Mental Health Authority (SMHA) agency within the Department of Health and Mental Hygiene responsible for the oversight of public mental health services in Maryland. Maryland operates the majority of its public mental health system under a Medicaid 1115 waiver. MHA is responsible for providing all medically necessary specialty mental health services. Specialty mental health care is carved out into a Fee-For Service (FFS) program that is managed by an administrative service organization (ASO) under contract to the Mental Hygiene Administration (MHA). Limited mental health services for the uninsured are paid with State funds through the ASO. The ASO's responsibilities include operating a utilization management system, paying claims, providing data collection and management information services, offering public information, consultation, training, evaluation services, managing special projects, and addressing stakeholder feedback. The goal of the system is to provide the benefits of the coordination of managed care, while preserving access to a comprehensive array of services, flexibility, and choice.

The Public Mental Health System (PMHS) is managed in collaboration with the Core Service Agencies (CSAs) and the Administrative Services Organization (ASO). The CSAs are entities at the local level that have the authority and responsibility, in collaboration with MHA, to develop and manage a coordinated network of Maryland's public mental health services in a defined service area. There are nineteen (19) CSAs covering all 24 jurisdictions. CSAs are agents of county or city government and may be county departments, quasi-government bodies, or private non-profit corporations. They vary in size, needs, budgets, and budget sources. CSAs are the administrative, program, and fiscal authority which are responsible for assessing local service needs and planning the implementation of a comprehensive local mental health delivery system that meets the needs of eligible individuals of all ages. Together, they are responsible for determining the criteria for utilization management, establishing performance standards, and evaluating appropriateness and effectiveness of service. Additionally, CSAs are important points of contact for consumers, families, and providers in the PMHS and develop partnerships with other local, state and federal agencies. CSAs provide numerous public education events and trainings. They are responsible for processing complaints, grievances, and appeals, as well as for monitoring the contract with the ASO and reporting findings to MHA. Additionally, local mental health advisory committees and CSA Boards have the opportunity and responsibility to advise CSAs regarding the PMHS and to participate in the development of local mental health plans and budgets.

The Maryland Association of Core Service Agencies, (MACSA) Inc., was established to promote and support the effectiveness of each CSA in Maryland to plan, monitor, and manage its local, publicly-funded mental health service system. Each fiscal year MHA requires that CSAs develop and report on their progress in identifying and meeting local needs and State priorities.

FY 2014 – 2015 MARYLAND MENTAL HEALTH BLOCK GRANT

Additionally, CSA representatives participate on the Maryland Advisory Council on Mental Hygiene/Planning Council and various MHA committees such as the Finance Committee and the Clinical Committee which promote direct involvement with PMHS issues. Also, the CSAs work closely with the MHA Management Information System (MIS) staff on the Data Committee to generate and disseminate data that is useful to the CSAs as they support initiatives and services that are the most beneficial for the public they serve. CSAs also serve as authorization agents for some specialized services and play point leadership roles in a number of federally funded local demonstration projects.

Additionally, MHA operates five inpatient psychiatric facilities and two residential treatment centers for children and adolescents. From the time of admission, facilities work collaboratively with Core Service Agencies (CSAs), community providers, consumers, and families toward patient discharge. The focus is on returning the individual to the lowest level of care necessary to meet the individual's medical needs. The State psychiatric hospitals are participants, along with the acute general hospitals and the private psychiatric hospitals, in the provision of psychiatric inpatient care in Maryland.

Alcohol and Drug Abuse Administration (ADAA) - The ADAA is the state governmental entity responsible for the establishment and support of a comprehensive service delivery system that provides access to high quality and effective substance abuse prevention, intervention and treatment services. As the Single State Authority (SSA) for Maryland, the ADAA is responsible for planning, developing and funding services to prevent harmful involvement with alcohol and other drugs, and for treating individuals in need of addiction services. The ADAA maintains a statewide, integrated service delivery system through a continuum of treatment modalities that promote public health and safety of patients, families, and communities. The ADAA designates, approves, plans and coordinates programming within Maryland that offers prevention, intervention, treatment and aftercare services; establishes and develops standards, regulations and methods of treatment to be employed for the treatment of substance use disorders (SUDs); gathers information and maintains statistical/other records relating to SUDs; disseminates "science to service" information relating to services for persons with SUDs; services for the prevention/diagnosis/treatment/rehabilitation of substance use, abuse and dependence; and supports services to sustain recovery beyond the treatment/rehabilitation episode. ADAA provides state-funded grants to the 24 local jurisdictions, including Baltimore City, largely through the Local Health Departments (LHD). ADAA grant dollars cover services for the non-Medicaid eligible population as well as non-reimbursable services for the full Medicaid and Primary Adult Care (PAC) populations.

Physical Health Care – Approximately 80 percent of all Maryland Medicaid beneficiaries receive somatic health services through a managed care organization (MCO), and this percentage will increase in January 2014 after the Medicaid expansion under the Affordable Care Act occurs. Maryland's HealthChoice (full benefit) and PAC (partial benefit) programs, authorized by Medicaid's 1115 waiver, are responsible for providing somatic care to all enrollees through a risk-based, capitated payment system. As of August 2012, seven MCO's were participating in the HealthChoice program, with five of those seven participating in the PAC program.

FY 2014 – 2015 MARYLAND MENTAL HEALTH BLOCK GRANT

The remaining 20 percent of the beneficiaries receive their somatic care through a fee-for-service (FFS) system. Populations whose services are paid FFS include individuals over the age of 65, dually eligible for Medicare and Medicaid, living in institutional health care facilities, in the Rare and Expensive Case Management (REM) program, or on certain Medicaid waivers.

Beginning in 2014, provisions in the ACA will allow Maryland to expand Medicaid eligibility to most individuals under 138% of the federal poverty level (FPL), and these individuals will qualify for Medicaid's behavioral health benefits. In addition, Maryland's state-operated health benefit exchange will require all participating health plans to cover the ACA's "essential health benefits", including behavioral health services.ⁱ

ⁱ DHMH Report – An Integration Model for Medicaid-Financed Behavioral Health Services

Mental Hygiene Administration – Office of Child and Adolescent Services (OCAS)

Maryland's Mental Hygiene Administration's Office of Child and Adolescent Services (OCAS) is responsible for planning, monitoring for program compliance, and building partnerships to ensure the delivery of mental health services to children and their families within the Public Mental Health System. The office works closely with other child-serving agencies and the core service agencies to improve access and coordination of care for this population. The Office, with its partners and stakeholders, provides leadership, expertise and guidance to promote wellness, prevention and resiliency in all child and adolescent mental health. These efforts range from universal prevention programs to the most intense levels of care in every jurisdiction. As Maryland continues to grow its System of Care – imbued with core values of being child-centered, family- and youth-driven, community-based, and culturally and linguistically competent – its role becomes even more important to the future of Maryland's children.

Blueprint Committee for Children's Mental Health

A Blueprint Committee for Children's Mental Health serves as an advisory committee to MHA on its provision of child and adolescent services.

This standing Blueprint Committee enables stakeholders to keep informed, and help create a system of mental health services that are based on the best data and knowledge in the field, while also being flexible enough to adapt to changing trends and demographics.

The committee also supports the work of the OCAS through a subcommittee structure that helps to meet a number of goals. The subcommittees include staff of the OCAS and their partners in other child-serving departments. Together they assist in realizing many of the goals outlined in the *Blueprint for Children's Mental Health* which was originally developed in March 2003. Within the overarching structure of the Public Health Model, the updated Blueprint is created with the intention of reinforcing the established Vision and Mission of the Mental Hygiene Administration.

The Blueprint operates on two levels. First, it provides recommendations for the Office of Child and Adolescent Mental Health as it operates to fulfill its mandate within Maryland's Public Mental Health System. Most of these services, funded by Medical Assistance, are treatment-oriented; however, MHA also administers grant-funded programs which emphasize prevention and early intervention. On another level, MHA staff together with their partners and stakeholders -- especially families and youth -- has long played a vital role in advancing the agenda for child and adolescent mental health initiatives in Maryland. These initiatives cross historical agency as well as public/private boundaries. The Blueprint speaks to these interagency initiatives and public/private involvements, and includes efforts to influence mental health parity within the private health insurance sector to the extent possible.

OCAS is committed to a resilience-based service system so that children with mental health needs and their families can, even in the face of many stressful life events, have a sense of optimism and hope for the future. To that end OCAS, in collaboration with other child serving agencies, has formed a Resilience Committee to develop recommendations for the integration of resilience principles in programs serving children with mental health needs and their families. The Committee is engaged in discussions with appropriate federal agencies and other states on promoting resilience.

OCAS Initiatives

Caring for Every Child's Mental Health Campaign, a statewide educational campaign conducted in collaboration with the Mental Health Association of Maryland and other organizations concerned with the mental health and well being of children.

Centers for Medicare and Medicaid Services Psychiatric Residential Treatment Facility (PRTF) Demonstration Grant 1915C Medicaid Waiver

- This waiver provides funding for youth who meet medical necessity criteria for Residential Treatment Center (RTC) level of care. It allows Medicaid to be used for home and community based services for youth who need RTC intensity of services but can be safely cared for in a community setting (diversion) and/or return from RTC placement.
- Its services are provided under a care management entity model with child and family teams developing a plan of care with a wraparound service delivery model.
- Youth have access to a range of public mental system services and/or special waiver services including Respite Care, Family Peer Support, Youth to Youth Peer Support, Expressive Therapies, Family Education, In Home Crisis and Stabilization Services.

Youth Suicide Prevention Plan

- Targets middle, high-school and college students, and at-risk populations aged 15-24 years.
- Provides crisis intervention, information, referral, and community outreach throughout the State via the Maryland Youth Crisis Hotline: 24/7 hotline network at 1- 800-422-0009.
- Offers additional information on the Maryland Youth Suicide Prevention Program on the Internet at www.dhmh.state.gov/suicideprevention

LISA L Lawsuit Settlement

- Coordinates interagency monitoring team which facilitates compliance with COMAR 14.31.03 and monitors youth in state custody admitted to designated psychiatric inpatient units to ensure timely discharge.
- Provides ongoing training and consultation to psychiatric hospitals, providers and agencies to facilitate compliance with the regulations governing interagency discharge planning for children and adolescents (COMAR 14.31.03).
- Monitors the Psychiatric Hospitalization Tracking System for Youth (PHTSY) and maintains data and reports generated by the system.

Child Mental Health Institute

A collaboration between the Child Psychiatry Divisions at University of Maryland and Johns Hopkins University Medical Schools, Maryland Coalition of Families for Children's Mental Health and University of Maryland Evidenced Based Practice Center. The Institute's primary focus is on evidenced based practices for child and adolescent mental health, including Evidence Based Practices research, statewide implementation and outcomes monitoring. The Youth MOVE (Motivating Others through Voices of Experience) initiative is part of the Children's Mental Health Institute.

Regional Care Management Entities (CMEs)

The Mental Health Transformation State Incentive Grant (MHT-SIG) provided fiscal and policy analyses to assist the Children's Cabinet in releasing a statewide Request For Proposal for Regional Care Management Entities (CMEs) for Wraparound service delivery to expand from four demonstration sites to statewide capacity. The CMEs provide supports to youth and families and system level functions. The populations to be served include:

- 1915 (c) residential Treatment Center (RTC) Medicaid Waiver
- SAMHSA-funded Systems Of Care grants-MD CARES and RURAL CARES
- Child Welfare's Place Matters Group Home Diversion using Resource Coordinators
- Juvenile Services' Out-of-Home Diversion using Wraparound Care Coordination

Centers of Excellence

Partnerships with the Maryland Coalition of Families for Children's Mental Health and Johns Hopkins University is supported by the Maryland Children's Cabinet, MHA, MHT-SIG and other child/family serving agencies. It is located at the University of Maryland and is comprised of the following Institutes:

- Maryland Child and Adolescent Innovations Institute
- Children's Mental Health Institute
- Juvenile Justice Institute

System of Care Training Institutes - hosts a statewide conference, in partnership with MHA, MHT-SIG and other state and local child/family serving agencies that supports the implementation of a coordinated interagency effort to develop a child-family serving system that can better meet the needs of children, youth and families.

Certificate Programs - to enhance the skills and knowledge of practitioners include:

- Certification of Family Support Partners and Supervisors
- Certification of Care Management Staff
- Certification of Youth Support Partners
- Advanced Practitioner Certification
- Child and Adolescent Needs and Strength (CANS) assessment Certification (online)

Maryland's Wraparound Fidelity Assessment System (WFAS) - provides useful and important data at both the State and local level by gathering data utilizing a series of survey instruments: 1) Wraparound Fidelity Index (WFI)-4.0 Telephone Interviews (4 per family), 2) Team Observation Measure (TOM) and Youth Services Survey (service satisfaction)

Maryland Coalition of Families for Children's Mental Health- is a grassroots family organization established in 1999. It has established a family Leadership Institute, a Steering Committee for Children with Emotional Disturbance in School Settings and the annual "Children's Mental Health Matters!" campaign, among other endeavors. The goal of the Psychopharmacology Practice Improvement is to foster rational medication prescribing and monitoring as a way to address public health concerns about increased use among youth in out-of-home placement through comprehensive strategies.

Behavioral Health and Disabilities Approach - This initiative entails a Steering Committee for Child/Adolescent Co-Occurring Disorders to assess needs and services of young people with emotional behavioral, developmental and substance abuse disorders. Workforce competencies will be developed to improve the services delivered to these youth with complex needs.

OCAS Collaborations

Maryland's Children's Cabinet and the Governor's Office for Children (GOC)

OCAS participates in interagency state level approaches to problem solving and policy development through representation on Children's Cabinet, State Coordinating Council, Interagency Licensing groups, Interagency Rates Committee and others

Department of Human Resources

- OCAS consults with the Baltimore City Department of Social Services on mental health assessment and treatment for children entering the foster care system
- OCAS collaborates with the Department of Human Resources to expand in-home mental health crisis and stabilization services for youth in their first foster care home or kinship care home to help stabilize their placement

Department of Juvenile Services (DJS)

- OCAS provides consultation to the Department of Juvenile Services in development of mental health programs
- OCAS provides mental health professionals to work in conjunction with DJS staff and some courts for mental health assessments and community referrals

Maryland State Department of Education (MSDE)

Early Childhood Mental Health

- Zero to Three Committee, in collaboration with Friends of the Family, working on prevention efforts for very young children and their families
- The Early Childhood Mental Health Steering Committee is co-chaired by Dr. Carol Ann Heath (MSDE) and Dr. Al Zachik (MHA)
- Mental health consultation is provided to all child care centers to promote the healthy social and emotional development of the child and to provide assessments, treatment, if needed, and supports to family and caregivers.
- CSEFEL (Center for the Social and Emotional Foundations of Early Learning) – provides training for early childhood staff in collaboration with Georgetown University and Vanderbilt University
- Certificate programs at University of Maryland for mental health providers and consultants in early childhood mental health

School Based Mental Health

- Community based mental health professionals working in schools
- Core competencies for working with foster care youth with mental health need in schools

Child and Adolescent Mental Health Workforce Steering Committee

- Developed core competencies for children's mental health professionals with MSDE
- Developing training modules for the core competences
- Developed a white paper on workforce development
- Offered a new certificate program by the University of Maryland for Masters level mental health professionals to be trained on working with children ages 0 to 5
- Developing certificate training program for Bachelors-level mental health professionals working with children ages 0 to 5

Juvenile Courts

Juvenile court orders are monitored in collaboration with core service agencies. This provides for juvenile competency educational attainment, as ordered

Mental Hygiene Administration's - Office of Adult Services

Maryland's Mental Hygiene Administration's Office of Adult Services ensures that a comprehensive system of mental health services and supports are available and accessible for adults from age 18 throughout the life-span. The office oversees the statewide planning, design, development, implementation, administration and monitoring of community-based mental health programs and services for adults, transition-age youth, and older adults. In addition, the office formulates policy, protocols, regulations and practice guidelines to support systems transformation for improved consumer outcomes; promotes evidence-based, consumer-directed and recovery-oriented rehabilitation, treatment and supports that have demonstrated effectiveness and are responsive to consumer needs and preferences. In addition, staff oversees federal legislation regarding the PASRR (Pre-Admission and Resident Review) program, and the Interstate Compact on Mental Health.

Collaborations:

The mission of the Office of Adult Services is to develop an integrated, coherent, consumer-centered service delivery system for adults of all ages. Efforts are enhanced through forging collaborations throughout the State, and at the federal and national levels. Staff of the Office of Adult Services works closely with the Department of Health and Mental Hygiene's (DHMH)

- Alcohol and Drug Abuse Administration,
- Developmental Disabilities Administration,
- Office of Health Care Quality; and
- Office of Health Services

Collaborations with other State agencies include:

- Maryland State Department of Education (MSDE),
- MSDE's Division of Rehabilitation Services (DORS),
- Department of Aging (MDDOA),
- Department of Disabilities (MDOD), and
- Department of Human Resources (DHR).

The Office works in close partnership with several national organizations and federal administrations, such as the:

- National Association of State Mental Health Program Directors,
- Substance Abuse and Mental Health Services Administration,
- Centers for Medicare and Medicaid Services;
- Social Security Administration.

It closely interacts with advocacy groups such as:

- On Our Own of Maryland,
- Mental Health Association of Maryland and the association's "Coalition on Mental Health and Aging," and
- National Alliance on Mental Illness – Maryland.

Established academic relationships exist with the

- University of Maryland, School of Medicine

- Dartmouth College and the Johnson & Johnson Community Mental Health Program.

Programs

The Office of Adult Services directs the state's plans, initiatives, and services for individuals with **Traumatic Brain Injury (TBI)**.

The **Ticket to Work Program** helps people who receive Social Security Disability Insurance (SSDI) or Supplemental Security Income (SSI) go to work. The program is free and voluntary. More information is available at <http://harfordmentalhealth.org/ticket-to-work>

Evidence-Based Practice (EBP): EBP refers to a specific practice or service that consists of a set of standardized, replicable interventions for which rigorous scientific research exists to demonstrate the effectiveness of the interventions when implemented as designed in achieving meaningful, positive outcomes for consumers who have received the service. The successful implementation of EBP programs -- or program fidelity -- is measured by a scale which assesses the degree to which the program adheres to the core principles and essential program elements of the practice which have been shown by research to be critical to the effectiveness of the program. EBP programs that have been rated high in fidelity on an approved fidelity scale by trained fidelity monitors have been shown to achieve superior outcomes relative to those programs that have been rated low in fidelity on the scale outcomes. Annual fidelity assessments are performed by adult services staff to ensure that programs meet established fidelity standards. In addition, training, technical assistance and consultation is provided to interested programs. The Office of Adult Services promotes and monitors the development and implementation of EBP programs and services in partnership with the University of Maryland's Evidence Based Practice Center. These include:

- **Assertive Community Treatment (ACT):** This program is designed to reduce recidivism by helping consumers to develop skills so they can live in the community. The program is customized to meet individual needs, and is delivered by a team of mental health clinicians who are available 24 hours a day.
- **Family Psycho education (FPE):** This program supports consumers and families in the recovery process by providing information on mental illness; helps to build social supports; and enhances problem solving, communications and coping skills.
- **Supported Employment (SE):** This program helps consumers secure jobs in the community that pays at least minimum wage and that anyone could secure regardless of their disability. Choices for work are based on the consumer's experiences, strengths, and preferences. Once a job is secured, the program continues to provide support to the consumer, based on her or his individual needs, to include helping the consumer to retain jobs, secure new or better jobs, and establish a career.

Case Management is governed by regulation, COMAR 10.09.45 and is located in each county. Case Management programs assist consumers in accessing a full array of mental health services and other supports, such as medical, social, financial assistance, counseling, education, and housing. The program is based on a brokerage model that supports eventual transitioning to more traditional services and supports.

Housing services are offered through the MHA-funded "Residential Rehabilitation Programs," which are homes designed to foster a consumer's ability to reside in the community following an in-patient stay in an MHA psychiatric facility. Among the available support services is psychiatric rehabilitation, which teaches life skills necessary for community living. The DHMH

sponsored “Capital Bond Program” provides annual funding for the development of additional housing units with a focus on Supported Housing. MHA along with other housing partners, including the Department of Housing and Community Development, developed pilot programs throughout the State (e.g. “Bridge Subsidy”) to promote additional affordable housing choices. Also, collaboration with local Public Housing Authorities has resulted in additional opportunities for consumers to access integrated community housing through federal programs.

The PASRR Program (Pre-Admission Screening and Resident Review) is a federal program governed by the Centers for Medicare and Medicaid Services. This program provides for a screening process to identify the psychiatric and medical needs of persons with a recent history of mental disabilities, requiring inpatient care within 2 years. It seeks to identify the most appropriate, least restrictive setting providing all necessary services for an individual, and supports nursing home placement when that is the most appropriate, least restrictive setting to meet the individual’s current treatment needs. The required evaluations are conducted by local health department professionals, and approved by the Office of Adult Services.

Interstate Compact on Mental Health facilitates the transfer back to a MHA inpatient psychiatric facility for Maryland residents who are currently “voluntary committed” to a publicly operated psychiatric facility outside of Maryland. This initiative also facilitates the transfer of an individual currently residing in a MHA psychiatric facility on a “voluntary committed” status back to an inpatient publicly operated facility in their State of residence.

Transition Age Youth (TAY) Program: Transition planning assists students with emotional disabilities as they progress through school and prepare for adult life. Transition-age services and supports are available to youth at age 16, and complement those provided by the local educational system. Services and supports are designed to prepare and facilitate achievement of their goals related to relevant transition domains, such as employment, career, educational opportunities, living situation, personal effectiveness and well-being community-life functioning.

II: Planning Steps

Step 2: Identify the unmet service needs and critical gaps within the current system.

Narrative Question:

This step should identify the data sources used to identify the needs and gaps of the populations relevant to each Block Grant within the State's behavioral health care system, especially for those required populations described in this document and other populations identified by the State as a priority.

The State's priorities and goals must be supported by a data driven process. This could include data and information that are available through the State's unique data system (including community level data) as well as SAMHSA's data set including, but not limited to, the National Survey on Drug Use and Health, the Treatment Episode Data Set, and the National Facilities Surveys on Drug Abuse and Mental Health Services. Those States that have a State Epidemiological Outcomes Workgroup (SEOW) must describe its composition and contribution to the process for primary prevention and treatment planning. States should also continue to use the prevalence formulas for adults with serious mental illness and children with serious emotional disturbances that have been historically reported. States should use the prevalence estimates, epidemiological analyses and profiles to establish substance abuse prevention, mental health promotion, and substance abuse treatment goals at the State level. In addition, States should obtain and include in their data sources information from other State agencies that provide or purchase behavioral health services. This will allow States to have a more comprehensive approach to identifying the number of individuals that are receiving behavioral health services and the services they are receiving.

In addition to in-state data, SAMHSA has identified several other data sets that are available by State through various Federal agencies such as the Center for Medicaid and Medicare Services or the Agency for Health Research and Quality. States should use these data when developing their needs assessment. If the State needs assistance with data sources or other planning information, please contact planningdata@samhsa.hhs.gov.

Footnotes:

FY 2014 – 2015 MARYLAND MENTAL HEALTH BLOCK GRANT

Section II-B: Planning Steps

STEP 2 – IDENTIFY UNMET SERVICE NEEDS AND CRITICAL GAPS WITHIN THE CURRENT SYSTEM

Strengths, Needs, and Existing Resources

Data

There are several sources of data which the MHA uses to identify unmet service needs and gaps. The ASO data systems combine MA eligibility, service authorization, and claims payment data into a rich, multi-variable database. A multitude of reports including consumer characteristics, service utilization, and expenditures can be generated. Special state reports on individuals with co-occurring illness show that they consume a disproportionate share of PMHS resources. Providers and programs proficient in working with co-occurring mental illness and substance abuse, as well as mental illness and developmental disabilities, are limited and the need far exceeds availability. All stored data can be retrieved and reported either in standard form, using an automated reporting system or by way of custom programming or ad hoc reports. The data may be formatted to produce monthly, quarterly, or fiscal reports. Maryland operates on a July-June fiscal year. Over 50 standard reports are generated to assist in general planning, policy, and decision making.

Recent discussions have centered on continuous improvement in the quality of services; assuring that services are effective, recovery focused, and consumer driven; and that those most in need are able to receive the services. Coordination of care between somatic and psychiatric sectors remains critical, and has been made evermore pressing by the publication of new reports on the morbidity and mortality of individuals with serious mental illnesses (SMI). Several strategies in the State Plan focus on the need to coordinate care between providers in the public mental health system and primary care providers in the managed care organizations responsible for the management of the primary health and mental health needs of individuals.

PMHS quarterly reports are published for public consumption on the Administration's Web site www.dhmh.state.md.us/mha. With ValueOptions® Maryland, the current ASO, MHA created standardized policy to provide Ad hoc reports requested by CSAs to aide them in responding to suggested budget cuts and methods of combating projected budget strategies. Having the detailed data readily available has helped the CSAs track cost, service utilization, and management of Medicaid reimbursements. Monthly data and information technology (IT) conference calls with the existing ASO are conducted to ensure proper execution of logic behind data reports and that all business rules are predefined. Reporting systems were fine tuned to promote ease of use. Additionally, quarterly reports and specialized data reports, as well as monthly StateStat reports are posted regularly to the Administration Web site.

In FY 2013, bi-monthly meetings were held to discuss data reports as well as trainings to help with accessing data system, and how to utilize the data for trending and analysis. Email alerts, presentations at Executive level meetings, dissemination of reports, and step-by-step instructions to access dashboard reports were provided. Efforts continue to allow for the request of county-specific raw data sets to promote the analysis and use of PMHS data to coordinate planning efforts. Additionally, technical assistance in data usage opportunities was

FY 2014 – 2015 MARYLAND MENTAL HEALTH BLOCK GRANT

expanded to the public and stakeholders outside of the MHA through the University of Maryland's, Systems Evaluation Center (SEC). The SEC provides data analysis and supports MHA system and management functions in areas of monitoring claims, eligibility and outcomes data, evaluating State Plan goals and objectives, assisting the CSAs in planning, and providing technical assistance. The SEC also assists with fulfilling reporting requirements such as Uniform Reporting System (URS), Client Level Data, and the Consumer Perception of Care Survey.

In efforts to further the PMHS system and the access of data to all stakeholders, the MHA Office of Management Information Systems (MIS) heads two monthly data-centered meetings. Representatives from MHA's MIS office and the Office of Planning and Training are present, as well as ASO, SEC and CSA members. The monthly meetings are used as a vehicle to filter data-specific information to all interested stakeholders, review and approve standard reports, and allow committee members the opportunity to make suggestions for the overall enhancement of the PMHS data system.

The Outcomes Measurement System (OMS) Public Web-based Datamart provides outcomes data at the Statewide and county-specific level for individuals ages 6-64 in the public mental health system outpatient treatment services. Clinicians conduct OMS interviews, which include various life domains, at intake and approximately every six months. The OMS process is required for authorization of outpatient services. In the OMS Datamart, two types of aggregated data analysis are presented:

- Results of individuals' most recent interview (point in time); and
- Comparison of the individuals' initial and most recent interviews (change over time).

The OMS Datamart is available to the general public. Providers and CSAs have access to program level data for program planning and system management.

Additionally, Data Shorts, a new project released by the MHA in collaboration with the SEC, provide concise behavioral health data and analysis that can be used by the various stakeholders. The aim of Data Shorts is to provide the reader with data related to behavioral health efforts scheduled throughout the fiscal year. For example, September has been designated by SAMHSA as Recovery Month. The debut issue of Data Shorts was related to MHA's OMS and Recovery. Other issues include data on suicide, smoking, legal issues and consumer perception of care and wellness. Distribution of the Data Shorts is available via the MHA and Department's Website, and Tweeter account. <http://dhmh.maryland.gov/mha>

FY 2014 – 2015 MARYLAND MENTAL HEALTH BLOCK GRANT

STEP 3 - PRIORITIZE STATE PLANNING ACTIVITIES

Maryland's Mental Hygiene Administration (MHA) State Mental Health Planning Process: The MHA's Office of Planning and Training is responsible for the development, implementation and oversight of the State, local and federal planning activities. Each year an extensive plan development process is implemented beginning in January with the submission, to the MHA, of local mental health plans and budgets from the Core Service Agencies (CSAs). The CSA Plan and Budget guidelines are generated through the MHA's Office of Planning and Training to guide the development of local plans in identify priorities, strengths, needs and service gaps of the local public mental health system as well as a description of stakeholder input.

Also, The MHA facilitates an annual plan development meeting in April for stakeholders throughout Maryland. This meeting includes a broad participation of stakeholders including representatives from consumer and family organizations, mental health advocacy organizations, CSAs, local mental health advisory committees, and members of the MHA Management Committee. Additionally, Maryland Advisory/Planning Council (Joint Council) is actively involved in the development of the State Mental Health Plan and the federal Mental Health Block Grant Application. This year, in an effort to enhance our planning process and discussions on health care reform implementation, representatives from the DHMH Alcohol and Drug Abuse Administration (ADAA), Developmental Disabilities Administration (DDA), and Federally Qualified Health Centers (FQHCs) were invited and participated in the planning activities. Also included were representatives of the Maryland Blue Print for Children's Mental Health to focus on child, adolescents and youth issues. This entity was established by a Maryland Family organization and is an ongoing strategic planning effort rooted in the broader public health approach to mental health, including promotion, prevention, and early intervention. Breakout groups engaged in discussion points on the six goals in the State Plan and identified recommendations for strategies for the FY 2014 Plan and Mental Health Block Grant.

During the process of updating and drafting the goals, objectives, and strategies for the FY 2014 State Mental Health Plan, MHA staff, advocates, and all involved parties reviewed the goals and recommendations. Many of the key goals and strategies in the final report are fundamental concepts in the Mission, Vision, and Values of Maryland's PMHS. All are covered in some aspect of the State Mental Health Plan, as we continue our efforts to promote recovery and resilience, implement evidence-based services, and cultivate a consumer and family driven system in which one's ethnic and cultural background is respected. Maryland takes pride in developing and delivering state-of-the art mental health services and will continue to do so while remaining fiscally and clinically responsible.

One of Maryland's priorities for the PMHS is the need to maintain continuity and access of services and to continue improvement in the delivery of prevention, treatment, and recovery support services. Additionally, MHA has continued to organize its FY 2014 plan activities based on the Substance Abuse and Mental Health Services Administration (SAMHSA's) Eight Strategic Initiatives.

Overview of the State's Public Behavioral Health System – Mental Health Services

The Mental Hygiene Administration (MHA) is the agency within the Department of Health and Mental Hygiene responsible for the oversight of public mental health services in Maryland. Maryland operates the majority of its public mental health system under a Medicaid 1115 waiver. The waiver permits the Secretary of DHMH to require that all Medical Assistance (MA) recipients, except certain exempted populations, be enrolled in and receive their somatic care through managed care organizations (MCOs). Waiver-eligible Medical Assistance recipients are enrolled in MCOs under Maryland's HealthChoice program. Under the terms of the waiver, MCOs receive a capitated rate for providing somatic care, substance abuse treatment, and primary mental health care to enrollees. Primary mental health services, as defined by the enabling legislation, means the clinical evaluation and assessment of mental health services needed by an individual and the provision of services or referrals for mental health services as deemed medically appropriate by a primary care provider. Both the MCOs and MHA are required to assure that somatic care and substance abuse treatments are coordinated with mental health care.

Under Maryland's 1115 Medicaid waiver, a redesigned public mental health system (PMHS) was conceptualized. Specialty mental health services - those mental health services that are beyond primary mental health services - are delivered through a "carve-out" arrangement that manages public mental health funds under a single payor system. The system serves Medicaid recipients and a subset of uninsured individuals who meet medical necessity criteria and financial and/or other specific criteria. The cost of mental health services is subsidized, in whole or in part with State general funds. Medically necessary mental health services are delivered to eligible individuals of all ages through the PMHS.

Prior to the waiver, MHA administered all State funds allocated to it by the legislature for mental health services as well as some federal grant funds, but only a portion of the State and federal Medicaid dollars, specifically money that paid for services under the Medicaid clinic, rehabilitation and targeted case management options. Through implementation of the public mental health system, July 1997, MHA began to administer all State and federal, including Medicaid, funds related to mental health services. Coverage includes both Medicaid recipients and the uninsured population. In FY 2012, 145,550 people of all ages received mental health services.

The PMHS is managed in collaboration with the Core Service Agencies (CSAs) and the Administrative Services Organization (ASO). The CSAs are entities at the local level that have the authority and responsibility, in collaboration with MHA, to develop and manage a coordinated network of Maryland's public mental health services in a defined service area. In September 2009, MHA began a five year contract with ValueOptions, Inc., the new ASO, for Maryland's PMHS, referred to as ValueOptions® Maryland. The major responsibilities of Value Options include: access to services, utilization management, data collection and management information services, claims processing and payment, evaluation services, and stakeholder feedback. The goal of the system is to provide the benefits of the coordination of managed care, while preserving access to a comprehensive array of services, flexibility, and choice.

From the time of admission, facilities work collaboratively with CSAs, community providers, consumers, and families toward patient discharge. The focus is on returning the individual to the lowest level of care necessary to meet the individual's medical needs. The State psychiatric hospitals are participants, along with the acute general hospitals and the private psychiatric hospitals, in the provision of psychiatric inpatient care in Maryland. MHA currently operates six inpatient psychiatric facilities that provide intermediate and long-term care for adults. Springfield Hospital Center offers inpatient care for individuals who are deaf or hard of hearing. In addition, MHA operates one psychiatric forensic facility and two residential treatment facilities for youth known as Regional Institutes for Children and Adolescents (RICAs

MHA recognizes that individuals with serious mental illnesses (SMI) and serious emotional disturbances (SED) often require services that are provided by other State departments and administrations, such as the State Department of Education, the Division of Rehabilitation Services, the State Department on Aging, the Governor's Office for Children, the State Department of Human Resources, the State Department of Juvenile Services, the State Department of Housing and Community Development, and other administrations within the Department of Health and Mental Hygiene. To ensure adequate access to those services, MHA maintains interagency agreements, and designated liaisons with those agencies, as well as many others. Through Maryland's Mental Health Transformation State Incentive Grant, two Children's Mental Health Initiative grants (Systems of Care grants), and a Community Alternatives to Psychiatric Residential Treatment Facilities Medicaid demonstration waiver, these interagency collaborations and partnerships continue to be solidified while new ones will be formed to further build the infrastructure to coordinate care and improve service systems.

As previously stated, Core Service Agencies (CSAs) are the entities at the local level that have the authority and responsibility to develop and manage a coordinated network of Maryland's public mental health services in a defined service area. There are nineteen (19) CSAs covering all 24 jurisdictions. CSAs are agents of county or city government and may be county departments, quasi-government bodies, or private non-profit corporations. They vary in size, needs, budgets, and budget sources. CSAs are the administrative, program, and fiscal authority which are responsible for assessing local service needs and planning the implementation of a comprehensive mental health delivery system that meets the needs of eligible individuals of all ages.

MHA and CSAs share responsibilities in the PMHS. Together, they are responsible for determining the criteria for utilization management, establishing performance standards, and evaluating appropriateness and effectiveness of service. Additionally, CSAs are important points of contact for both consumers and providers in the PMHS and develop partnerships with other local, state and federal agencies. CSAs provide numerous public education events and trainings. They are responsible for processing complaints, grievances, and appeals, as well as for monitoring the contract with the ASO and reporting findings to MHA. Additionally, local mental health advisory committees and CSA Boards have the opportunity and responsibility to advise CSAs regarding the PMHS and to participate in the development of local mental health plans and budgets.

The Maryland Association of Core Service Agencies, (MACSA) Inc., was established to promote and support the effectiveness of each CSA in Maryland to plan, monitor and manage its local, publicly-funded mental health service system. Each fiscal year MHA requires that CSAs develop and report on their progress in identifying and meeting local needs and State priorities. Additionally, CSA representatives participate on the Maryland Advisory Council on Mental Hygiene/Planning Council and various MHA committees such as the Finance Committee and the Clinical Committee which promote direct involvement with PMHS issues. Also, the CSAs work closely with the MHA Management Information System (MIS) staff on the Data Committee to generate and disseminate data that is useful to the CSAs as they support initiatives and services that are the most beneficial for the public they serve.

LOCAL MENTAL HEALTH/BEHAVIORAL HEALTH AUTHORITIES (CORE SERVICE AGENCIES -CSAS) IN MARYLAND

JURISDICTION	TITLE OF CSA	ORGANIZATIONAL LOCUS	DIRECTOR LOCATION
Allegany County	Allegany County Mental Health Systems	Part of County Health Department	Lesia Diehl Cumberland MD
Anne Arundel County	Anne Arundel Co. Mental Health Agency, Inc.	Private - Non-Profit	Adrienne Mickler Annapolis MD
Baltimore City	Baltimore Mental Health Systems, Inc.	Private- Non-Profit	Bernard McBride Baltimore MD
Baltimore County	Baltimore Co. Dept of Health, Bureau of Mental Health	Part of County Health Department	David Goldman Towson MD
Calvert County	Calvert County Health Department Core Service Agency	Part of County Health Department	Julie Ohman Prince Frederick MD
Carroll County	Carroll County Core Service Agency	Part of County Health Department	Sarah Hawkins Westminster MD
Cecil County	Cecil County Mental Health Department Core Service Agency	Part of County Health Department	Shelly Gullede Elkton MD
Charles County	Charles County Human Services Partnership	Part of County Health Department	Karyn Black LaPlata MD
Frederick County	Mental Health Management Agency of Frederick County, Inc.	Private - Non Profit	Robert Pitcher Frederick MD
Garrett County	Mountain Top Mental Health Associates, Inc.	Part of County Health Department	Fred Polce Oakland MD
Harford County	Core Service Agency of Harford County	Private - Non-Profit	Terry Farrell Bel Air MD
Howard County	Howard Co. Mental Health Authority	Quasi-Governmental	Donna Wells Columbia MD
Mid-Shore: Kent,	Mid-Shore Mental Health Systems, Inc.	Private - Non-Profit	Holly Ireland

Caroline, Queen Anne's, Talbot, Dorchester Counties			Easton MD
Montgomery County	Montgomery County, Department of Health and Human Services, Mental Health Core Service Agency	Part of County Government	Raymond Crowel Rockville MD
Prince George's County	Prince George's Co. Dept. of Family Services, Mental Health Authority Division	Part of County Department of Family Services	L. Christina Waddler Hyattsville MD
St. Mary's County	Mental Health Authority of St. Mary's Co., Inc.	Part of County Health Department	Cynthia Brown Leonardtwn MD
Washington County	Washington County Mental Health Authority, Inc.	Private - Non-Profit	Rick Rock Hagerstown MD
Wicomico/Somerset Counties	Wicomico-Somerset County Regional Core Service Agency	Part of County Health Department	Heather Brown Salisbury MD
Worcester County	Worcester County Core Service Agency	Part of County Health Department	Jennifer LaMade Snow Hill MD

Role of the State Mental Health Agency

Mental Hygiene Administration (MHA) recognizes the importance of promoting mental health within the broader system. MHA staff have active liaisons with other State agencies, participate in other agency workgroups, and advocate for the availability of services offered in the broader system to persons with psychiatric disabilities. MHA Executive Director, Brian Hepburn, M.D. received awards and recognition from the Maryland Rehabilitation Association for his contributions to the rehabilitation of persons with disabilities and was also presented a public service award by NAMI Maryland for his support for NAMI programs and the organization's participation in state mental health issues.

Maryland's DHMH Secretary has been the visionary lead for the Mental Health First Aid© (MHFA) program. In collaboration with the Missouri Department of Mental Health and the National Council for Behavioral Healthcare, the Mental Health Association of Maryland, and On Our Own of Maryland (OOOMD), MHA has adopted the Australian-based program to educate the general public to recognize signs of an emerging mental illness or a mental health crisis. Maryland has been instrumental in adapting the MHFA curriculum for American audiences (the original MHFA program was developed in Australia) and setting the instructor standards to ensure educational fidelity to the program. Maryland's efforts are led by the Mental Health Association of Maryland (MHAMD) charged with producing and distributing the materials nationally as well as managing the training program in Maryland.

Since its inception more than 5,300 Maryland residents have been certified to provide MHFA. In FY 2013, 78 MHFA trainings were conducted, certifying more than 1,300 Marylanders. In addition, more than 120 instructors are now certified in Maryland. Since the official launch of the program in late 2009, almost 113,000 participant manuals and over 2,300 instructor kits have been distributed nationally. During the FY 2013, the MHAMD added closed captioning in English and Spanish to the DVDs included in the teaching kits to help ensure accessibility. A comprehensive Youth Mental Health First Aid program, for adults who work with youth, was launched in-state in FY 2013 and was offered in early FY 2014.

MHA continues to forge strong relationships with agencies responsible for housing and employment opportunities in order to create greater access to their programs. MHA has taken the lead in reaching out to the Department of Public Safety and Correctional Services to initiate, sustain, and identify potential collaborations. MHA's work with Medical Assistance, which is the major financier of the mental health system, helps that organization remain attuned to mental health needs. MHA works with other leaders from community provider associations to address workforce issues through revisions to the PMHS rate structure and collaborates with professional associations and state regulators to maintain the quality of the workforce.

II: Planning Steps

Table 1 Step 3,4: -Priority Area and Annual Performance Indicators

Priority #:	1
Priority Area:	Public Awareness and Education – Mental Health First Aid-Training
Priority Type:	MHP
Population (s):	Other (Adolescents w/SA and/or MH, Students in College, LGBTQ, Rural, Military Families, Criminal/Juvenile Justice, Persons with Disabilities, Children/Youth at Risk for BH Disorder, Homeless, all)
Goal of the priority area:	
	Increase public awareness and support for improved health and wellness
Strategies to attain the goal:	
	MHA, in collaboration with the Department of Health and Mental Hygiene (DHMH), the Missouri Department of Health, the National Council for Community Behavioral Health, and the Mental Health Association of Maryland, Inc. (MHAMD) will continue implementation of the Mental Health First Aid-USA (MHFA USA) initiative for adults and youth in Maryland and throughout the United States. (Year 1 and Year 2)
Annual Performance Indicators to measure goal success	
Indicator #:	1
Indicator:	• Number of people trained
Baseline Measurement:	5000 Marylanders Certified/Trained in MHFA and 235 Credentialed Instructors
First-year target/outcome measurement:	1750 Certified/Trained and 100 Credentialed Instructors
Second-year target/outcome measurement:	1750 Certified/Trained and 100 Credentialed Instructors
Data Source:	
	Training activity reports

Description of Data:

Number of Completed training; Number of Credentialed Instructors

Data issues/caveats that affect outcome measures::

training cancellations due to low registration numbers

Priority #: 2

Priority Area: Recovery Supports

Priority Type: MHP

Population Other

(s):

Goal of the priority area:

Increase public awareness and support for improved health and wellness

Strategies to attain the goal:

MHA, in collaboration with Alcohol and Drug Abuse Administration (ADAA), On Our Own of Maryland (OOOMD), and other key staff will continue to support statewide activities to further enhance peer recovery supports, utilizing best practices within the consumer movement.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Development of a Peer Credentialing Model in Maryland through utilization of the SAMHSA Bringing Recovery Supports to Scale Technical Assistance (BRSS TACS) Policy Academy Award (a funding source to support coordinated efforts to adopt recovery-oriented systems of care on a broad scale)

Baseline Measurement: n/a

First-year target/outcome measurement: Recruit and train peer recovery providers

Second-year target/outcome measurement: Explore requirements to obtain Medicaid reimbursement for peer recovery support services

Data Source:

BRSS TACS Strategic Action Plan/Logic Model, Research and Development process for Medicaid reimbursement, Research Institute for Peer Certification

Description of Data:

Bi-monthly reports, tracking sheets, documentation of project activities

Data issues/caveats that affect outcome measures::

Maryland's Behavioral Health Integration process and ACA implementation may effect timelines for achieving outcomes

Priority #: 3

Priority Area: Tobacco/Smoking Cessation

Priority Type: MHP

Population Other (Adolescents w/SA and/or MH)

(s):

Goal of the priority area:

Promote a system of integrated care where prevention of substance abuse and mental illness are common practice across the life span

Strategies to attain the goal:

MHA, in collaboration with ADAA, the MDQuit Center of the University of Maryland/Baltimore County (UMBC), consumers, providers, the CSAs, and other stakeholders, will continue to promote and implement behavioral health and wellness initiatives regarding smoking cessation and related activities toward the reduction of early mortality rates in Maryland. (Year 1 and Year 2)

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Reduce tobacco use among individuals with behavioral health disorders
Baseline Measurement:	Percentage of adults receiving outpatient mental health treatment who report smoking during their most recent interview
First-year target/outcome measurement:	By end of FY 2014, the average adults receiving outpatient mental health treatment who report smoking will be less than 50%

Second-year target/outcome measurement: By end of FY 2015, the average adults receiving outpatient mental health treatment who report smoking will be less than 50%

Data Source:

*Outcomes Measurement System (OMS), Maryland State Stat, Data Shorts Analysis

Description of Data:

The Outcomes Measurement System (OMS) Public Web-based Datamart provides outcomes data at the Statewide and county-specific level for individuals ages 6-64 in the public mental health system outpatient treatment services. Clinicians conduct OMS interviews, which include various life domains, at intake and approximately every six months. The OMS process is required for authorization of outpatient services. In the OMS Datamart, two types of aggregated data analysis are presented:

- Results of individuals' most recent interview (point in time); and
- Comparison of the individuals' initial and most recent interviews (change over time).

*Rolling 12 months data are reported monthly and are based on OMS data that includes the previous 12 months with a 30 day lag

Data issues/caveats that affect outcome measures::

none at this time

Indicator #:

2

Indicator:

Reduce tobacco use among adolescents with behavioral health disorders.

Baseline Measurement:

First-year target/outcome measurement:

By the end of FY 2014, the average of adolescents receiving mental health treatment who report smoking will be less than 10%

Second-year target/outcome measurement:

By the end of FY 2015, the average of adolescents receiving mental health treatment who report smoking will be less than 10%

Data Source:

Outcome Measurement System (OMS), Maryland State Stat, Data Shorts Analysis

Description of Data:

The Outcomes Measurement System (OMS) Public Web-based Datamart provides outcomes data at the Statewide and county-specific level for individuals ages 6-64 in the public mental health system outpatient treatment services. Clinicians conduct OMS

interviews, which include various life domains, at intake and approximately every six months. The OMS process is required for authorization of outpatient services. In the OMS Datamart, two types of aggregated data analysis are presented:

- Results of individuals' most recent interview (point in time); and
- Comparison of the individuals' initial and most recent interviews (change over time).

*Rolling 12 months data are reported monthly and are based on OMS data that includes the previous 12 months with a 30 day lag

Data issues/caveats that affect outcome measures::

none at this time

Priority #: 4

Priority Area: Behavioral Workforce Development

Priority Type: MHP

Population Other (Behavioral Health Professionals)

(s):

Goal of the priority area:

Provide coordinated approach to increase employment and promote integration of services and training to develop and sustain an effective behavioral health workforce.

Strategies to attain the goal:

STRATEGY 1: MHA, in collaboration with ADAA and Developmental Disabilities Administration (DDA), will act as the lead DHMH Behavioral Health Workforce Consortium and the central repository of workforce development training and information. (Year 1) STRATEGY 2: MHA, in collaboration with the Maryland State Department of Education (MSDE), the Maternal and Child Health Bureau, the Maryland Early Childhood Mental Health Steering Committee, the University of Maryland, and other stakeholders continue to build infrastructure and workforce development initiatives to support the delivery of high quality mental health promotion, prevention, early intervention, and treatment services for young children and their families. (Year 1 and 2) STRATEGY 3: MHA, in collaboration with ADAA, will continue to enhance workforce development by expanding the involvement of Peer Support Specialists in behavioral health integration. (Year 1)

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Develop a work plan to guide workforce development efforts in the public behavioral health system.

Baseline Measurement: Mapping of existing Behavioral Health Workforce Initiatives/Activities Statewide

First-year target/outcome measurement: Assessment of knowledge and training of behavioral health providers for transition to behavioral health system of care

Second-year target/outcome measurement: Workplan developed on best approaches to cultivate and train behavioral health professionals, including Peer Support / Recovery Specialists

Data Source:

Recommendations from resources: Health Care 2020 - Governor's Workforce Investment Board; Mapping of the DHMH Behavioral Health Workforce;

Description of Data:

Recommendations from resources: Health Care 2020 - Governor's Workforce Investment Board; Mapping of the DHMH Behavioral Health Workforce;

Data issues/caveats that affect outcome measures::

Maryland's Behavioral Health Integration process and implementation of the Affordable Care Act may effect timelines for achieving outcomes.

Indicator #: 2

Indicator: Support the implementation of SAMHSA funded Project LAUNCH and utilize implementation data to modify and sustain strategies and support policy reform, workforce development and public awareness initiatives.

Baseline Measurement: N/A

First-year target/outcome measurement: Implementation data from the SAMHSA funded National Evaluation of project and local Maryland evaluation

Second-year target/outcome measurement: Implementation data from the SAMHSA funded National Evaluation of project and local Maryland evaluation

Data Source:

University of Maryland, School of Social Work evaluation and data analysis; Social and Emotional Foundations for Early Learning (SEFEL) - Maryland Early Childhood Mental Health Certificate Program Implementation data; Coordination of existing data/resources

Description of Data:

Data protocols not yet established

Data issues/caveats that affect outcome measures::

Data elements of the National evaluation must be approved by SAMHSA and are subject to Institutional Review Board (IRB) approval by both the Department and the University

Priority #: 5

Priority Area: Suicide Prevention

Priority Type: MHP

Population SMI, SED, Other (LGBTQ, Military Families)

(s):

Goal of the priority area:

Promote a system of integrated care where prevention of substance abuse and mental illness are common practice across the life span.

Strategies to attain the goal:

Increase and broaden the public's awareness of suicide, its risk factors, and its place as a serious and preventable public health concern. MHA, in collaboration with CSAs and other stakeholders, will continue efforts to address and implement suicide prevention/intervention/postvention activities for youth, adults, and older adults. (Year 1 and 2)

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Enhance the use and capacity of suicide prevention hotlines, implement evidence based and promising practices; Establish a baseline listing of existing services and supports across prevention, intervention and post-vention (attempters and survivors)
Baseline Measurement:	Maryland Suicide rate (number of deaths due to suicide in a year) - In FY 2010 - 505
First-year target/outcome measurement:	Maryland rate decreased.
Second-year target/outcome	Maryland's rate decreased.

measurement:

Data Source:

Maryland Vital Statistics, U.S. Census Bureau, Maryland Suicide Prevention Hotlines

Description of Data:

September was set aside as Suicide Awareness and Prevention month by the US Military and October is Suicide Prevention Month in Maryland.

Data will be examined on recent Maryland and National suicide rates.

Data issues/caveats that affect outcome measures::

Priority #: 6

Priority Area: Co-Occurring Disorders – Promotion of Dual Diagnosis Capability/Training

Priority Type: MHP

Population SMI, SED

(s):

Goal of the priority area:

Promote a system of integrated care where prevention of substance abuse and mental illness are common practice across the life span.

Strategies to attain the goal:

STRATEGY 1: In collaboration with DHMH, continue to provide training, technical assistance, and consultation to promote Dual Diagnosis Capability (DDC) in mental health treatment. STRATEGY 2: Plan a system of integrated behavioral health promotion, prevention, and treatment services for children, youth, and young adults who are at risk for, or have mental health and/or substance abuse disorders. (Year 1)

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Ongoing consultation to jurisdictions and programs on improved integration of services for the COD population; ongoing training for behavioral health providers on scientifically validated screening and assessment tools, and on empirically supported behavioral health interventions, for the COD population

Baseline Measurement: n/a

First-year target/outcome measurement: Number of trainings and consultations provided to jurisdictions/programs on integrated care; number of behavioral health providers received training.

Second-year target/outcome measurement: Number of trainings and consultations provided to jurisdictions/programs on integrated care; number of behavioral health providers received training.

Data Source:

Tracking grid of DDC training, Bi-annual reports

Description of Data:

Quarterly and Bi-annual reporting on COD/DDC activities with behavioral health providers

Data issues/caveats that affect outcome measures::

Priority #: 7

Priority Area: Access to Services for Children and Adults

Priority Type: MHS

Population Other
(s):

Goal of the priority area:

To maintain access to public mental health services for eligible individuals with mental illness.

Strategies to attain the goal:

STRATEGY 1: In collaboration with CSAs and stakeholders, monitor the ASO contractual obligations and performance, monitor the system's growth and expenditures, identify problems, and, as needed, provide corrective action and maintain an appropriate level of care.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Monitor access to public mental health services.

Baseline Measurement: Number of children and adults served in the public mental health system

First-year target/outcome measurement: Number of children and adolescents served; number of adults served

Second-year target/outcome measurement: Number of children and adolescents served; number of adults served

Data Source:

Maryland PMHS Data - Administrative Services Organization, PMHS quarterly reports, special reports

Description of Data:

The ASO data systems combine MA eligibility, service authorization, and claims payment data.

Data issues/caveats that affect outcome measures::

Indicator #: 2

Indicator: Financing approach identified for populations served by Care Management Entities (CMEs)

Baseline Measurement: CMEs have been funded through the PRTF 1915i waiver demonstration project, which has ended

First-year target/outcome measurement: Submission of a 1915(i) State Plan Amendment (SPA) to CMS for the provision of Care Coordination Organizations (CCOs)

Second-year target/outcome measurement: Implementation of the approved 1915(i) SPA to CMS for the provision of CCOs

Data Source:

Documents, MMIS, Administrative Services Organization (ASO) for behavioral health system

Description of Data:

After approval of the SPA, utilization and financial data for CCO will be available after implementation

Data issues/caveats that affect outcome measures::

The SPA is subject to CMS approval and availability of funding.

Priority #: 8

Priority Area: Access to Services for Special Populations

Priority Type: MHS

Population Other

(s):

Goal of the priority area:

Work collaboratively to effectively serve individuals with serious mental illness and other special needs

Strategies to attain the goal:

STRATEGY 1: Provide training and consultative services to providers of forensic services who work with individuals residing in the community on conditional release from the Mental Hygiene Administration (MHA) and, the Developmental Disabilities Administration (DDA) facilities. STRATEGY 2: Continue to expand the Supplemental Security Income/ Social Security Disability Insurance (SSI/SSDI) Outreach, Access, and Recovery (SOAR) program statewide to further develop an integrated behavioral health model to improve access to services. STRATEGY4: MHA's Office of Special Needs Populations, in collaboration with the Core Service Agencies, local detention centers, DHMH, DPSCS's criminal justice team, and other key stakeholders, will develop and implement new practices to provide cost effective, coordinated, and recovery-oriented services to individuals who have mental illnesses or co-occurring substance abuse disorders who are incarcerated in local detention centers or prisons. (Year 1 and Year 2).

Annual Performance Indicators to measure goal success

Indicator #:

1

Indicator:

Develop training designed to educate providers on psychiatric diagnoses "triggers/symptoms of relapse, departmental policies and procedures and strategies to reduce the recidivism of individuals residing in the community to MHA and/or DDA facilities.

Baseline Measurement:

N/A

First-year target/outcome measurement:

Training developed, provider linkages established

Second-year target/outcome measurement:

Training developed, provider linkages established

Data Source:

Monthly reports on training efforts. Data that is collected by the Community Forensic After Care Program (CFAP) assists in future

training activities and gauging the numbers of positive placements and outcomes.

Description of Data:

The Community Forensic After Care Program (CFAP) is training providers of service who work with individuals on conditional release. CFAP staff discusses expectations with the providers as well as requirements, i.e., submission of monthly progress notes, ensuring individuals attend appointments, notifying CFAP of elopements and other violations of conditions, etc. CFAP also trains staff on some of the antecedent behaviors that cause an individual to decompensate and, possibly return to the hospital.

The goal for the training is to educate providers of service of contractual obligations and expectations and, to reduce the number of individuals in the community from being returned to the public mental health hospitals.

Data issues/caveats that affect outcome measures::

Indicator #:	2
Indicator:	Number of individuals assisted with benefit applications using the Supplemental Security Income/ Social Security Disability Insurance (SSI/SSDI) Outreach, Access, and Recovery (SOAR) processed
Baseline Measurement:	Number of existing SOAR sites; number of existing SOAR certified providers
First-year target/outcome measurement:	Increase SOAR sites developed; SOAR certification expanded
Second-year target/outcome measurement:	Increase SOAR sites developed;SOAR certification expanded

Data Source:

Monthly Data SOAR Summary Reports

Description of Data:

Site Training on SOAR; Data collected on applications processed and completed, number of decisional SOAR cases; average processing times; number of providers holding certificates

Data issues/caveats that affect outcome measures::

Indicator #: 3

Indicator: Implementation of Second Chance Grant for 75 individuals with co-occurring disorders transitioning from prison to the community

Baseline Measurement: N/A

First-year target/outcome measurement: Percentage of participants who complete the program; rate of recidivism for program participants

Second-year target/outcome measurement: Percentage of participants who complete the program; rate of recidivism for program participants

Data Source:

Consumer interviews, Evaluation/data analysis, Provider progress reports

Description of Data:

Data will be collected from provider and evaluation conducted. Data and report will include key measures on participants completion of program, unsuccessful exits, rate of recidivism.

Data issues/caveats that affect outcome measures::

Priority #: 9

Priority Area: Evidence-Based Practices

Priority Type: MHS

Population Other
(s):

Goal of the priority area:

Utilize data and health information technology to evaluate, monitor, and improve the quality of PMHS services and outcomes

Strategies to attain the goal:

STRATEGY 1: Continue, in collaboration with the University of Maryland, CSAs, and key stakeholders, statewide implementation of evidence-based practice (EBP) models in supported employment, assertive community treatment, and family psycho-education; also explore pilot implementation of Integrated Illness Management and Recovery (IIMR) program. (Year 1 and Year 2)

STRATEGY 2: MHA, in conjunction with Baltimore Mental Health Systems, Inc. (BMHS) and the University of Maryland Systems Evaluation Center (UMD SEC), will produce preliminary outcome data reports from the administration of the Assertive Community Treatment (ACT) protocol. (Year 1 and Year 2)

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of individuals receiving Supported Employment services

Baseline Measurement: Number received SE in FY 2012 - 3,056; FY 2013 - 3,076

First-year target/outcome measurement: Number of individuals receiving EBP SE

Second-year target/outcome measurement: Number of individuals receiving EBP SE

Data Source:

PMHS Data, URS Tables

Description of Data:

PMHS Claims data
Supported Employment is provided through 57 approved community mental health provider sites. Forty of which have received EBP training and technical assistance on implementation of EBP, and 23 of which currently meet EBP SE fidelity standards.

Data issues/caveats that affect outcome measures::

Indicator #: 2

Indicator: Number of individuals receiving Assertive Community Treatment (ACT/Mobile Treatment services

Baseline Measurement: Number received mobile treatment: FY 2012-3,000; FY 2013- 3,421

First-year target/outcome measurement: Number of individuals receiving EBP ACT

Second-year target/outcome measurement: Number of individuals receiving EBP ACT

Data Source:

PMHS Data; URS tables, bi-annual reports

Description of Data:

Mobile Treatment is the program model in Maryland which resembles assertive community treatment. Regulations require the delivery of clinical and case management services and the availability of multi-disciplinary staff, preferably in a team approach. PMHS Claims Data, monthly/quarterly data reports. There are 27 mobile treatment programs serving adults, 16 are EBP ACT.

Data issues/caveats that affect outcome measures::

N/A

Indicator #:

3

Indicator:

Production and analysis of outcome data of ACT

Baseline Measurement:

During FY 2013 (pilot year of this project), 100% of programs (n=17) submitted outcome reports for every month

First-year target/outcome measurement:

First data analysis completed

Second-year target/outcome measurement:

First data analysis completed

Data Source:

Outcome reports from the Core Service Agency and MHA

Description of Data:

Assertive Community Treatment (ACT) quarterly reports based on monthly data collected and provided to the Systems Evaluation Center (SEC), data analyzed by SEC, strategies developed for future planning and EBP implementation.

Data issues/caveats that affect outcome measures::

footnote:



III: Use of Block Grant Dollars for Block Grant Activities

Table 2 State Agency Planned Expenditures

Planning Period - From 07/01/2013 to 06/30/2014

Activity (See instructions for using Row 1.)	A. Substance Abuse Block Grant	B. Mental Health Block Grant	C. Medicaid (Federal, State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other
1. Substance Abuse Prevention* and Treatment							
a. Pregnant Women and Women with Dependent Children*							
b. All Other							
2. Substance Abuse Primary Prevention							
3. Tuberculosis Services							
4. HIV Early Intervention Services							
5. State Hospital			\$	\$	\$	\$	\$
6. Other 24 Hour Care		\$	\$211,281,978	\$	\$37,131,535	\$	\$
7. Ambulatory/Community Non -24 Hour Care		\$	\$477,866,295	\$	\$100,849,333	\$	\$
8. Mental Health Primary Prevention		\$	\$	\$	\$	\$	\$
9. Mental Health Evidenced- based Prevention and Treatment (5% of total award)		\$563,214	\$	\$	\$	\$	\$
10. Administration (Excluding Program and Provider Level)		\$149,147	\$	\$	\$	\$	\$
11. Total	\$	\$712,361	\$689,148,273	\$	\$137,980,868	\$	\$

* Prevention other than primary prevention

footnote:

These expenditures relate to Fee for Service expenditures budgeted for 7/1/2013 - 6/30/2015. Medicaid expenditures include both Federal and State Expenditures for Medical Assistance consumers. The Medicaid Expenditure information is for FY2014 only, as it is expected that these expenditures are being transferred to another agency in FY 2015.

III: Use of Block Grant Dollars for Block Grant Activities

Table 3 State Agency Planned Block Grant Expenditures by Service

Planning Period - From 07/01/2013 to SFY 06/30/2015

Service	Unduplicated Individuals	Units	Expenditures
Healthcare Home/Physical Health			\$
Specialized Outpatient Medical Services			\$
Acute Primary Care			\$
General Health Screens, Tests and Immunizations			\$
Comprehensive Care Management			\$
Care coordination and Health Promotion			\$
Comprehensive Transitional Care			\$
Individual and Family Support			\$
Referral to Community Services Dissemination			\$
Prevention (Including Promotion)			\$
Screening, Brief Intervention and Referral to Treatment			\$

Brief Motivational Interviews			\$
Screening and Brief Intervention for Tobacco Cessation			\$
Parent Training			\$
Facilitated Referrals			\$
Relapse Prevention/Wellness Recovery Support			\$
Warm Line			\$
Substance Abuse (Primary Prevention)			\$
Classroom and/or small group sessions (Education)			\$
Media campaigns (Information Dissemination)			\$
Systematic Planning/Coalition and Community Team Building(Community Based Process)			\$
Parenting and family management (Education)			\$
Education programs for youth groups (Education)			\$
Community Service Activities (Alternatives)			\$
Student Assistance Programs (Problem Identification and Referral)			\$
Employee Assistance programs (Problem Identification and Referral)			\$

Community Team Building (Community Based Process)			\$
Promoting the establishment or review of alcohol, tobacco, and drug use policies (Environmental)			\$
Engagement Services			\$906,223
Assessment			\$293,929
Specialized Evaluations (Psychological and Neurological)			\$372,294
Service Planning (including crisis planning)			\$
Consumer/Family Education			\$180,000
Outreach			\$60,000
Outpatient Services			\$
Evidenced-based Therapies			\$
Group Therapy			\$
Family Therapy			\$
Multi-family Therapy			\$
Consultation to Caregivers			\$
Medication Services			\$2,550

Medication Management			\$2,550
Pharmacotherapy (including MAT)			\$
Laboratory services			\$
Community Support (Rehabilitative)			\$264,245
Parent/Caregiver Support			\$19,246
Skill Building (social, daily living, cognitive)			\$
Case Management			\$54,999
Behavior Management			\$190,000
Supported Employment			\$
Permanent Supported Housing			\$
Recovery Housing			\$
Therapeutic Mentoring			\$
Traditional Healing Services			\$
Recovery Supports			\$85,000
Peer Support			\$85,000
Recovery Support Coaching			\$

Recovery Support Center Services			\$
Supports for Self-directed Care			\$
Other Supports (Habilitative)			\$236,086
Personal Care			\$61,335
Homemaker			\$
Respite			\$56,731
Supported Education			\$
Transportation			\$5,600
Assisted Living Services			\$112,420
Recreational Services			\$
Trained Behavioral Health Interpreters			\$
Interactive Communication Technology Devices			\$
Intensive Support Services			\$208,562
Substance Abuse Intensive Outpatient (IOP)			\$
Partial Hospital			\$

Assertive Community Treatment			\$
Intensive Home-based Services			\$62,000
Multi-systemic Therapy			\$
Intensive Case Management			\$146,562
Out-of-Home Residential Services			\$
Children's Mental Health Residential Services			\$
Crisis Residential/Stabilization			\$
Clinically Managed 24 Hour Care (SA)			\$
Clinically Managed Medium Intensity Care (SA)			\$
Adult Mental Health Residential			\$
Youth Substance Abuse Residential Services			\$
Therapeutic Foster Care			\$
Acute Intensive Services			\$3,783,470
Mobile Crisis			\$3,198,604
Peer-based Crisis Services			\$

Urgent Care			\$551,000
23-hour Observation Bed			\$
Medically Monitored Intensive Inpatient (SA)			\$
24/7 Crisis Hotline Services			\$33,866
Other (please list)			\$2,704,404
Trauma Informed care training, Transitional Housing, TAY, Prevention, School-based mental health, Evidence Based Practice Implementation, Systems Evaluation, 3% set aside Provider billing training and Administration support			\$2,704,404

footnote:

III: Use of Block Grant Dollars for Block Grant Activities

Table 6b MHBG Non-Direct Service Activities Planned Expenditures

Planning Period - From 07/01/2013 to 06/30/2014

Service	Block Grant
MHA Technical Assistance Activities	\$ 1,054,329
MHA Planning Council Activities	\$
MHA Administration	\$ 258,284
MHA Data Collection/Reporting	\$ 13,665
Enrollment and Provider Business Practices (3 percent of total award)	\$ 245,716
MHA Activities Other Than Those Above	\$
Total Non-Direct Services	\$1571994
Comments on Data: <input type="text"/>	

footnote:

IV: Narrative Plan

C. Coverage M/SUD Services

Narrative Question:

Beginning in 2014, Block Grant dollars should be used to pay for (1) people who are uninsured and (2) services that are not covered by insurance and Medicaid. Presumably, there will be similar concerns at the state-level that state dollars are being used for people and/or services not otherwise covered. States (or the Federal Marketplace) are currently making plans to implement the benchmark plan chosen for QHPs and their expanded Medicaid programs (if they choose to do so). States should begin to develop strategies that will monitor the implementation of the Affordable Care Act in their states. States should begin to identify whether people have better access to mental and substance use disorder services. In particular, states will need to determine if QHPs and Medicaid are offering mental health and substance abuse services and whether services are offered consistent with the provisions of MHPAEA.

Please answer the following questions:

1. Which services in Plan Table 3 of the application will be covered by Medicaid or by QHPs on January 1, 2014?
2. Do you have a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs and Medicaid?
3. Who in your state is responsible for monitoring access to M/SUD services by the QHPs? Briefly describe their monitoring process.
4. Will the SMHA and/or SSA be involved in reviewing any complaints or possible violations of MHPAEA?
5. What specific changes will the state make in consideration of the coverage offered in the state's EHB package?

Footnotes:

FY 2014 – 2015 MARYLAND MENTAL HEALTH BLOCK GRANT

C. Public Mental Health System (PMHS) Service Utilization and Expenditures

Coverage - The PMHS services both Medicaid recipients and the uninsured population. The total number of individuals served in the fee-for-service PMHS has increased from 134,915 in FY 2011 to 145,550 in FY 2012, a 7.9 percent increase. Tables on the following pages provide data on consumers served by age group in FY 2011, 2012 and 2013. FY 2012 data shows 145,550 individuals had claims submitted for mental health services through the fee-for-service system. Of the total, 89,435 are adults, and 56,115 are children. This total has increased by 8% during the same time period from FY 2011. In FY 2012, 11,259 uninsured individuals utilized PMHS services who meet specific eligibility criteria.

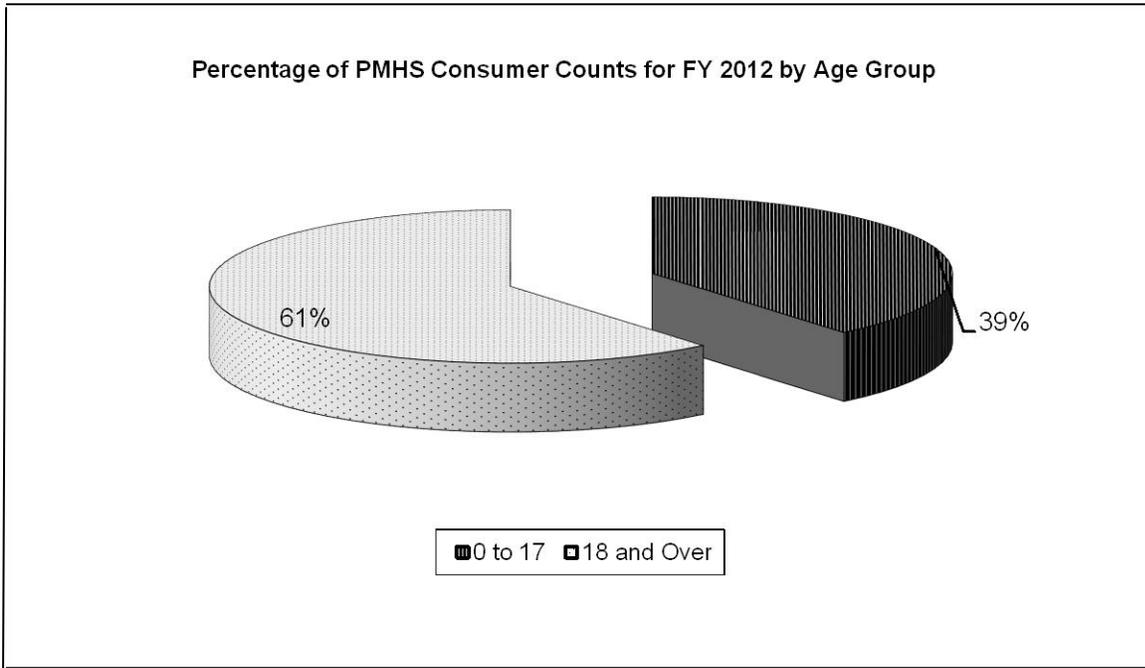
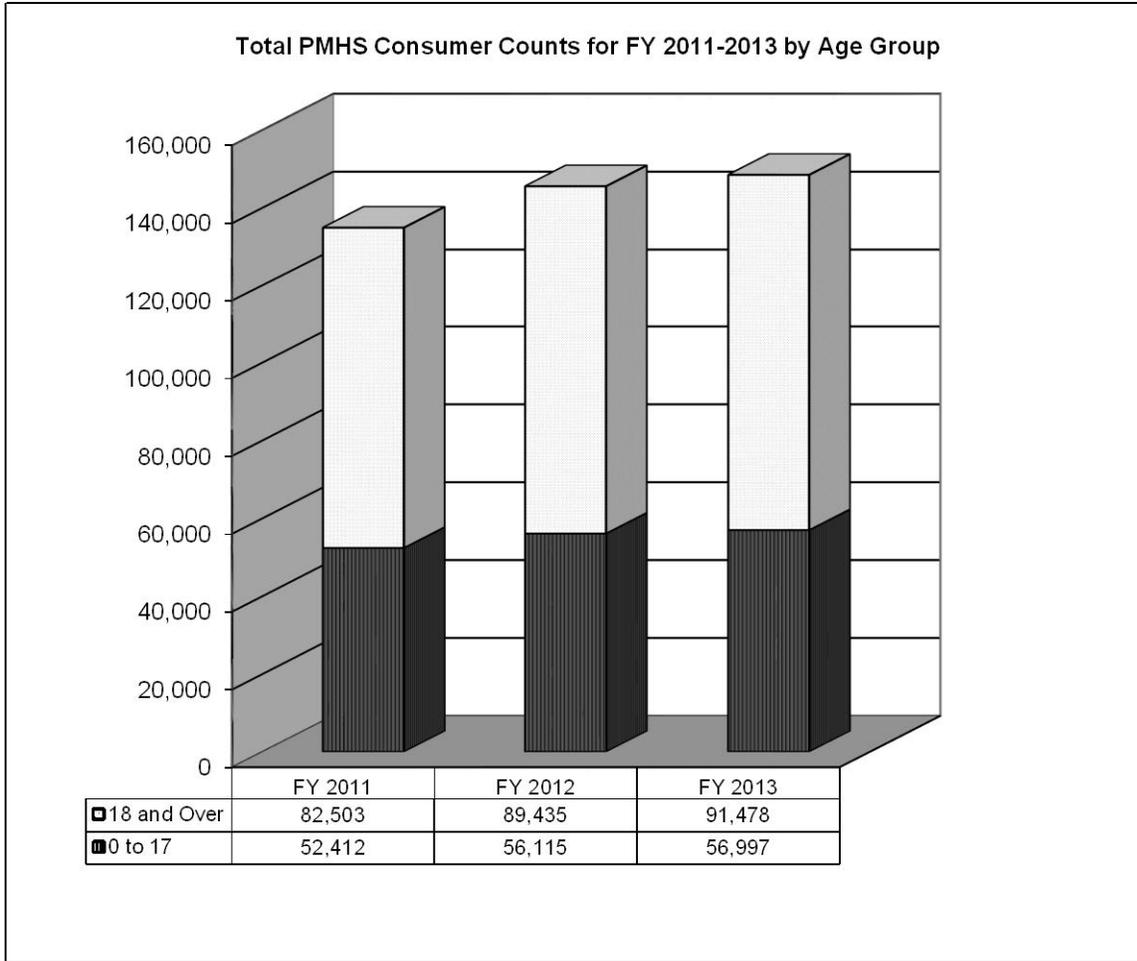
Demographics of Consumers Served in the Fee-For-Service System - The number of children and adolescents aged 0-21 grew over 19 percent while adults 22 and older experienced a similar growth, increasing the numbers served by 21 percent over the same time period between FY 2010-2012.

Access to services is critical for any mental health system. In recent years and as an ongoing strategy in the FY 2014 State Plan, MHA will “continue to monitor the system for growth, maintaining an appropriate level of care for at least the same number of individuals in the populations who have historically utilized the PMHS”. Data relevant to this national indicator on access to services continue to support the achievement of this target.

The Administrative Services Organization’s Management Information System (ASO MIS) was utilized to produce most of the data. Data for FY 2012 are based on claims paid through June 30, 2013. Since claims can be submitted up to twelve months following the date of service, the data for FY 2013 is still incomplete. Specific diagnoses were used to define SMI. An individual was categorized as Serious Mental Illness (SMI) if, at any time during the fiscal year, a diagnosis in the specific categories was submitted on a claim.

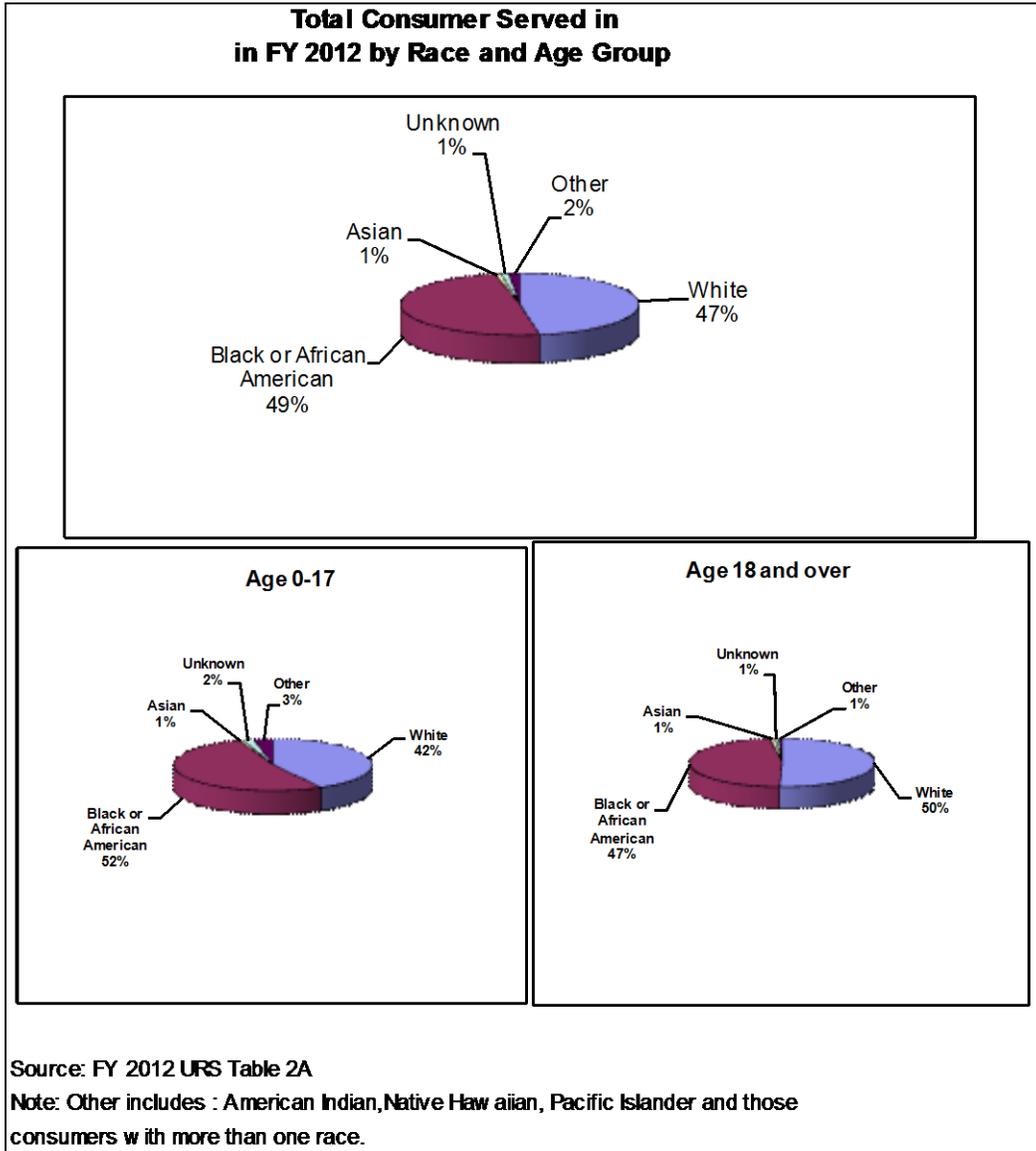
Based on claims paid through 06/30/2013, the number of individuals served in the fee-for-service PMHS has increased 8% from FY 2011. The number of child and adolescents increased by 7% while the number of adults served in FY 2012 increased by 8.4% since FY 2011. Many of these increases result from preparing for implementation or implementing some of the components of the Affordable Care Act, which provided funding allowing states to cover more people with Medicaid. The expansion of Medicaid, especially the extension of Medicaid to the parents of children in Maryland’s Children’s Health Program (MCHP), improved access to health care and services. It is estimated that an additional 25,000 Marylanders will be eligible for Medicaid and 15-17 percent of that population will use PMHS services within the coming fiscal years.

FY 2014 - 2015 MARYLAND MENTAL HEALTH BLOCK GRANT



FY 2014 – 2015 MARYLAND MENTAL HEALTH BLOCK GRANT

Currently, 61 percent of the people served are adults and 39 percent are children. The racial distribution of PMHS population is 49% Black, 47 % White, 1% Asian, 2% other and 1% unknown.

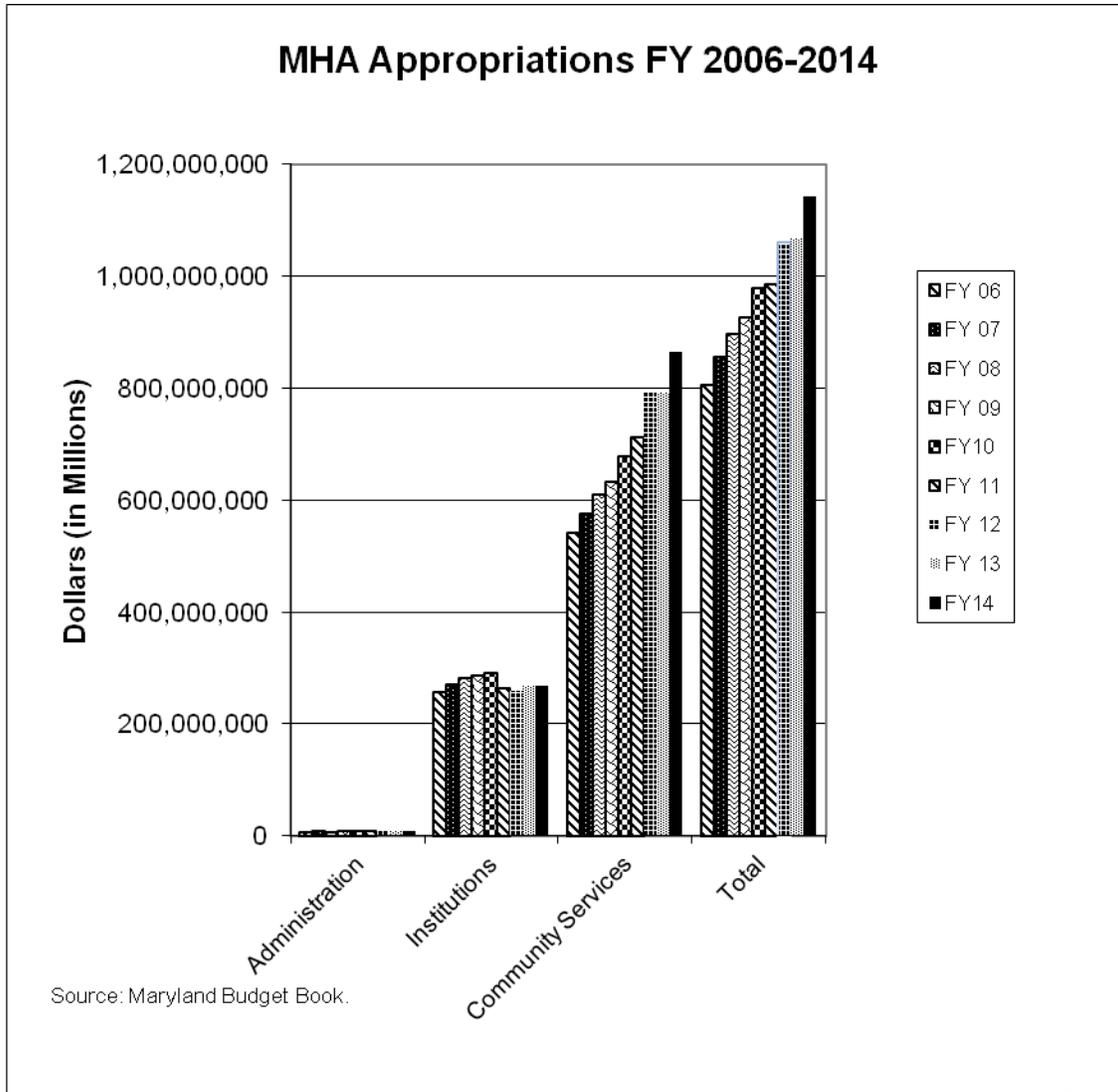


FY 2014 – 2015 MARYLAND MENTAL HEALTH BLOCK GRANT

Expenditures and Funding Sources for Marylanders in the PMHS – In FY 2013, 74.4 % of total expenditures were for community-based services (including those in the fee-for-service system and in grants and contracts). In FY 2014, a total of \$1,142,465,269 has been appropriated for the MHA. Of this amount, \$865.6 million (\$743 million MA service funds) is for community services, \$268.9 million for State-operated institutions and \$7.9 million for program administration. (Seventy-six point five percent (76.5%) of the FY 2014 funds are targeted for community services). Several local jurisdictions contribute mental health funding, which is not included in these budget numbers. In addition, MHA continues to contract directly with CSAs to support those programs that provide specialized services that are either not included in the standard benefit package or do not lend themselves to payment through the fee-for-service system. This consists of approximately \$45.5 million in State general funds and \$21.6 million in federal funds.

The majority of expenditures in the fee-for-service PMHS are for services reimbursed by MA. Federally matched MA expenditures represent 87-90% of total expenditures. Non-MA expenditures include those for MA-ineligible recipients, non-MA reimbursable services provided to MA recipients, and for services for individuals within state-only MA eligibility categories. In an effort to maximize all MA federally matched funds, MHA continued its practice of converting eligible individuals to PAC, the Primary Adult Care waiver. PAC is a statewide program which covers the fees of Outpatient clinic and Pharmacy services.

FY 2014 - 2015 MARYLAND MENTAL HEALTH BLOCK GRANT



FY 2014 – 2015 MARYLAND MENTAL HEALTH BLOCK GRANT

POPULATIONS – CHILDREN AND ADOLESCENTS WITH SERIOUS EMOTIONAL DISORDERS (SED)

INCIDENCE AND PREVALENCE FOR CHILDREN AND ADOLESCENTS

Maryland has revised its methodology for the calculation of prevalence according to the federal regulations. For children and adolescents, the recalculated Maryland poverty level changed the prevalence rates to be used in calculating number of children and adolescents with serious emotional disturbance (SED). Two estimates were used based upon the most recent information available. The estimates utilized were tied to the child poverty rate and the lowest and most upper limits of levels of functioning in the federal calculation. This translates from 6% up to 12% of the population under 18. The population under 18 for each county was multiplied by the two rates cited in the federal definition.

When developing MHBG prevalence estimates for SED, Maryland relies on age specific population estimates from Maryland Vital Statistics Annual Report presented each year by the Vital Statistics Administration of the Maryland DHMH. In the past five years the number of children under age 18 in the total population in Maryland has declined by *31,000. This average loss is approximately 6,000 children per year. During this same period the total population (both adult and child) has grown slowly by approximately 5% each year (117,000). This trend results from the aging or graying of Maryland's population. The trend was not fully projected in our previous applications, which had assumed uniform growth rates for both the adult and child populations. (Future population projections relied on estimates from the Maryland State Department of Planning in collaboration with the U.S. Census Bureau)

Estimates of treated prevalence; however, were of necessity based upon a somewhat stricter definition of SED. Specific Axis I and II diagnoses codes were selected to identify the SED treated in the system. A mechanism to define levels of functioning through the data system is not available, hence the reliance on diagnoses. Slight modifications were made this year to the list of diagnoses included under the SED category. Specific pervasive developmental disorder and learning disorder diagnoses were further restricted. All data have been updated to reflect this change. As Maryland has implemented the PMHS, careful consideration has been given to maintaining services to the previously defined priority populations in both the fee-for-service and contract-based systems.

FY 2014 – 2015 MARYLAND MENTAL HEALTH BLOCK GRANT

"Priority population" means those children and adolescents, for whom, because of the seriousness of their mental illness, extent of functional disability, and financial need, the Department has declared priority for publicly-funded services. MHA's priority population includes a child or adolescent, younger than 18 years old, with SED which is a condition that is:

- Diagnosed with a mental health diagnosis, according to a current diagnostic and statistical manual of the American Psychiatric Association (with the exception of the "V" codes, substance use, and developmental disorders unless they co-exist with another diagnosable psychiatric disorder); and
- Characterized by a functional impairment that substantially interferes with or limits the child's role or functioning in the family, school, or community activities.

Family and other surrogate caregivers should also be prioritized for services as research has shown that these persons are at high risk for the development of their own mental illnesses, particularly depression, as a result of their caring for a person with psychiatric disabilities.

FY 2014 – 2015 MARYLAND MENTAL HEALTH BLOCK GRANT

Mental Hygiene Administration Prevalence Estimates for Serious Emotional Disorder (SED) by County Child and Adolescent Population

County	Under 18 Population	Low Prevalence	High Prevalence
		6%	12%
Allegany	16,396	984	1,968
Anne Arundel	138,424	8,305	16,611
Baltimore County	199,550	11,973	23,946
Calvert	24,995	1,500	2,999
Caroline	8,930	536	1,072
Carroll	44,493	2,670	5,339
Cecil	27,411	1,645	3,289
Charles	42,461	2,548	5,095
Dorchester	7,715	463	926
Frederick	64,805	3,888	7,777
Garrett	7,243	435	869
Harford	65,182	3,911	7,822
Howard	81,267	4,876	9,752
Kent	4,367	262	524
Montgomery	256,535	15,392	30,784
Prince George's	234,640	14,078	28,157
Queen Anne's	12,293	738	1,475
St. Mary's	30,799	1,848	3,696
Somerset	6,016	361	722
Talbot	7,999	480	960
Washington	36,823	2,209	4,419
Wicomico	26,544	1,593	3,185
Worcester	10,249	615	1,230
Baltimore City	153,545	9,213	18,425
Statewide Total	1,508,682	90,521	181,042

Source: Census 2010 Modified Race data (MR(31)-CO.txt) prepared by the U.S. Census Bureau, May 2012.

FY 2014 – 2015 MARYLAND MENTAL HEALTH BLOCK GRANT

POPULATIONS – ADULTS WITH SERIOUS MENTAL ILLNESS (SMI)

INCIDENCE AND PREVALENCE FOR ADULTS

Maryland has revised its methodology for the calculation of prevalence according to the federal regulations. For adults, the current estimate of population aged 18 and over for each county was multiplied by the rate cited in the federal definitions (5.4%).

Estimates of treated prevalence were of necessity based upon a somewhat stricter definition of SMI. Specific Axis I and II diagnostic codes were selected to identify the SMI treated in the system. Very slight modifications were made within the diagnostic categories this year. All data have been updated to reflect these changes. A mechanism to define levels of functioning through the data system is not available, hence the reliance on diagnoses. As Maryland has implemented the PMHS, careful consideration has been given to maintaining services to the previously defined priority populations in both the fee-for-service and contract-based systems.

Family and other surrogate caregivers should also be prioritized for services as research has shown that these persons are at high risk for the development of their own mental illnesses, particularly depression, as a result of their caring for a person with psychiatric disabilities. Maryland's priority population remains as follows:

"Priority population" means adults for whom, because of the seriousness of their mental illness, extent of functional disability, and financial need, the Department has declared priority for publicly-funded services.

Priority population includes:

- An adult, aged 18 to 64, with a serious and persistent mental disorder, which is a disorder that is:
 - Diagnosed, according to a current diagnostic and statistical manual of the American Psychiatric Association as:
 - Schizophrenic disorder,
 - Major affective disorder,
 - Other psychotic disorder, or
 - Borderline or schizotypal personality disorders, with the exclusion of an abnormality that is manifested only by repeated criminal or otherwise antisocial conduct; and
 - Characterized by impaired role functioning, on a continuing or intermittent basis, for at least two years, including at least three of the following:
 - Inability to maintain independent employment; social behavior that results in intervention by the mental health system,
 - Inability, due to cognitive disorganization, to procure financial assistance to support living in the community,
 - Severe inability to establish or maintain a personal social support system, or
 - Need for assistance with basic living skills.

FY 2014 – 2015 MARYLAND MENTAL HEALTH BLOCK GRANT

- An elderly adult, aged 65 or over, who:
 - Is diagnosed, according to a current diagnostic and statistical manual of the American Psychiatric Association as:
 - Schizophrenic disorder,
 - Major affective disorder,
 - Other psychotic disorder, or
 - Borderline or schizotypal personality disorders, with the exclusion of an abnormality that is manifested only by repeated criminal or otherwise antisocial conduct; or
 - Experiences one of the following:
 - Early stages of serious mental illness, with symptoms that have been exacerbated by the onset of age-related changes,
 - Severe functional deficits due to cognitive disorders and/or acute episodes of mental illness, or
 - Psychiatric disability coupled with a secondary diagnosis, such as alcohol or drug abuse, developmental disability, physical disability, or serious medical problem.
- An individual committed as not criminally responsible who is conditionally released from a Mental Hygiene Administration facility, according to the provisions of Health General Article, Title 12, Annotated Code of Maryland.

FY 2014 – 2015 MARYLAND MENTAL HEALTH BLOCK GRANT

Mental Hygiene Administration Prevalence Estimates for Serious Mental Illness (SMI) by County Adult Population

County	Over 18 Population	Prevalence 5.4%
Allegany	58,296	3,148
Anne Arundel	405,979	21,923
Baltimore County	610,391	32,961
Calvert	64,261	3,470
Caroline	24,055	1,299
Carroll	122,795	6,631
Cecil	74,283	4,011
Charles	106,669	5,760
Dorchester	24,925	1,346
Frederick	171,940	9,285
Garrett	22,808	1,232
Harford	181,307	9,791
Howard	211,875	11,441
Kent	15,837	855
Montgomery	733,259	39,596
Prince George's	636,593	34,376
Queen Anne's	36,061	1,947
St. Mary's	76,685	4,141
Somerset	20,323	1,097
Talbot	30,026	1,621
Washington	111,380	6,015
Wicomico	72,646	3,923
Worcester	41,265	2,228
Baltimore City	465,948	25,161
Statewide Total	4,319,607	233,259

Source: Census 2010 Modified Race data (MR(31)-CO.txt) prepared by the U.S. Census Bureau, May 2012.

IV: Narrative Plan

D. Health Insurance Marketplaces

Narrative Question:

Health Insurance Marketplaces (Marketplaces) will be responsible for performing a variety of critical functions to ensure access to desperately needed behavioral health services. Outreach and education regarding enrollment in QHPs or expanded Medicaid will be critical. SMHAs and SSAs should understand their state's new eligibility determination and enrollment system, as well as how insurers (commercial, Medicaid, and Medicare plans) will be making decisions regarding their provider networks. States should consider developing benchmarks regarding the expected number of individuals in their publicly-funded behavioral health system that should be insured by the end of FY 2015. In addition, states should set similar benchmarks for the number of providers who will be participating in insurers' networks that are currently not billing third party insurance.

QHPs must maintain a network of providers that is sufficient in the number and types of providers, including providers that specialize in mental health and substance abuse, to assure that all services will be accessible without unreasonable delay. Mental health and substance abuse providers were specifically highlighted in the rule to encourage QHP issuers to provide sufficient access to a broad range of mental health and substance abuse services, particularly in low-income and underserved communities.

Please answer the following questions:

1. How will the state evaluate the impact that its outreach, eligibility determination, enrollment, and re-enrollment systems will have on eligible individuals with behavioral health conditions?
2. How will the state work with its partners to ensure that the Navigator program is responsive to the unique needs of individuals with behavioral health conditions and the challenges to getting and keeping the individuals enrolled?
3. How will the state ensure that providers are screening for eligibility, assisting with enrollment, and billing Medicaid, CHIP, QHPs, or other insurance prior to drawing down Block Grant dollars for individuals and/or services?
4. How will the state ensure that there is adequate community behavioral health provider participation in the networks of the QHPs, and how will the state assist its providers in enrolling in the networks?
5. Please provide an estimate of the number of individuals served under the MHBG and SABG who are uninsured in CY 2013. Please provide the assumptions and methodology used to develop the estimate.
6. Please provide an estimate of the number of individuals served under the MHBG and SABG who will remain uninsured in CY 2014 and CY 2015. Please provide the assumptions and methodology used to develop the estimate.
7. For the providers identified in Table 8 -Statewide Entity Inventory of the FY 2013 MHBG and SABG Reporting Section, please provide an estimate of the number of these providers that are currently enrolled in your state's Medicaid program. Please provide the assumptions and methodology used to develop the estimate.
8. Please provide an estimate of the number of providers estimated in Question 7 that will be enrolled in Medicaid or participating in a QHP. Provide this estimate for FY 2014 and a separate estimate for FY 2015, including the assumptions and methodology used to develop the estimate.

Footnotes:

FY 2014 – 2015 MARYLAND MENTAL HEALTH BLOCK GRANT

D. Maryland's Implementation of Health Care Reform

In 2011, and in response to the enactment of the Patient Protection and Affordable Care Act (PPACA), Maryland Governor Martin O'Malley created the Maryland Office of Health Care Reform through an Executive Order. As recommended in the 2010 final report of the Health Care Reform Coordinating Council, the Office is tasked with coordinating the implementation of health care reform, developing consensus and providing direction on the State's health care reform policies, and staffing the Council. Through these efforts, the Office is helping expand access to quality, affordable health care to all Marylanders.

Additionally, in April 2011 Governor O'Malley signed a law that established the Health Benefit Exchange. On May 26, 2011 he appointed a nine member board to oversee the Exchange. The DHMH's Secretary serves as a board member for the Exchange.

Maryland's Health Benefit Exchange/Health Insurance Marketplace

The *Patient Protection and Affordable Care Act* requires each state to establish a **"health insurance exchange"** by 2014. A marketplace where individuals and small businesses explore, compare and enroll in health insurance and public assistance programs as well as access federal tax credits and cost-sharing subsidies. States had a choice to establish a state-based exchange, join a partnership or the federally-facilitated exchange; Maryland opted to establish a state-based health insurance exchange.

Maryland's exchange is called Maryland Health Connection. The Maryland Health Connection is the marketplace for individuals, families and small businesses to compare and enroll in health insurance, as well as determine eligibility for Medicaid and other assistance programs, federal tax credits and cost-sharing reductions. Enrollment through Maryland Health Connection is scheduled to begin October 2013, with insurance coverage beginning January 1, 2014. An estimated 150,000 individuals are expected to enroll in qualified health plans (QHPs) during the first year, increasing to approximately 275,000 by 2020 www.MarylandHealthConnection.gov. Marylanders will be able to shop on MHC, make apples-to-apples comparisons and determine eligibility for financial assistance (tax credits) to reduce the cost of monthly insurance premiums. Consumer assistance will also be available through a call center or in-person throughout the state in Local Health Departments, Departments of Social Services and a network of consumer assistance organizations known as "Connector Entities".¹

Maryland will contract with up to six Connector Entities who will be responsible for all outreach and education in their region and Network of Navigators. The Navigators will:

- Conduct public education and outreach as required by the Affordable Care Act
- Distribute fair and impartial information
- Facilitate enrollment in health plans
- Provide referrals for grievances, complaints and questions
- Provide information in a culturally and linguistically appropriate manner
- Maintain expertise in eligibility, enrollment and program specifications

¹ MarylandHealthConnection.gov

FY 2014 – 2015 MARYLAND MENTAL HEALTH BLOCK GRANT

- Refer insured small groups and individuals back to producers

Additionally, the Maryland Department of Health and Mental Hygiene (DHMH), the Maryland Health Benefit Exchange (MHBE) and the Community Health Resources Commission (CHRC) have launched the Maryland's Access to Care Program. The Access to Care Program is designed to foster collaboration between the state, health insurers and safety net providers as each plans for newly insured Marylanders who will start to access healthcare services in 2014. This program is built on the requirement that network plans offered through Maryland Health Connection provide meaningful access to critical health services including primary, reproductive, HIV/AIDS and behavioral health care.

State Innovation Models (SIM) Initiative

Maryland is one of six states to participate in the Center for Medicare and Medicaid's State Innovation Models Initiative (SIM). States were selected based on their efforts and readiness to transform its health care delivery system through multi-payer reform and other state led initiatives. As part of the State Innovation Models (SIM), Maryland will receive funding from the Centers for Medicare and Medicaid Innovation (CMMI) to engage in a planning process to develop a "Community-Integrated Medical Home" (CIMH) model. This model will integrate patient-centered medical care with community-based resources while enhancing the capacity of local health entities to monitor and improve the health of individuals and their communities as a whole. The state of Maryland is committed to designing the CIMH based on input from a wide range of health care stakeholders. Over the course of six months, the Department will lead a stakeholder engagement process to define key aspects of the model. There will be a Payer and Provider group to address programmatic standards and administrative and governance structures. The second will be Local Health Improvement Coalitions which are panels of local health departments, physicians, hospitals and other entities, to address community health and medical care to develop plans for capacity enhancement. Additionally, prototypes of data tools for population health monitoring and new mapping technologies to reach high-cost individuals in their communities will be presented.

IV: Narrative Plan

E. Program Integrity

Narrative Question:

The Affordable Care Act directs the Secretary of HHS to define EHBs. Non-grandfathered plans in the individual and small group markets both inside and outside of the Marketplaces, Medicaid benchmark and benchmark-equivalent plans, and basic health programs must cover these EHBs beginning in 2014. On December 16, 2011, HHS released a bulletin indicating the Secretary's intent to propose that EHBs be defined by benchmarks selected by each state. The selected benchmark plan would serve as a reference plan, reflecting both the scope of services and any limits offered by a "typical employer plan" in that state as required by the Affordable Care Act.

SMHAs and SSAs should now be focused on two main areas related to EHBs: monitoring what is covered and aligning Block Grant and state funds to compensate for what is not covered. There are various activities that will ensure that mental and substance use disorder services are covered. These include: (1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including EHBs as per the state benchmark; (2) ensuring that individuals are aware of the covered mental health and substance abuse benefits; (3) ensuring that consumers of substance abuse and mental health services have full confidence in the confidentiality of their medical information; and (4) monitoring utilization of behavioral health benefits in light of utilization review, medical necessity, etc.

States traditionally have employed a variety of strategies to procure and pay for behavioral health services funded by the SABG and MHBG. State systems for procurement, contract management, financial reporting, and audit vary significantly. SAMHSA expects states to implement policies and procedures that are designed to ensure that Block Grant funds are used in accordance with the four priority categories identified above. Consequently, states may have to reevaluate their current management and oversight strategies to accommodate the new priorities. They may also be required to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment. States should describe their efforts to ensure that Block Grant funds are expended efficiently and effectively in accordance with program goals. In particular, states should address how they will accomplish the following:

1. Does the state have a program integrity plan regarding the SABG and MHBG?
2. Does the state have a specific staff person that is responsible for the state agency's program integrity activities?
3. What program integrity activities does the state specifically have for monitoring the appropriate use of Block Grant funds? Please indicate if the state utilizes any of the following monitoring and oversight practices:
 - a. Budget review;
 - b. Claims/payment adjudication;
 - c. Expenditure report analysis;
 - d. Compliance reviews;
 - e. Encounter/utilization/performance analysis; and
 - f. Audits.
4. How does the state ensure that the payment methodologies used to disburse funds are reasonable and appropriate for the type and quantity of services delivered?
5. How does the state assist providers in adopting practices that promote compliance with program requirements, including quality and safety standards?
6. How will the state ensure that Block Grant funds and state dollars are used to pay for individuals who are uninsured and services that are not covered by private insurance and/or Medicaid?

SAMHSA will review this information to assess the progress that states have made in addressing program integrity issues and determine if additional guidance and/or technical assistance is appropriate.

Footnotes:

IV: Narrative Plan

F. Use of Evidence in Purchasing Decisions

Narrative Question:

SAMHSA is interested in whether and how states are using evidence in their purchasing decisions, educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is concerned with what additional information is needed by SMHAs and SSAs in their efforts to continue to shape their and other purchasers decisions regarding mental health and substance abuse services. SAMHSA is requesting that states respond to the following questions:

- 1) Does your state have specific staff that are responsible for tracking and disseminating information regarding evidence-based or promising practices?
- 2) Did you use information regarding evidence-based or promising practices in your purchasing or policy decisions?
 - a) What information did you use?
 - b) What information was most useful?
- 3) How have you used information regarding evidence-based practices?
 - a) Educating State Medicaid agencies and other purchasers regarding this information?
 - b) Making decisions about what you buy with funds that are under your control?

Footnotes:

IV: Narrative Plan

G. Quality

Narrative Question:

Up to 25 data elements, including those listed in the table below, will be available through the Behavioral Health Barometer which SAMHSA will prepare annually to share with states for purposes of informing the planning process. The intention of the Barometer is to provide information to states to improve their planning process, not for evaluative purposes. Using this information, states will select specific priority areas and develop milestones and plans for addressing each of their priority areas. States will receive feedback on an annual basis in terms of national, regional, and state performance and will be expected to provide information on the additional measures they have identified outside of the core measures and state barometer. Reports on progress will serve to highlight the impact of the Block Grant-funded services and thus allow SAMHSA to collaborate with the states and other HHS Operating Divisions in providing technical assistance to improve behavioral health and related outcomes.

	Prevention	Substance Abuse Treatment	Mental Health Services
Health	Youth and Adult Heavy Alcohol Use - Past 30 Day	Reduction/No Change in substance use past 30 days	Level of Functioning
Home	Parental Disapproval Of Drug Use	Stability in Housing	Stability in Housing
Community	Environmental Risks/Exposure to prevention Messages and/or Friends Disapproval	Involvement in Self-Help	Improvement/Increase in quality/number of supportive relationships among SMI population
Purpose	Pro-Social Connections Community Connections	Percent in TX employed, in school, etc - TEDS	Clients w/ SMI or SED who are employed, or in school

- 1) What additional measures will your state focus on in developing your State BG Plan (up to three)?
- 2) Please provide information on any additional measures identified outside of the core measures and state barometer.
- 3) What are your states specific priority areas to address the issues identified by the data?
- 4) What are the milestones and plans for addressing each of your priority areas?

Footnotes:

IV: Narrative Plan

H. Trauma

Narrative Question:

In order to better meet the needs of those they serve, states should take an active approach to addressing trauma. Trauma screening matched with trauma-specific therapies, such as exposure therapy or trauma-focused cognitive behavioral approaches, should be used to ensure that treatments meet the needs of those being served. States should also consider adopting a trauma-informed care approach consistent with SAMHSA's trauma-informed care definition and principles. This means providing care based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate so that these services and programs can be more supportive and avoid being traumatized again.

Please answer the following questions:

1. Does your state have any policies directing providers to screen clients for a personal history of trauma?
2. Does the state have policies designed to connect individuals with trauma histories to trauma-focused therapy?
3. Does your state have any policies that promote the provision of trauma-informed care?
4. What types of evidence-based trauma-specific interventions does your state offer across the life-span?
5. What types of trainings do you provide to increase capacity of providers to deliver trauma-specific interventions?

Footnotes:

FY 2014 – 2015 MARYLAND MENTAL HEALTH BLOCK GRANT

H. Trauma

MHA's Office of Special Needs Populations collaborates with ADAA and/or local health departments to address the needs of those with co-occurring disorders who have histories of trauma, are homeless, deaf or hard of hearing, or have criminal justice involvement. The Maryland Community Criminal Justice Treatment Program (MCCJTP) mental health staff work in partnership with the substance abuse staff from the local health departments to coordinate services for those with mental illness and substance abuse disorders. MHA also co-leads the Maryland Correctional Administrators Association (MCAA) mental health and substance abuse subcommittee to address the needs of those incarcerated in local detention centers. ADAA participates on the MCAA subcommittee. In MHA's TAMAR Programs, 88% of the program's participants have co-occurring disorders. In the Chrysalis House Healthy Start Program 64% have a co-occurring disorder and over 50% of those in PATH and the Shelter Plus Care Program have co-occurring disorders.

Services for Women who are Pregnant and Have A Substance Use and/or Mental Health

Disorder - The majority of the women with co-occurring disorders in the criminal justice system have children and a smaller population is pregnant while incarcerated. MHA was instrumental in developing and implementing a program for eligible pregnant women who were incarcerated or at risk of incarceration in local detention centers and the Maryland Correctional Institute for Women (MCIW).

The Chrysalis House Healthy Start Program, which replaced the TAMAR's Children Program in 2007, is a collaborative effort with the Department of Public Safety and Correctional Services, the Administrative Office of the Courts, the Alcohol and Drug Abuse Administration, the Family Health Administration, Baltimore Mental Health Systems, Inc. and the Archdiocese of Baltimore. This program, funded through state general funds, consists of a 16-bed diagnostic and transitional facility for pregnant and post-partum women and their babies. Pregnant women are referred by the court, the State's Defense Attorney, or DHMH. A comprehensive assessment is conducted by a licensed clinician and an individualized treatment plan is developed between each woman and the treatment team. After the newborn's birth, the mother and baby remain in the residential facility and receive a comprehensive array of services. Services include: medical care through contract with a health care organization; mental health treatment; which includes trauma and attachment-based treatment interventions; substance abuse treatment and co-occurring treatment services; legal services; parenting and childcare services (which include involvement from the Healthy Start and Family Tree Programs) housing; after-hours residential support; health education; and other support services.

Between July 2007 and June 2012, there have been over 80 admissions to the program and 49 healthy babies have been born during this period. The majority of women are known to have both mental health and substance abuse issues and over 85% have a stated history of significant trauma. An evaluation in SFY 2012 found that 88% of those admitted are on probation and over 80% were admitted to the program from local detention centers. Over 40%

FY 2014 – 2015 MARYLAND MENTAL HEALTH BLOCK GRANT

of the women were previously incarcerated at Baltimore City Detention Center or Baltimore City Women's Detention Center.

Evaluations undertaken have consistently shown significant reported improvements in mental health, overall health, and day to day functioning and significant reductions reported in criminal behavior. Eight of the women have subsequently moved into Shelter Plus Care housing programs.

Trauma Informed Care - In July of FY 2011, an advisory committee was formed to implement Senate Bill 556/House Bill 1150 written to develop and implement strategies to promote the principles of trauma informed care. One strategy included providing training in trauma-informed care principles as well as trauma specific services for staff and consumers within State-operated facilities. Facilities identified key staff to attend workshops on trauma with the goal of creating similar workshops to their internal curricula. The trauma specific training included the Adverse Childhood Experience (ACE) trauma screening tool. A consultant was retained to recommend workshops on sexual assault/ sexual harassment prevention. In addition to training, policies were revised to create uniform response and report procedures with regard to sexual assault and harassment.

The bill also included launching a pilot program of a single gender unit to provide a greater sense of comfort and safety for women who did not wish to share a unit with men. This unit was launched in March of 2012 on the Eastern Shore. When asked about why they preferred the single-gender unit, many women made similar comments reflecting that it was more peaceful without men and without men you can learn to be on your own. The discussion generated goals, such as, learning about trauma education, having more group discussions, and moving to Stepping Stones, a transitional unit focused on independent living. Some of the women suggested that the group discussions include topics, such as, medication management, interacting with others who have a mental illness, nutrition/diet, and first aid. The group was interested in having peer specialists co-lead groups.

IV: Narrative Plan

I. Justice

Narrative Question:

The SABG and MHBG may be especially valuable in supporting care coordination to promote pre-adjudication or pre-sentencing diversion, providing care during gaps in enrollment after incarceration, and supporting other efforts related to enrollment.

Communities across the United States have instituted problem-solving courts, including those for defendants with mental and substance abuse disorders. These courts seek to prevent incarceration and facilitate community-based treatment for offenders, while at the same time protecting public safety. There are two types of problem-solving courts related to behavioral health: drug courts and mental health courts. In addition to these behavioral health problem-solving courts, some jurisdictions operate courts specifically for DWI/DUI, veterans, families, and reentry, as well as courts for gambling, domestic violence, truancy, and other subject-specific areas.^{42,43} Rottman described the therapeutic value of problem-solving courts: Specialized courts provide a forum in which the adversarial process can be relaxed and problem solving and treatment processes emphasized. Specialized courts can be structured to retain jurisdiction over defendants, promoting the continuity of supervision and accountability of defendants for their behavior in treatment programs. Youths in the juvenile justice system often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient utilization of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; and therefore, risk factors remain unaddressed.⁴⁴

A true diversion program takes youth who would ordinarily be processed within the juvenile justice system and places them instead into an alternative program. States should place an emphasis on screening, assessment, and services provided prior to adjudication and/or sentencing to divert persons with mental and/or substance use disorders from correctional settings. States should also examine specific barriers such as lack of identification needed for enrollment; loss of eligibility resulting from incarceration; and care coordination for individuals with chronic health conditions, housing instability, and employment challenges. Secure custody rates decline when community agencies are present to advocate for alternatives to detention

Please answer the following questions:

1. Does your state have plans to enroll individuals involved in the criminal and juvenile justice systems in Medicaid as a part of coverage expansions?
2. What screening and services are provided prior to adjudication and/or sentencing for individuals with mental and/or substance use disorders?
3. Are your SMHA and SSA coordinating with the criminal and juvenile justice systems with respect to diversion of individuals with mental and/or substance use disorders, behavioral health services provided in correctional facilities, and the reentry process for those individuals?
4. Do efforts around enrollment and care coordination address specific issues faced by individuals involved in the criminal and juvenile justice systems?
5. What cross-trainings do you provide for behavioral health providers and criminal/juvenile justice personnel to increase capacity for working with individuals with behavioral health issues involved in the justice system?

42 The American Prospect: In the history of American mental hospitals and prisons, The Rehabilitation of the Asylum. David Rottman, 2000.

43 A report prepared by the Council of State Governments. Justice Center. Criminal Justice/Mental Health Consensus Project. New York, New York for the Bureau of Justice Assistance Office of Justice Programs U.S. Department of Justice, Renee L. Bender, 2001.

44 Journal of Research in Crime and Delinquency: Identifying High-Risk Youth: Prevalence and Patterns of Adolescent Drug Victims, Judges, and Juvenile Court Reform Through Restorative Justice. Dryfoos, Joy G. 1990, Rottman, David, and Pamela Casey, McNiel, Dale E., and Renée L. Binder. OJJDP Model Programs Guide.

Footnotes:

FY 2014 – 2015 MARYLAND MENTAL HEALTH BLOCK GRANT

I. Services for Individuals in the Criminal Justice System

The Maryland Community Criminal Justice Treatment Program (MCCJTP), with total annual state funds of \$1.9 million, supports specific programs targeted at adults 18 years of age and older with SMI in detention centers. The development and delivery of care extended to these individuals is rooted in two key principles: 1) a continuum of care should be created by providing a variety of services by mental health professionals working within the jail and in the community; and 2) The continuum of care should be structured according to the needs of the local community. Local advisory boards have been established to advise on needs assessment and service planning. In FY 2013 the MCCJTP operated in 22 Maryland counties. The program received an estimated total of 10,000 referrals from which an estimated 9,000 received treatment. From a combination of State and local funding the program anticipates providing over 5,500 hours of psychiatric services, nearly 22,000 hours of combined individual and group psychotherapy, and more than 20,000 hours of case management. While MCCJTP is unable to track recidivism from county to county until information technology is in place, the current recidivism rate is estimated to be between five percent (5%) and ten percent (10%).

In addition to working with the counties, MHA continued to partner with Baltimore City to provide post-booking aftercare planning through the Forensic Aftercare Services Team (FAST). In FY 2013 FAST screened and conducted face-to-face evaluations with more than 1,300 individuals for program appropriateness and expects to monitor approximately 40 individuals in the community as part of a court ordered release plan.

Maryland's efforts to address the issues of individuals with mental illnesses in the criminal justice system were also driven by legislative action which led to the establishment of various workgroups. Starting in FY 2007, a "think-tank" was established in response to House Bill (HB) 990/Senate Bill (SB) 960. The group was charged with exploring issues targeted at "breaking the cycle of re-arrest and re-incarceration" for individuals with mental illnesses. Now formed as the Mental Health and Criminal Justice Partnership (MHCJP), it continues to work with corrections, mental health, substance abuse, consumer and advocacy groups, and other key stakeholders. Their mission is to identify services that aid in reducing recidivism to detention centers. The workgroup and its subcommittees continue to assist with the implementation of key projects, such as, data link, reentry services, and mental health first aid training.

Also, the Maryland Advisory Council on Mental Hygiene/PL 102-321 Planning Council, in collaboration with the Mental Health & Criminal Justice Partnership and the Interagency Forensic Services Committee, continued to promote the development of services including early intervention, diversion, and re-entry for individuals with mental illnesses who encounter the criminal justice system. Additionally, MHA submitted a report detailing its plan to enter into memoranda of understanding with local detention centers to establish a data sharing initiative.

FY 2014 – 2015 MARYLAND MENTAL HEALTH BLOCK GRANT

Additionally, the Secretaries of the Department of Health and Mental Hygiene and the Department of Public Safety and Correctional Services (DPSCS) created a special criminal justice “dream” team to examine best practices for pre-trial coordination between community mental health and substance abuse; post trial assessments for care in the detention center; health information/data sharing; and new models for discharge for those being released from the Department of Corrections. MHA’s Office of Special Needs Populations serves as the team lead for DHMH. The special criminal justice team is comprised of MHA’s Office of Special Needs Populations, CSAs, ADAA, and representatives from the DPSCS. In FY 2012, the team worked collaboratively to re-initiate the DataLink Project in Baltimore City and have expanded the program to Howard and Anne Arundel counties in FY 2013. A DataLink subcommittee has also been developed in SFY 2014, to determine new sites for the next expansion, develop public health outcomes, troubleshoot and provide technical assistance to new and existing sites. With DataLink, booking data is sent by the DPSCS to the Administrative Service Organization (ASO) for the Public Mental Health System (PMHS). The data is cross referenced against PMHS. The CSA receives the file of individuals who have been arrested with one or more authorizations for the PMHS within the last two years. BMHS notifies the providers and identify areas where individuals could potentially benefit from service enhancements and make connections with the individual to ensure continuity of care and to assist with the release planning.

The DHMH and DPSCS team also submitted a grant application to the Department of Justice for Second Chance grant funding to develop a Reach-In Program. The Reach-In Program is designed to target and serve approximately 75 offenders, with moderate to high risk histories of chronic mental illness and substance use and/or dependence issues. A team of case managers and peer support specialist has been hired and are connecting offenders within four months prior to release to assess community needs and establish or re-establish community linkages. The team will continue to provide services six months post-release and assist with linkages to community based treatment, medical and behavioral care, assistance with applying for entitlements, assistance in securing housing, residential supports, and employment.

MHA also provides \$440,000 in State general funds for the Trauma, Addictions, Mental Health, and Recovery (T.A.M.A.R.) Project which provides treatment for incarcerated men and women who have histories of trauma and have been diagnosed with a mental illness and/or co-occurring substance abuse disorder. The project is available in nine county detention centers; Anne Arundel, Baltimore, Caroline, Dorchester, Frederick, Garrett, Harford, Prince George’s, Washington Counties and at Springfield Hospital Center. For FY 2014, TAMAR is expected to serve nearly 500 individuals with a combination of services that include individual and group counseling, grief counseling, and case management. To date, 92 percent of treated individuals were identified with a co-occurring substance abuse disorder.

FY 2014 – 2015 MARYLAND MENTAL HEALTH BLOCK GRANT

Between July 2007 and June 2013, there have been 99 separate admissions to the program and 53 healthy babies have been born during this period. The majority of women are known to have both mental health and substance abuse issues and have a history of significant trauma. The largest source of referrals is from Baltimore City Detention Center and Baltimore City Women's Detention Center. Evaluations undertaken have consistently shown significant reported improvements in mental health, overall health, and day to day functioning and significant reductions reported in criminal behavior. A recent evaluation report indicated a correlation between length of stay and subsequent involvement in the criminal justice system with those staying longest at CHHS seeming to be least likely to have further involvement in the criminal justice system.

Services to the Homeless - Project for Assistance in Transition from Homelessness (PATH) and Shelter Plus Care funds will be used to continue to meet the needs of homeless individuals and those coming from detention centers. This year, MHA will continue to work with courts, detention centers, public safety, and correctional services to better address the mental health needs of individuals entering or exiting these systems, as well as the needs of individuals in MHA facilities who are court-involved and ready for discharge.

The PATH program provided services in all 23 counties and Baltimore City in FY 2011. In SFY 2012, the funding level was \$1,284,000 in funding, a decrease of \$3,000. In SFY 2012, local PATH supported agencies provided outreach to 6,127 individuals. Of these, 2,345 were enrolled in the PATH program and received additional services. In SFY 2013, PATH received \$1,281,000 in funding data will be available in the fall of 2013. In FY 2013, PATH will be funded at \$1,203,000, a decrease of \$78,000 from SFY 2013. Maryland's PATH programs are projected to serve an estimated 4,107 individuals and families.

In FY 2012 Shelter Plus Care Housing grant was renewed for \$4,542,852 for 19 Shelter Plus Care renewal grants. For FY 2013, MHA was awarded funding in the total amount of \$4,610,592 for the Shelter Plus Care renewal grants. The renewal grant award was slightly increased due to increases in the Fair Market Rental Values, increases in the number of units funded by HUD, and the renewal of all five-year grants. Currently, MHA is receiving 19 grants from HUD, and is serving a total of 779 persons, 191 single individuals with mental illness, 187 families with 342 children and 59 other family members through all of the Shelter Plus Care grant programs.

Another important development in the provision of co-occurring services to individuals with mental illnesses and substance disorders was the Substance Abuse and Mental Health Services Administration (SAMHSA) grant awarded to the MHA to provide substance abuse and mental health services for people who are homeless. The grant enables communities to expand and strengthen their treatment services for individuals who are homeless with substance abuse disorders, mental illness, or co-occurring (substance use disorders and mental illness).

IV: Narrative Plan

J. Parity Education

Narrative Question:

SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity. As one plan of action states can develop communication plans to provide and address key issues. SAMHSA is in a unique position to provide content expertise to assist states, and is asking for input from states to address this position.

Please answer the following questions:

1. How will or can states use their dollars to develop communication plans to educate and raise awareness about parity?
2. How will or can states coordinate across public and private sector entities to increase awareness and understanding about benefits (e.g., service benefits, cost benefits, etc.?)
3. What steps and processes can be taken to ensure a broad and strategic outreach is made to the appropriate and relevant audiences that are directly impacted by parity?

Footnotes:

FY 2014 – 2015 MARYLAND MENTAL HEALTH BLOCK GRANT

J. Parity Education

Parity education and activities have been implemented through The Mental Health Association of Maryland's (MHAMD) Parity Project. The Project spent the last 24 months educating consumers and providers about their rights under the Federal Parity Law and assisting them in filing appeals and complaints to address discriminatory health insurance plans.

More than 150,000 people have been reached through the activities described below and assisted 101 individuals with insurance and service access complaints. As a result of these efforts, the MHAMD secured changes to benefit plans as well as retrospective reimbursement for services that had been wrongly denied by the insurer. They have been instrumental in guiding efforts to develop strategy and policy recommendations to ensure that implementation of the Affordable Care Act improves access to necessary behavioral health services for those in need. The following goals have been identified:

Goal 1: Education and Community Outreach

Proposed Outcome: Develop and distribute print materials to educate the public, policymakers and targeted audiences

- Created and distributed 850 Parity Toolkits to key stakeholders including legislators, executive branch officials, providers, consumers, family members and the media.
- Developed and disseminated more than 10,000 pieces of literature, ranging from fact sheets to bookmarks.

Proposed Outcome: Implement outreach strategies to ensure campaign messages reach targeted communities

Meetings and Events

- Participated in more than 90 events, including health fairs and parity trainings, directly reaching more than 5,000 individuals, including policymakers, consumers, state employees, providers and advocates who in turn have shared parity information and resources to a broader network.
- Developed, promoted and presented five webinars to consumer, family and policy audiences.
- Developed two standard PowerPoint presentations that are customized for specific audiences.
- Convened a public event featuring a presentation by U.S. Department of Labor (USDOL) parity investigators.
- Co-hosted a Parity Forum with Congressman Van Hollen and Representative Kennedy in June 2012 that has become the model used for parity forums in other states across the nation.
- Provided technical assistance to numerous other states interested in replicating the Maryland Parity Project.
- Collaborated in development of a webcast in partnership with the University of Maryland Drug Policy Clinic and the Maryland Medicaid Matters Coalition.

FY 2014 – 2015 MARYLAND MENTAL HEALTH BLOCK GRANT

Print Media and Website

- Earned more than 100,000 media impressions including Politico Pro, Mental Health Weekly, Salisbury Times, WPOC-FM and WEAA-FM.
- Placed stories and print advertisements in 9 newsletters and other publications of state level professional, provider and advocacy organizations.
- Provided media training for providers and consumers.
- Designed and launched www.MarylandParity.org, to educate consumers and providers about their insurance coverage and rights. To date MarylandParity.org has had more than 20,000 views, including more than 12,000 views of the companion Parity Perspectives blog, which is updated weekly with parity and health care reform posts.

Goal 2: Consumer and Provider Complaint Assistance

The Maryland Parity Project takes pride in the prioritization of case assistance whether it is answering questions about parity, directing a consumer to the appropriate resource for affordable insurance, assisting in the appeals process, filing a complaint on behalf of a consumer or provider, or empowering someone to share his/her story of insurer discrimination.

Proposed Outcome: Provide case assistance in lodging complaints by consumers, families and providers regarding inappropriate care denials

- Provided direct case assistance to 101 consumers and providers with insurance concerns, 67 directly related to the federal parity law. Non-parity issues raised include insurance access concerns that were not resolved by the federal parity law, access to affordable insurance and prescription medication.
- Implemented a call tracking procedure to document access barriers as healthcare reform unfolds. Data from this process is used to inform system change activities.
- Filed complaints against four insurance companies doing business in Maryland with the USDOL and the Maryland Insurance Administration (MIA); secured removal of outpatient visit limits from a small employer plan; two still under investigation.
- Assisted in filing six appeals; three with the Attorney General's Health Education and Advocacy Unit and three directly with providers and consumers; won an appeal that provided retroactive reimbursement.
- Surveyed more than 250 providers to identify possible patterns of parity violations and key issues of concern; results are being analyzed and will be released in early 2013.

FY 2014 – 2015 MARYLAND MENTAL HEALTH BLOCK GRANT

Goal 3: Policy and Systems Change

While systems change was not an original goal set forth at project inception, the depth of need for parity expertise in the public policy arena quickly became evident. The majority of parity-related calls we have taken fall in areas that must be further clarified in federal regulations, causing us to prioritize close collaboration with the National Parity Implementation Coalition to advocate for final regulations. The Affordable Care Act will bring federal parity protections to the small group and individual insurance markets in 2014, but without an enforceable parity law, this protection is meaningless for the increased number of Marylanders with behavioral health needs who will receive insurance coverage. As such, Parity staff have worked closely with health care reform implementation committees and staff to ensure proper implementation.

Additionally, during the 2013 Session of the Maryland General Assembly, the MHAMD and coalition partners worked successfully in to protect rights, address gaps in PMHS and federal parity law. As a result of advocacy efforts, HB 1216/SB 581 passed, which requires insurers to provide notice on their websites and annually in print to members (1) of the benefits required under State and federal parity laws and (2) that the member may contact the Maryland Insurance Administration (MIA) for further information. The bill will also assist consumers in enforcing their rights by making important 'release of information' documents more accessible and by requiring the MIA to post on its website information about the complaint process, including where an individual may turn for assistance in filing a complaint.

Also, passed was HB 1252/SB 582. This bill requires that the criteria and standards used in conducting utilization review for mental health and substance use benefits are in compliance with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). With this standard in statute, MIA will now have authority to examine the utilization review criteria of private review agents to ensure they comply with federal parity.

IV: Narrative Plan

K. Primary and Behavioral Health Care Integration Activities

Narrative Question:

Numerous provisions in the Affordable Care Act and other statutes improve the coordination of care for patients through the creation of health homes, where teams of health care professionals will be rewarded to coordinate care for patients with chronic conditions. States that have approved Medicaid State Plan Amendments (SPAs) will receive 90 percent Federal Medical Assistance Percentage (FMAP) for health home services for eight quarters. At this critical juncture, some states are ending their two years of enhanced FMAP and returning to their regular state FMAP for health home services. In addition, many states may be a year into the implementation of their dual eligible demonstration projects.

Please answer the following questions:

1. Describe your involvement in the various coordinated care initiatives that your state is pursuing?
2. Are there other coordinated care initiatives being developed or implemented in addition to opportunities afforded under the Affordable Care Act?
3. Are you working with your state's primary care organization or primary care association to enhance relationships between FQHCs, community health centers (CHC), other primary care practices and the publicly funded behavioral health providers?
4. Describe how your behavioral health facilities are moving towards addressing nicotine dependence on par with other substance use disorders.
5. Describe how your agency/system regularly screens, assesses, and addresses smoking amongst your clients. Include tools and supports (e.g. regular screening with a carbon monoxide (CO) monitor) that support your efforts to address smoking.
6. Describe how your behavioral health providers are screening and referring for:
 - a. heart disease,
 - b. hypertension,
 - c. high cholesterol, and/or
 - d. diabetes.

Footnotes:

FY 2014 – 2015 MARYLAND MENTAL HEALTH BLOCK GRANT

K. Primary and Behavioral Health Care Integration Activities

Department of Health and Mental Hygiene (DHMH) Behavioral Health Integration Activities

The Integration Process

As part of the State FY 2012 budget (for the fiscal year July 1, 2011-June 30, 2012) the Maryland General Assembly asked the DHMH to convene a workgroup and provide recommendations “to develop a system of integrated care for individuals with co-occurring serious mental illness and substance abuse issues”. In making this request, the General Assembly recognized the current need for improved coordination in Maryland’s approach to individuals with behavioral health conditions.

In 2011, the DHMH Secretary engaged an experienced consultant to examine the current system, consider integration options, and provide recommendations regarding financing structures to best support integrated care. The Secretary outlined seven principles to guide the future integration work. At that time, the consultants recommended two models:

- **Model 1 - Protected Carve In** – Maryland would bundle funding for medical care, mental health and substance abuse in the HealthChoice program. The carve-in of behavioral health services would be “protected” because the model would ensure adequate and identifiable funding for behavioral health services.
- **Model 2 - Risk Bearing Carve Out** – Under this model, Maryland would hire an organization to manage behavioral health benefits (both substance abuse and mental health) under some form of performance and/or financial risk model, and this entity would coordinate the services for which it has responsibility with the physical health benefits now managed by the MCOs in the HealthChoice program.

After reviewing the report and before finalizing a decision on the recommendations, the DHMH Secretary determined that more work needed to be done. Therefore, in 2012, the Department established a Steering Committee led by the Deputy Secretary for Health Care Financing to review financing and integration options. The Committee was comprised of representatives from key programmatic units of the Department including Medicaid, the Mental Hygiene Administration, the Alcohol and Drug Abuse Administration and the Chief Medical Officer. A third option was also proposed for consideration:

- **Model 3 -Risk Based Population Carve Out** – As in Model 1, all Medicaid-financed behavioral health benefits and general somatic benefits would be delivered under a comprehensive risk-based arrangement. In this model, however, Medicaid would competitively select one or more specialty managed care entity (SMCE) to manage the comprehensive benefit package for individuals with serious behavioral health disorders.

Between March and September 2012, the Department held a series of large public stakeholder meetings to inform the selection of a financing model. Four workgroups were established with the task of addressing specific issues related to the selection of a financing model. An email list was developed that included 831 individuals. Meeting announcements, materials and resource information was distributed. Webinars of the meetings and other discussions were utilized.

After considering all input, on November 1, 2012, the Steering Committee issued a report recommending Model 2, a specialty behavioral health carve-out. The Steering Committee recommended that the carve-out operate using an administrative services organization (ASO),

FY 2014 – 2015 MARYLAND MENTAL HEALTH BLOCK GRANT

with significant and meaningful performance risk at the ASO and behavioral health provider levels. Model 2 offers the following advantages:

- Covers all Medicaid eligible's
- Reduces burden on providers
- Adaptable when somatic programs change
- Adaptable when demographic patterns change
- Relationship to non-medical systems
- Eligibility churn
- Relationship to Health Benefit Exchange; and
- Relationship to State and local wraparound services.

Behavioral Health Integrated Regulations Workgroup

The Department of Health and Mental Hygiene, Behavioral Health and Disabilities aims to strengthen the foundation for an integrated behavioral health care system by integrating the regulations applicable to community-based mental health and substance use disorder services in Maryland.

In July, 2011 the Deputy Secretary for Behavioral Health and Disabilities appointed a Behavioral Health Integrated Regulations Workgroup to develop integrated regulations governing providers of behavioral health, which includes both mental health and substance use disorder services. The Workgroup consisted of representatives from the Mental Hygiene and Alcohol and Drug Abuse Administrations, the Office of the Attorney General, the Office of Health Care Quality, the Office of Health Care Financing, as well as providers of behavioral health services.

The Workgroup has been guided by these principles:

- Reflect and encourage both system and service integration
- Promote administrative simplicity
- Facilitate and support the use of evidence-based interventions
- Support a person-centered approach

Further, given the direction of behavioral health care's role vis-à-vis medical health care, the workgroup used the regulatory structure of somatic health care as a touchstone. This meant a new regulatory structure was viewed through the lens of how medical services are regulated, which are highly reliant upon the scope of a professional's license. Although the charge was to develop an integrated regulatory structure, there were inevitable discussions about the financial structure and how this workgroup's activity both impacted upon, and would be impacted by, the future financial model for behavioral health services. Those issues would be under consideration during Phase 3 in the development of the financial model for behavioral health services.

FY 2014 – 2015 MARYLAND MENTAL HEALTH BLOCK GRANT

As a result of the workgroup's activities to date, the workgroup is recommending that the Department of Health and Mental Hygiene (DHMH) require that treatment programs currently covered through mental health regulations (COMAR 10.21) or substance use disorder regulations (COMAR 10.47) apply for and become accredited by a State-approved accrediting organization by July 1, 2015. The State will require that programs be approved for licensure through DHMH in order to provide behavioral health services. Receiving accreditation is one step in the process to becoming licensed to provide behavioral health services. This approach, then, requires accreditation as part of the application for licensure to operate in Maryland as a behavioral health provider.

Next Steps

The "next steps" in the Behavioral Health Integration (BHI) process include the development of the Request for Proposal (RFP) to select an Administrative Services Organization (ASO) to administer the new MA financing model, as well as collaborative process with stakeholders to develop performance measures, shared savings models, quality and access to care standards and a financing approach that complements emerging clinical models of integration.

Additionally, the next steps in the BHI, is the combining of the mental health and the substance abuse administrations into a behavioral health administration. This process is overseen by the DHMH Deputy Secretary of Behavioral Health and Disabilities. The behavioral health administration organizational process is well underway with the recent appointment of a clinical director for mental health and substance abuse and the merger of the forensic services of three administrations (MHA, ADAA and Developmental Disabilities Administration (DDA)). In the process of blending the administrations, the Department has supported efforts to maintain the strengths and characteristics of each administration that are unique and serve to expedite and support many current initiatives.

Models of Primary Care and Behavioral Health Integration:

- **Behavioral Health Integration Program in Primary Care (B-HIPP)** – The DHMH and the State Department of Education (MSDE), along with the Johns Hopkins Bloomberg School of Public Health, the University of Maryland School of Medicine and the Salisbury University Department of Social Work, have launched a program aiming to support the efforts of pediatric primary care providers to assess and manage mental health concerns in their patients. B-HIPP is supported by funding from DHMH and MSDE. B-HIPP offers this assistance through four main components, all of which are available to primary care providers without charge and without regard to a patient's insurance status:
 - Phone Consultation Service – B-HIPP provides phone consultation for primary care providers with child mental health specialists (child psychiatrist, psychologists, clinical social workers and licensed professional counselors) at the UMD and JHU.
 - Continuing Education – B-HIPP will offer opportunities for mental health skills training for primary care providers.

FY 2014 – 2015 MARYLAND MENTAL HEALTH BLOCK GRANT

- Referral and Resource Networking – B-HIPP will work to increase access to children’s mental health services by improving links between primary care providers and the mental health providers in their communities.
- Social Work Co-Location – In partnership with Salisbury University, B-HIPP is piloting social work co-location in four pediatric primary care practices on the Eastern Shore of Maryland. In the co-location model, social work interns are available on-site to provide screening, brief intervention, referral and real-time consultation to primary care providers.

Maryland’s Medicaid Health Homes Initiative – The health home provision authorized by the Affordable Care Act (ACA) provides an opportunity to build a person-centered system of care that achieves improved outcomes for recipients of state Medicaid programs. Health Homes aim to further integration of behavioral and somatic care through improved coordination. Medical treatment and behavioral health care not only are provided at the same location, but as components of a single treatment plan for the whole person.

The MHA continues to collaborate with Maryland Medicaid on the implementation of a Chronic Health Home SPA. Maryland’s implementation model will enable health homes to act as a locus of coordination for individuals with a serious and persistent mental illness (SPMI) or serious emotional disorder (SED), in combination with meeting medical necessity criteria for Psychiatric Rehabilitation Programs (PRP) or Mobile Treatment (MT) services, or an opioid substance use disorder that is being treated with methadone, and at risk for an additional chronic condition due to current alcohol, tobacco, or substance use. Health Home services also include: comprehensive care management, health promotion, comprehensive transitional care, individual and family support and referral to community and social support. Provider training and stakeholder education activities have begun. The program is expected to go-live October 1, 2013.

Additionally, in 2012, Way Station, a behavioral health provider, implemented a Three-County Health Home pilot project. The project includes a comprehensive evaluation to measure the clinical effectiveness and cost efficiency of these interventions and assess the project’s success in achieving its goals. Dartmouth Medical School, in collaboration with DHMH, will conduct research of national significance with regard to this project, evaluating various clinical outcomes and analyzing Medicaid claims for all medical services to project participants.

IV: Narrative Plan

L. Health Disparities

Narrative Question:

In the Block Grant application, states are routinely asked to define the population they intend to serve (e.g., adults with SMI at risk for chronic health conditions, young adults engaged in underage drinking, populations living with or at risk for contracting HIV/AIDS). Within these populations of focus are subpopulations that may have disparate access to, use of, or outcomes from provided services. These disparities may be the result of differences in insurance coverage, language, beliefs, norms, values, and/or socioeconomic factors specific to that subpopulation. For instance, Latino adults with SMI may be at heightened risk for metabolic disorder due to lack of appropriate in-language primary care services, American Indian/Alaska Native youth may have an increased incidence of underage binge drinking due to coping patterns related to historical trauma within the American Indian/Alaska Native community, and African American women may be at greater risk for contracting HIV/AIDS due to lack of access to education on risky sexual behaviors in urban low-income communities.

While these factors might not be pervasive among the general population served by the Block Grant, they may be predominant among subpopulations or groups vulnerable to disparities. To address and ultimately reduce disparities, it is important for states to have a detailed understanding of who is being served or not being served within the community, including in what languages, in order to implement appropriate outreach and engagement strategies for diverse populations. The types of services provided, retention in services, and outcomes are critical measures of quality and outcomes of care for diverse groups. In order for states to address the potentially disparate impact of their Block Grant funded efforts, they will be asked to address access, use, and outcomes for subpopulations, which can be defined by the following factors: race, ethnicity, language, gender (including transgender), tribal connection, and sexual orientation (i.e., lesbian, gay, bisexual).

In the space below please answer the following questions:

1. How will you track access or enrollment in services, types of services (including language services) received and outcomes by race, ethnicity, gender, LGBTQ, and age?
2. How will you identify, address and track the language needs of disparity-vulnerable subpopulations?
3. How will you develop plans to address and eventually reduce disparities in access, service use, and outcomes for the above disparity-vulnerable subpopulations?
4. How will you use Block Grant funds to measure, track and respond to these disparities?

Footnotes:

FY 2014 – 2015 MARYLAND MENTAL HEALTH BLOCK GRANT

L. Health Disparities

Maryland Health Improvement and Disparities Reduction Act of 2012 (SB 234)

The law, signed April 10, 2012, establishes a \$4 million pilot project to reduce health disparities in the state, improve health outcomes such as infant mortality, obesity and cancer and lower health costs and hospital admissions. The primary focus of the Legislation was the creation of the Health Enterprise Zones (HEZs). HEZs are designed to reduce health disparities among Maryland's racial and ethnic groups and between geographic areas, improve healthcare access and health outcomes, and reduce healthcare costs by providing incentives to defined geographic areas with high rates of disparities. Core aspects of the law include:

- Create Health Enterprise Zones (HEZs) where health outreach will be targeted, with grants for community non-profits and government agencies along with tax breaks for health care providers who come to practice there
- Establish a standardized way to collect data on race and ethnicity in health care and ensure carriers are working to track and reduce disparities
- Require hospitals to launch community health initiatives and report on their success.
- Establishes a process to set criteria for health care providers on cultural competency and health literacy training and continuing education

Additionally, through Maryland's Office of Minority Health and Health Disparities, the Mental Hygiene Administration participates in activities coordinated by the Maryland Health Disparities Collaborative, which was established in 2008 and is comprised of more than 200 state health experts, health care organizations, academics and health advocates. The Collaborative was fully engaged in assisting the Department with the implementation of the Maryland Health Improvement and Disparities Reduction Act of 2012. The Collaborative established five workgroups (Awareness, Leadership and Capacity Building, Health and Health Systems, Cultural and Linguistic Competency and Research and Evaluation) to address the core aspects of the Act and develop recommendations.

IV: Narrative Plan

M. Recovery

Narrative Question:

SAMHSA encourages states to take proactive steps to implement recovery support services. SAMHSA is in a unique position to provide content expertise to assist states, and is asking for input from states to address this position. To accomplish this goal and support the wide-scale adoption of recovery supports, SAMHSA has launched Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.

Indicators/Measures

Please answer yes or no to the following questions:

1. Has the state has developed or adopted (or is the state in the process of developing and/or adopting) a definition of recovery and set of recovery values and/or principles that have been vetted with key stakeholders including people in recovery?
2. Has the state documented evidence of hiring people in recovery in leadership roles (e.g., in the state Office of Consumer Affairs) within the state behavioral health system?
3. Does the state's plan include strategies that involve the use of person-centered planning and self-direction and participant-directed care?
4. Does the state's plan indicate that a variety of recovery supports and services that meets the holistic needs of those seeking or in recovery are (or will be) available and accessible? Recovery supports and services include a mix of services outlined in The Good and Modern Continuum of Care Service Definitions, including peer support, recovery support coaching, recovery support center services, supports for self-directed care, peer navigators, and other recovery supports and services (e.g., warm lines, recovery housing, consumer/family education, supported employment, supported employments, peer-based crisis services, and respite care).
5. Does the state's plan include peer-delivered services designed to meet the needs of specific populations, such as veterans and military families, people with a history of trauma, members of racial/ethnic groups, LGBT populations, and families/significant others?
6. Does the state provide or support training for the professional workforce on recovery principles and recovery-oriented practice and systems, including the role of peer providers in the continuum of services?
7. Does the state have an accreditation program, certification program, or standards for peer-run services?
8. Describe your state's exemplary activities or initiatives related to recovery support services that go beyond what is required by the Block Grant application and that advance the state-of-the-art in recovery-oriented practice, services, and systems. Examples include: efforts to conduct empirical research on recovery supports/services, identification and dissemination of best practices in recovery supports/services, other innovative and exemplary activities that support the implementation of recovery-oriented approaches, and services within the state's behavioral health system.

Involvement of Individuals and Families

Recovery is based on the involvement of consumers/peers and their family members. States must work to support and help strengthen existing consumer, family, and youth networks; recovery organizations; and community peer support and advocacy organizations in expanding self-advocacy, self-help programs, support networks, and recovery support services. There are many activities that SMHAs and SSAs can undertake to engage these individuals and families. In the space below, states should describe their efforts to actively engage individuals and families in developing, implementing and monitoring the state mental health and substance abuse treatment system. In completing this response, state should consider the following questions:

1. How are individuals in recovery and family members utilized in the planning, delivery, and evaluation of behavioral health services?
2. Does the state sponsor meetings or other opportunities that specifically identify individuals' and family members' issues and needs regarding the behavioral health service system and develop a process for addressing these concerns?
3. How are individuals and family members presented with opportunities to proactively engage the behavioral health service delivery system; participate in treatment and recovery planning, shared decision making; and direct their ongoing care and support?
4. How does the state support and help strengthen and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services?

Housing

1. What are your state's plans to address housing needs of persons served so that they are not served in settings more restrictive than necessary?
2. What are your state's plans to address housing needs of persons served so that they are more appropriately incorporated into a

supportive community?

Footnotes:

M. Recovery

Maryland's Implementation of BRSS TACS 2013 Policy Academy: Bringing Recovery Supports to Scale

Maryland is a state where quality peer recovery support services are universally accessible, flexible, person-centered, sustainable, and valued. Peer recovery support services are delivered based on a clearly defined set of principles and outcomes. MHA continues to promote recovery in all aspects of the behavioral health care system. Maryland's agency for substance abuse, the Alcohol and Drug Abuse Administration (ADAA) applied for the BRSS TACS 2013 Policy Academy Application. In collaboration with ADAA this grant is joined by senior level representatives of the Mental Hygiene Administration (ADAA's partner agency within the Behavioral Health and Disabilities portion of the Maryland Department of Health and Mental Hygiene) as well as senior staff from the Office of Health Services, (Medicaid) and prominent members of the substance use disorder and mental health recovery systems.

The substance use disorder system and the mental health system in Maryland offer continuums of care including prevention, intervention, treatment, and recovery services in all jurisdictions across Maryland, but are striving to strengthen and expand the available peer-based services and supports through certification, eligibility for Medicaid reimbursement and workforce development. The most significant strengths are the existing recovery systems for both mental health and substance use disorders. The mental health system has engaged peers in a variety of roles and the substance use disorder field, with the implementation of the Recovery-Oriented System of Care (ROSC), is carving out a more integrated role for Peer Recovery Support Specialists. Both systems have offered training opportunities for their workforces that address recovery-oriented services and supports.

The Administrations jointly support the solicitation of feedback and meaningful involvement of consumers in the development of policy and services of the department. To that end, the Office of Consumer Affairs Advisory Council held a retreat in July, 2012, to foster the development of consumer led mission and vision statements. The group revised their name to the Peer Integrated Care Advisory Council of MD, and is comprised of consumers of behavioral health services (addictions, mental health, and co-occurring) representing all jurisdictions in Maryland who use their lived experiences to provide feedback to the Mental Hygiene Administration through the Office of Consumer Affairs. The Council advises and consults to the Mental Hygiene Administration Office of Consumer Affairs regarding policies and procedures that educate, empower and advocate for consumers, including quality improvement initiatives that focus on consumer rights, community building and the promotion of integrated care.

In January, 2013, a work group on peer certification was convened in order to evaluate any existing addiction and/or mental health core curricula that might potentially be able to be used towards a Peer Recovery Support Specialist certification. Core curricula were assessed in relation to the IC&RC's 4 core competencies for Peer Specialists (Peer Mentors). Two curricula

FY 2014 – 2015 MARYLAND MENTAL HEALTH BLOCK GRANT

were selected for in-depth review, the Connecticut Community for Addiction Recovery (CCAR)'s Recovery Coach Academy core training for Substance Use Disorder (SUD) Specialists and a Mental Health corollary core curriculum, the Wellness Recovery Action Plan (WRAP) facilitators training. The group had also explored other well-known mental health (MH) curricula including Intentional Peer Support, Mental Health First Aid, and Trauma Informed Care. The group found that CCAR's Recovery Coach Academy training satisfied 31 of the International Certification and Reciprocity Consortium (IC&RC)'s required core competencies, and the WRAP's facilitator training would provide 22 of the 46 hours required by the proposed IC&RC Peer Mentor credential. The group then worked on identifying other courses that would help bridge the deficit of the two core curricula.

All of these strengths reference above indicate the ability of the Maryland team to utilize the assistance of the Policy Academy in order to facilitate the expansion and enhancement of peer recovery support services, and the development of the Peer Recovery Support Specialist workforce within efforts to expand insurance coverage.

Additionally, MHA, in collaboration with On Our Own of Maryland (OOOMD), will continue statewide delivery of Wellness and Recovery Action Plan (WRAP) training as part of ongoing efforts to increase the wellness and recovery orientation, enhance peer support activities, utilize best practices within the consumer movement, and continue to incorporate WRAP within community mental health programs. The Plan also addresses our increasing efforts to actively involve consumers and families in quality improvement and evaluation activities.

Partners in Recovery and Resilience -The strength of Maryland's PMHS comes mainly from its long-time collaboration with consumer, family, advocacy, and provider organizations. MHA has partnered with these organizations since their inceptions and, in fact, fostered their development. Additionally, MHA's partnerships include academic institutions and federal, state, and local agencies.

FY 2014 – 2015 MARYLAND MENTAL HEALTH BLOCK GRANT

INVOLVEMENT OF INDIVIDUALS AND FAMILIES

Partners in Recovery and Resilience -The strength of Maryland’s PMHS comes mainly from its long-time collaboration with consumer, family, advocacy, and provider organizations. MHA has partnered with these organizations since their inceptions and, in fact, fostered their development. Additionally, MHA’s partnerships include academic institutions and federal, state, and local agencies.

Youth & Family Involvement - The value placed on youth and family member participation continues as a major priority of the Child and Adolescent Mental Health System. This value also appears as the first element of the Interagency Strategic Plan. MHA and its partners encourage the input of youth, family members, and adult consumers across the board. A concerted effort is made to include all in the planning, development, and monitoring of the PMHS. In FY 2014, MHA will continue to fund the Maryland Coalition of Families (MCF) for Children’s Mental Health, a statewide child and family advocacy group, to develop local family support activities. The Coalition’s mission is to inform families of children and adolescents about policy, to teach them about becoming participants in the policy and decision-making process, and to provide feedback about the operations of the Public Mental Health System. The Coalition participates on more than 22 state and local policy shaping committees. At the current time, over 50 family members are employed by the Coalition, its local counterparts, or in local child serving systems as providers of peer-to-peer support and assistance to families in navigating the system.

A highly successful project of MCF, jointly with the Maryland Mental Health Association, is the “Children’s Mental Health Matters” public awareness campaign. This project is a significant social marketing effort designed to: improve public information, reduce the stigmatization of youth with mental health conditions, and garner public support for innovative system development through a major public awareness campaign. The campaign is a partnership with local broadcast affiliates and involves Maryland’s Governor, Martin O’Malley and First Lady, Katie O’Malley, as Honorary Chair. A major media blitz occurred during Children’s Mental Health Week during this past May and will be continued in the upcoming year.

www.childrensmentalhealthmatters.org).

MCF has conducted extensive research over the years, including studies using focus group design, of parents involved with custody relinquishment, the juvenile justice system, transition-age youth (TAY) and families of young children engaged with the early childhood education system. These studies have been described in past year’s plans and they provide an excellent and highly effective basis to support advocacy and policy initiatives designed to improve the child and adolescent system of care. In addition, MCF established a Family Leadership Institute (FLI) which has continued producing new advocates every year since. FLI provides a six-month training program for families in becoming advocates in their communities and the state. The sixth Family Leadership Institute was held this year with 20 graduates, increasing the total number of trained family advocates to 115 over the eight years of the Institute’s implementation.

FY 2014 – 2015 MARYLAND MENTAL HEALTH BLOCK GRANT

Maryland maintains an ongoing commitment to consumer and family involvement in planning, policy and program development, and evaluation. In conjunction with its commitment to system transformation, MHA maintains a focus on consumer and family involvement to assure that services are continuously examined and redesigned to best support recovery and resiliency. The MHA Office of Consumer Affairs (OCA) participates in systems level activities at all pertinent MHA meetings. MHA, in collaboration with the Maryland Mental Health Transformation Office (MHTO), has made a number of significant investments in promoting consumer-driven care through several specific programs/initiatives.

MHA and the local CSAs have been instrumental in encouraging the development of local advocacy organizations throughout Maryland. MHA, in collaboration with the CSAs has supported On Our Own of Maryland's (OOOMD) initiatives to transform its consumer network toward a wellness and recovery-oriented system and to enhance peer support activities and the use of best practices within the community. These collaborations include:

- Recovery Training Project (formerly the Advocacy Training Project) which provides training to adult psychiatric rehabilitation programs (PRPs), outpatient mental health clinics (OMHCs), and consumer groups as a step in a longer term effort to assist Maryland's Public Mental Health System (PMHS) to begin or continue to incorporate practices based on recovery into their agencies. Three Workshops have been developed within this project to include 1) "Motivational Vitamins" provides information to help participants to work through common hesitations about entering or re-entering the workforce; 2) Discovering your Recovery Muse, which approaches recovery from a non-traditional angle introduces participants to better health through various creative processes such as art, dance, music, and writing; and 3) Steps to a Healthier You designed to motivate and inspire participants to make smarter choices about nutrition, increase physical activity, and develop helpful habits.
- MHA also, in partnership with OOOMD, developed a project under the federal Olmstead Planning Grant titled the Olmstead Peer Support Program. Three Peer Support Specialists (PSS), who are also WRAP facilitators, facilitate consumer discharges and provide ongoing support during the consumers' transition into the community from three state facilities: Springfield, Eastern Shore, and Finan Hospital Centers. In FY 2011 a total of 111 consumers in state hospitals were seen by the PSS staff. PSS staff also provided help and referrals to Wellness & Recovery centers (22 of the 25 Centers are OOOMD affiliates), CSAs, and other organizations that work to enhance recovery.
- WRAP Trainings – a 2 ½ day "Introduction to Mental Health Recovery including WRAP training was held in March 2013, in collaboration with MHA's Office of Special Populations. The Outreach Project in the state is now up to 139 WRAP facilitators.
- OOOMD and MHA continue to collaborate to fight stigma within the mental health system through the Anti-Stigma Project (ASP) which helps participants identify stigmatizing behaviors and attitudes as well as possible solutions, communication techniques, and actions as vehicles for change. Workshops may be designed and tailored to address specific populations and situations such as issues related to cultural competency, housing, co-occurring disorders, and the reduction/elimination of

FY 2014 – 2015 MARYLAND MENTAL HEALTH BLOCK GRANT

seclusion and restraint and are presented in a wide spectrum of venues, such as local Wellness & Recovery centers, housing authorities, homeless shelters, and statewide conferences and universities. In FY 2013, the ASP presented 51 workshops throughout the state which trained 1,112 people in the full program and reached at least 259 additional participants on various levels. OOOMD continues to receive requests for the teaching videotape, "Stigma...In Our Work, In Our Lives", which is now being used in more than 39 states and four other countries. A new workshop has been added on internalized stigma, "An Inside Look at Stigma," as well as a workshop on creating non-stigmatizing environments. ASP is currently using resources from the MHT-SIG to collaborate with researchers to evaluate the quantitative impact of this training project and its possibilities as a best or promising evidence-based tool.

Maryland provides support to the statewide National Alliance on Mental Illness of Maryland (NAMI MD) organization and its local affiliates. MHA worked successfully with NAMI MD in promoting the NAMIWALKS, a successful kick-off event for promoting *MAY MENTAL HEALTH MONTH*. In 2013, the annual NAMIWALKS, that takes place on the first Sunday each May, was expanded to include two major walks; one in Baltimore City and one in Montgomery County. NAMI MD has developed a strong Family-to-Family Education presence in the state. The "In Our Own Voice" program is an informational outreach program on recovery. Peer-to-Peer is a unique, experiential learning program for people with serious mental illness who are interested in establishing and maintaining their wellness and recovery. With support from MHTO, NAMI MD has begun two initiatives to support the integration of physical and mental health – NAMI MD's Healthy Hearts and Minds education program and an information dissemination project. Additionally, NAMI MD presents an annual education conference for families, consumers, and providers. In FY 2014 MHA will continue to support NAMI MD's public education and training efforts. Maryland's strong, well-developed network of consumer, family, advocacy, and provider participation continues to play an essential role in the ongoing success of the PMHS.

Housing

MHA has long funded residential rehabilitation programs (RRPs), which are programs that offer residential services to persons with serious mental illnesses (SMI) in need of intensive services and supports to eventually integrate into the community. Expansion of RRP beds in the last several years has been targeted to specific initiatives. Currently there are 2,500 RRP beds in the system. Based on claims paid through 12/31/2012, a total of 4,020 individuals with SMI received RRP services and a total of 4,344 adults had claims paid for RRP services in fiscal year 2012. MHA continues to encourage the expansion of the supported living model through which individuals with psychiatric disabilities may access an array of flexible service delivery programs, including psychiatric rehabilitation programs (PRPs), case management, and other supports to enable them to live in housing of their choice. In this model, consumer housing is not dependent on the receipt of services. Statistics, available from the ASO showing the admissions and discharges from RRP over the years 2009, 2010 and part of 2011, show an increase in the number of consumers moving out of RRP. The number of individuals leaving the hospital has

FY 2014 – 2015 MARYLAND MENTAL HEALTH BLOCK GRANT

increased since in-reach and out-reach with providers has started and collaboration with clinics and other community-based resources have improved. MHA has promoted:

- Identification of ways to in-reach with patients in the hospital (providers come to meet and educate them about their services) by offering access to resources such as: local and state administered funding such as HOME and the HUD Community Development Block Grant (CDBG); benefit applications; delivery of Supplemental Social Security, Outreach, Access, and Recovery (SOAR) training; and conducting training for RRP providers on working with individuals with forensic needs.
- Assistance through case management and other agencies for individuals with disabilities to look for accessible and affordable housing.
- Diversion of individuals from admissions and/or discharging individuals from the hospitals to assist in further reductions in the hospitals' census. This process includes individuals transitioning from RRPs to supported housing so that individuals in state hospitals may access the vacant RRP beds.
- Conducting an ongoing group with RRP providers, CSAs, and state hospitals to reduce the number of vacancies in the RRP,
- Giving access to housing in the community by persons with SMI through licensed assisted living providers located throughout the state.
- Ongoing partnerships with local public housing authorities (PHAs) and other housing programs to assist with helping individuals to step down from their placement in the community to more independent housing.
- Supported housing providers, as well as a few developers applying for tax credits through the Department of Housing and Community Development (DHCD), are working on blended funding and resources already established in the community to serve individuals coming out of the state hospitals or stepping down from RRPs.
- Development and updating of the RRP Survey Manual by hospital staff, providers, and CSAs to detail the process that promotes movement from RRPs into supported housing or other independent living situations.

MHA's priority for Administration-Sponsored Capital Program grant (Community Bond) financing is the development of affordable housing projects. Through the DHMH Community Bond a total of \$4.5 million was approved for FY 2012 to serve individuals with mental health needs, by providing new housing options under this program. On January 26, 2012 MHA and DHMH Community Bond staff convened a meeting to inform more than 30? potential provider/applicants of the benefits of community bond funding as a way to increase affordable housing options and to explain the application process. To date, more than 525 housing units have been developed through Community Bond funding and the following entities, including mental health provider organizations: Main Street Housing, Prologue, Humanim, Way Station, Supported Housing Developers, Community Housing Associates, Key Point, Alliance, Family Services Foundation, Mosaic, Crossroads, People Encouraging People, Project PLASE and others.

In 2011, a collaborative effort among Springfield Hospital Center, Housing Unlimited, Inc. (HUI), and the Montgomery County Core Service Agency (CSA), community bond funding was

FY 2014 – 2015 MARYLAND MENTAL HEALTH BLOCK GRANT

leveraged with the goal, over two years, of transitioning 20 Springfield Hospital Center patients into RRP. The residents in the RRP programs would move into supported housing provided through HUI. Funding to match the Community Bond award came from the Springfield Hospital Center budget to offer rental assistance to tenants moving into HUI units. To date, nine individuals have been placed in HUI supporting housing units.

In February, 2013, Maryland was chosen as one of 13 states to participate in the U.S. Department of Housing and Urban Development's (HUD's) Section 811 Supportive Housing for Persons with Disabilities Project Rental Assistance (PRA) Demonstration. This Demonstration is designed to assist state housing agencies to expand integrated supportive housing opportunities for people with the most significant and long term disabilities and enables persons with disabilities who earn less than 30 percent of median income to live in integrated mainstream settings.

The Maryland Department of Housing and Community Development (DHCD) in partnership with the Department of Health and Mental Hygiene and the Department of Disabilities will administer the funding of \$10,917,383, which will serve 150 individuals. Section 811 PRA Demo funds will be leveraged with federal and state resources such as Low-Income Housing Tax Credits, private activity bonds used for multifamily development, FHA Risk Share Lending, and HOME Investments Partnership Program, Maryland's Rental Housing Production Program, Maryland Housing Rehabilitation Program-Multi-Family, the Partnership Rental Housing Program and other resources. The targeted populations of persons under Maryland's PRA Demo are particularly vulnerable non-elderly adults with disabilities prioritized as one or more of the following: institutionalized Medicaid recipients; households at risk of institutionalization due to a current housing situation; Developmental Disabilities Administration Community Pathways Waiver participants moving from Group Homes/Alternative Living Units to independent living; Mental Hygiene Administration Residential Rehabilitation Program participants moving to independent living; and/or homeless persons who are Medicaid recipients.

Also, MHA's strong interagency collaboration with DHCD and the Department of Disabilities (MDOD) has resulted in increased housing options for consumers of behavioral health services. In May 2011, an announcement was made by Governor Martin O'Malley to highlight efforts between DHCD, the Weinberg Foundation, and DHMH to fund non-profit developers with capital financing to offer housing units to persons at Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI) level of income. Under a Memorandum of Understanding, the Weinberg Foundation and the above mentioned state agencies will work together to finance affordable, quality, independent, integrated housing opportunities for persons with very low income and disabilities who meet certain eligibility criteria. The Weinberg units will house non-elderly individuals with disabilities at 15-30% AMI (Area Median Income) who pay 30% of their income for rent. Work will continue with local public housing authorities (PHAs) to help secure access to and stability in housing for consumers. A referral process for Weinberg Housing units and HUD 811 (when awarded) is in the process of being developed and will be coordinated through MDOD to place consumers on a waiting list for

FY 2014 – 2015 MARYLAND MENTAL HEALTH BLOCK GRANT

community-based supported housing. Monthly meetings are held with other housing partners to address the waiting list process for Weinberg units.

Housing that is affordable, accessible, and integrated in the community is a major factor in enhancing the recovery of persons with serious mental illnesses (SMI). Toward this end, MHA actively collaborates with the Maryland Department of Housing and Community Development (DHCD), federal Housing and Urban Development (HUD), county housing authorities, local housing coalitions, and county agencies, as well as non-profit developers and mental health providers. These partnerships promote access to housing development that is affordable with assistance from specialized federal and state government-supported housing opportunities, as well as local county resources and private foundations. DHCD is represented on the Joint Maryland Advisory Council on Mental Hygiene/PL 102-321 Planning Council.

MHA encourages the CSAs to work with local housing authorities and housing developers to develop affordable and safe housing in their regions. This has resulted in extensive partnerships to provide consumers with affordable housing and rental subsidies along with accompanying support services as needed and requested by the consumer. MHA has worked toward efforts to increase availability of housing vouchers through the following processes:

- MHA has encouraged providers of residential rehabilitation services (RRPs) with CSA support to submit applications for HUD 811 that come with designated Flexible Housing Choice Vouchers.
- MHA participates in working with a steering committee – Maryland Partnership for Affordable Housing (MPAH) Advisory Group – chaired by MDOD and Money Follows the Person representatives, to implement the changes within the HUD 811 program in preparation for the HUD Notice of Funds Availability (NOFA), which are posted throughout the year for HUD projects. MHA participates in an ongoing interagency group meeting every other month to access vacancies and access resources and supports.
- MHA also promotes the efforts of case management and other agencies to assist in the implementation of the NED Notice of Funds Availability that provided new vouchers for persons with disabilities in Howard, Baltimore, Carroll, and Montgomery counties; Baltimore City; and other jurisdictions designated by DHCD. These NED vouchers (Category I and II) assist individuals who cannot access affordable housing in senior-only buildings. In 2012, this program received \$3.8 million from HUD's Rental Assistance Program for a total of 372 vouchers distributed to Non-Elderly Persons with Disabilities in Maryland. However, due to changes in the federal budget priorities and the increase cost of all housing, access to new housing vouchers for individuals with disabilities has been limited.

FY 2014 – 2015 MARYLAND MENTAL HEALTH BLOCK GRANT

- MHA [along with the Technical Assistance Collaborative (TAC) and other state and local agencies] continues to monitor developments in funding with HUD for special groups such as its **Veterans Affairs Supportive Housing (VASH) program (which received funding of \$1.5 million to** combine Housing Choice Voucher rental assistance for homeless veterans with case management and clinical services provided by Veterans Affairs (VA) at its medical centers and in the community). A total of 140 vouchers became available through HUD funding. As funding (including special funding that can assist with developing a uniform and fair referral system) becomes available, MHA notifies agencies that are eligible to apply.
- Rates in the fee-for-service system help to support individuals' abilities to live in their own homes.
- Additionally, the DHCD Web site, mdhousing.org, continues to be a resource for landlords to post vacancies and for tenants and future tenants to explore available units.
- MHA continues to fund Main Street Housing, Inc. (MSH), a consumer-operated project, whose mission is to enable consumers with limited income to live in the least restrictive setting. Main Street Housing, a subsidiary non-profit corporation of On Our Own of Maryland, is dedicated to providing safe and affordable housing to persons with psychiatric disabilities. Main Street Housing is now designated as a Community Housing Development Organization (CHDO). It has recently updated its database system to track tenant outcomes. The system will focus on understanding the relationship between stable, permanent housing and the stability of the tenants.

IV: Narrative Plan

N. Evidence Based Prevention and Treatment Approaches for the MHBG (5 percent)

Narrative Question:

States are being asked to utilize at least five percent of their MHBG funds to award competitive grants to implement the most effective evidence-based prevention and treatment approaches focusing on promotion, prevention and early intervention. States that receive two percent or more of the total FY 2014 state allotment will be required to implement a competitive sub award process. States should describe how they intend to implement the competitive grants and/or sub award process.

Footnotes:

FY 2014 – 2015 MARYLAND MENTAL HEALTH BLOCK GRANT

N. Evidence-Based Practices (EBPs)

The mental health field has benefited from a substantial body of research about practices that can improve the lives of many people who experience mental illness. The Mental Health Systems Improvement Collaborative (MHSIC) was created in 2001 as a joint venture between the Mental Hygiene Administration (MHA) and the University of Maryland, Baltimore (UMB). MHSIC is located in the Division of Services Research, which is a unit of the School of Medicine's Department of Psychiatry. MHSIC is made up of the Mental Health Services Training Center, the Evidence-Based Practice Center (EBPC) and the Systems Evaluation Center (SEC). Through the block grant, MHA funds the EBPC and the SEC at the MHSIC. These three Centers work in partnership with MHA to foster and support the continued development of the Public Mental Health System (PMHS). The combination of Centers provides an opportunity to initiate changes in system management, policy development, and service delivery while assessing and analyzing system performance.

The EBPC is in the 10th year of active implementation of Evidence-Based Practices (EBPs) for adults. These include Supported Employment (SE), Assertive Community Treatment (ACT) and Family Psychoeducation (FPE). Additionally a Co-Occurring Disorders Specialist is working to move the system towards Dual Diagnosis Capability, and is also monitoring the activities of two programs implementing Integrated Dual Disorders Treatment. Fidelity assessments for programs offering the EBPs of ACT, FPE and SE are conducted by MHA Fidelity Monitors annually to determine a program's eligibility to receive the enhanced EBP reimbursement rate. Sites must score minimum thresholds on the fidelity measurement tool, taken from the SAMHSA toolkit, in order to bill at the enhanced rate.

MHA's relationship with the state Division of Rehabilitation Services (DORS) is another example of Maryland's collaborative strengths and commitment to supported employment. Outstanding integration between MHA and DORS at the state level and among CSAs, programs, and local DORS offices, has been recognized as exceptional by national leaders in implementation of evidence-based practices. DORS and MHA jointly applied for and were awarded a grant from the Johnson and Johnson – Dartmouth Community Mental Health Program (J & J – Dartmouth Program), designed to further promote EBP SE services. The number of SE programs grew considerably and as of 2013, there are 57 approved community mental health provider sites across Maryland that provide SE services and supports to customers with SMI, 40 of which have received training and technical assistance in EBP SE implementation, and 23 of which currently meet EBP SE fidelity standards in order to demonstrate eligibility for an enhanced EBP rate in recognition of the additional services provided. This creative partnership between MHA and DORS has been nationally recognized as a promising practice by the Centers for Medicare and Medicaid Services (CMS) and by the Rehabilitation Services Administration (RSA) and with the receipt of the Inaugural Science to Service Implementation Award from the Substance Abuse and Mental Health Services Administration. The EBP SE Implementation Initiative in Maryland has enhanced the quality of SE services, increased competitive employment outcomes for SE consumers (average of 57% in competitive employment among EBP sites since inception of initiative) In FY 2013, 3,105 consumers were served in SE.

FY 2014 – 2015 MARYLAND MENTAL HEALTH BLOCK GRANT

In July 2011, Maryland began piloting the newly expanded Assertive Community Treatment (ACT) assessment tool developed through initial funding by the Washington State Mental Health Division, Department of Social and Health Services, Health and Recovery Administration. Named the *Tool for Measurement of Assertive Community Treatment* (TMACT), this instrument will eventually replace the current mechanism for gauging adherence to the established ACT model. The *Dartmouth Assertive Community Treatment Scale* (DACTS) has been the assessment tool used to monitor Maryland ACT services since 2002, and to which reimbursement rates are tied.

The TMACT, based on the DACTS, expands the assessment to include qualitative information along with team structuring. TMACT measures six subscales: (1) Operations and Structure, (2) Core Team, (3) Specialist Team, (4) Core Practices, (5) Evidence-Based Practices and (6) Person Centered Planning and Practices, integrating team structure, staffing and practices. Monitoring of these subscales will improve ACT service delivery. Currently piloted in several states, TMACT is still undergoing revisions and refinements. This tool will be used for quality improvement purposes until the research is completed. Fidelity scoring for ACT teams will rely solely on the DACTS until TMACT research is completed.

MHA fidelity monitors are utilizing TACT during fidelity assessments. ACT providers receive both a DACTS score and a TMACT score as well as qualitative analysis and recommendations for enhance service quality. Results are shared with the EBPC's ACT consultant who provides technical support to teams to implement TMACT recommendations. Of the 27 mobile treatment (MT) teams in Maryland, sixteen (16) are EBP ACT.

MHA will continue to promote efforts to help individuals improve their overall health status through prevention, early intervention and wellness activities. Strategies will be developed with an emphasis on, coordination, evidence-based practices, suicide prevention and developing more effective programs to support safer schools and communities.

IV: Narrative Plan

O. Children and Adolescents Behavioral Health Services

Narrative Question:

Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with over 160 grants awarded to states and communities, and every state has received at least one CMHI grant. In 2011, SAMHSA awarded System of Care Expansion grants to 24 states to bring this approach to scale in states. In terms of adolescent substance abuse, in 2007, SAMHSA awarded State Substance Abuse Coordinator grants to 16 states to begin to build a state infrastructure for substance abuse treatment and recovery-oriented systems of care for youth with substance use disorders. This work has continued with a focus on financing and workforce development to support a recovery-oriented system of care that incorporates established evidence-based treatment for youth with substance use disorders.

SAMHSA expects that states will build on this well-documented, effective system of care approach to serving children and youth with behavioral health needs. Given the multi-system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs and better invest resources. The array of services and supports in the system of care approach includes non-residential services, like wraparound service planning, intensive care management, outpatient therapy, intensive home-based services, substance abuse intensive outpatient services, continuing care, and mobile crisis response; supportive services, like peer youth support, family peer support, respite services, mental health consultation, and supported education and employment; and residential services, like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification.

Please answer the following questions:

1. How will the state establish and monitor a system of care approach to support the recovery and resilience of children and youth with mental and substance use disorders?
2. What guidelines have and/or will the state establish for individualized care planning for children/youth with mental, substance use and co-occurring disorders?
3. How has the state established collaboration with other child- and youth-serving agencies in the state to address behavioral health needs (e.g., child welfare, juvenile justice, education, etc.)?
4. How will the state provide training in evidence-based mental and substance abuse prevention, treatment and recovery services for children/adolescents and their families?
5. How will the state monitor and track service utilization, costs and outcomes for children and youth with mental, substance use and co-occurring disorders?

Footnotes:

FY 2014 – 2015 MARYLAND MENTAL HEALTH BLOCK GRANT

O. Behavioral Health Services for Children, Adolescents and Adults

Comprehensive Community – Based Mental Health Service System

AVAILABLE SYSTEMS OF TREATMENT, REHABILITATION, AND SUPPORT SERVICES

At this time, community-based services in the fee-for-service benefits package include:

- Psychiatric hospitals
- Psychiatric units of acute care general hospitals
- Residential treatment centers (RTCs) (children and adolescents only)
- Psychiatric day treatment (also called partial hospitalization)
- Outpatient mental health clinics (many of which provide school-based and after-school treatment programs)
- Psychiatric rehabilitation programs (PRPs)
- Residential rehabilitation programs (RRPs)
- Case Management
- Mobile treatment services (MTS)
- Supported living programs
- Supported employment (SE) and vocational services
- Respite care
- Residential crisis services
- Therapeutic behavioral aides
- Mental health related laboratory services

MHA also provides funds through contracts to programs that offer specialized services (e.g., mobile crisis) that do not fit the fee-for-service model. These programs are eligible to apply for funds, as are consumer support programs such as peer support programs, family support groups, consumer-run businesses, and protection and advocacy services (at least two of which are peer-run).

Any provider who meets appropriate licensing, certification, accreditation, or other applicable standards is eligible to become a provider in the fee-for-service system. Eligible providers include facilities, programs, and individual practitioners. Individual practitioners include physicians, psychologists, nurse psychotherapists, clinical social workers, occupational therapists, and licensed clinical professional counselors who are allowed to practice independently under their Practice Acts. This increase in the provider community offers consumers an expanded choice of providers.

In addition, Maryland has recently submitted an application to CMS to create a child and adolescent Health Home program, which, if approved, will provide an additional set of coordination services with primary and specialty somatic care as well as wellness services through selected PRP providers.

FY 2014 – 2015 MARYLAND MENTAL HEALTH BLOCK GRANT

Center for Medicare/ Medicaid Services PRTF Waiver - Maryland is in the final year of operating a Section 1915(c) Medicaid waiver for home and community-based services for children and youth in the Psychiatric Residential Treatment Facility (PRTF) level of care. At the current time the waiver is not open to new enrollments and is only serving youth and families enrolled before September 30, 2013. Maryland was one of ten states selected to participate in the Centers for Medicare and Medicaid (CMS) sponsored PRTF demonstration which is based on using section 1915(c) federal Medicaid demonstration waivers to divert youth from psychiatric residential treatment and provide them with community-based services. Children may remain in the waiver for up to 24 months with an annual review.

A major component of the implementation of the waiver was the statewide development of Interagency Care Management Entities (CMEs). This effort is strongly integrative of the agency efforts in Maryland. CMEs provide care management, in addition to youth in the PRTF waiver, to {1} youth placed at the group home level by both DHR and DJS; {2} youth under auspices of two SAMHSA funded SOC grants in Baltimore City and on the Eastern Shore of Maryland.

Children’s Health Insurance Program Reauthorization Act (CHIPRA) Quality Demonstration Grants - Maryland applied successfully to CMS for the CHIPRA Quality Demonstration grant as the head of a consortium of states, including fellow PRTF demo partner, the State of Georgia, and the State of Wyoming. The grant is the only behavioral health grant among all 10 awarded by CMS, focusing on the implementation, expansion and sustainability of Care Management Entities (CMEs) as described above. As a result, the five year CHIPRA Quality Demonstration becomes an anchor in the sustainability planning for CME and System of Care efforts started up under the 1915(c) and SAMHSA SOC grants.

In brief, the CHIPRA grant will support a number of projects toward sustainability over the course of the two years covered by this block grant application: These include the following:

- Finance project- Development of a financial sustainability plan, including the development of a Section 1915(i) state plan amendment
- Psychopharmacological Project--Developing State of the art mechanisms to assure appropriate uses of medications with children and adolescents in the Medicaid program.
- Somatic health—Strengthen CMEs to expand their focus to include coordination of somatic care such as access to well child visit, EPSDT, dental, smoking cessation , obesity, poor nutrition, and health care consumer skills, and other critical health care coordination issues as they arise.
- Peer Support--Refining and strengthening Maryland’s approach to family to family peer support and developing appropriate reimbursement mechanisms to support peer support as a Medicaid service. Possible examination of the difficult area of developing youth peer support services and developing infrastructure to support this service.

FY 2014 – 2015 MARYLAND MENTAL HEALTH BLOCK GRANT

SERVICES FOR PERSONS AT RISK OF HAVING SUBSTANCE USE AND/OR MENTAL HEALTH DISORDERS

Mental Hygiene Administration's Office of Child and Adolescent Services (OCAS) is responsible for planning, monitoring for program compliance and building partnerships to ensure the delivery of mental health services to children and their families within the public mental health system (PMHS). The Office works closely with other child-serving agencies and the core service agencies to improve access and coordination of care for the child and adolescent population.

The Office, with its partners and stakeholders, provides leadership, expertise and guidance to promote wellness, prevention and resiliency in all child and adolescent mental health. These efforts range from a few universal prevention programs to the most intense levels of care in every jurisdiction. Maryland continues to make progress in growing its System of Care, imbued with core values of being child-centered, family and youth driven, community-based and culturally and linguistically competent.

The Children's Cabinet is Maryland's state level interagency body charged with development and implementation of an integrated interagency system of care for children, youth and families. Maryland was among the first states in the nation to legislatively create an interagency coordination body with the passage of Chapter 426 of the Acts of 1978. Subsequently, the General Assembly formalized the creation of the Subcabinet for Children Youth and Families in 1990. The existence of such an enduring interagency structure creates a highly effective venue for interagency policy development and implementation.

The Children's Cabinet is composed of the Secretaries of all the major executive departments that directly provide or finance service delivery to youth and their families. These agencies include: Maryland State Department of Education (MSDE), Department of Health and Mental Hygiene (DHMH), Department of Juvenile Services (DJS), Department of Human Resources (DHR), Department of Disabilities (MDOD), and Department of Budget Management (DBM). The Governor's Office for Children (GOC) provides staffing and coordination functions for the Children's Cabinet. A working subgroup of the Children's Cabinet, the Children's Cabinet Results Team (CCRT), meets more frequently to move the work of the Cabinet forward. The CCRT membership includes Deputy Secretaries and other key members from the same agencies as the Cabinet. The Director of MHA's Child and Adolescent Services is a major participant in the CCRT's work, providing staff support to the Secretary of Health and Mental Hygiene in his role on the Children's Cabinet and representing DHMH on CCRT. As a result, mental health is well represented with major input into all policy decisions and programs. The Children's Cabinet collaborates to promote the vision of the state for a stable, safe, and healthy environment for children and families. The Children's Cabinet also assesses need, establishes budget priorities, and develops interagency initiatives to address these specific priority needs.

Maryland has a long track record in creating extensive interagency infrastructure and interagency mechanisms for sustaining and improving an integrated system of care for children, youth, and families under the broad aegis of the Children's Cabinet. Much of our success in

FY 2014 – 2015 MARYLAND MENTAL HEALTH BLOCK GRANT

interagency planning is based on the next element of the narrative, Maryland's commitment to youth and family involvement.

Social Services - The social service sector in Maryland is primarily housed in the Department of Human Resources (DHR). For child and adolescent planning purposes, the majority of social services are administratively located in the Social Services Administration (SSA). The principal functions of SSA are child welfare focused including child protection, kinship care, and formal custodial placement of children in a variety of out of home placements, family reunification, and adoption/post adoption services. Collaboration with social service providers is particularly important given the high prevalence of mental health disorders among children who are in custody of the state's child welfare system. MHA tracks the percentage of selected categories of youth in the child welfare systems who receive services via the PMHS as a performance indicator.

- **“Place Matters”**--A current major priority of DHR is the “Place Matters” campaign. The agency joined with the Annie E. Casey Foundation's Casey Strategic Consulting Group to reform foster care in the state. DHR is spearheading an effort to bolster new foster family homes so that children live in closer proximity to their family members and their communities. Key Performance Measures for Place Matters include: {1} reducing the number of children in out-of-home care; {2} reducing the number of children in group homes; {3} increasing the number of children placed in their home jurisdiction; {4} increasing the number of children who reunite with their family; and {5} increasing the number of adoptions.
- **“Other DHR”** - Other DHR social services, outside of child welfare, include homeless services, domestic violence services, victim services, adult services, and Medicaid eligibility services, (notably for Medicaid waivers). Child care services, typically considered a social service, are administratively housed in Maryland within the Department of Education and will be discussed in conjunction with early childhood education. For those in the transitional youth age range, the full array of adult oriented social services also become a part of the overall system of integrated services required.
- **“MD CARES & Rural CARES”** – Funded through two SAMHSA systems of care grants, MD CARES and Rural CARES projects are key child welfare collaborations in major geographic and population centers of the State.
- **Project LIFT**- The most recent system of care grant awarded to Maryland is the four year implementation grant, designed to take the innovations of earlier grant fully to scale across the system. Starting in Baltimore County, Project LIFT envision making wraparound available to children and families statewide.
- **Maryland LAUNCH** will enhance the collaboration among State and local child-serving agencies; increase the use of early screenings, assessments, and mental health consultations; increase integration of behavioral health and primary care; enhance home visiting; and provide family strengthening and parent skills training. Maryland LAUNCH will establish State and Local Young Child Wellness Councils to develop infrastructure and workforce development planning, promote public awareness of young child wellness, and continuously evaluate and improve Maryland LAUNCH

FY 2014 – 2015 MARYLAND MENTAL HEALTH BLOCK GRANT

implementation. In addition, Maryland LAUNCH will provide training on developmental screening and assessment tools for primary care providers, early childhood educators, and home visiting programs.

Educational services (including those provided by local schools and the Individuals with Disabilities Education Act (IDEA) – School Based Mental Health

- MHA continues its extensive work with the Maryland State Department of Education (MSDE), both in regard to strengthening student support services for students in regular classrooms and in special education settings governed by the requirements of the Individuals with Disabilities Education Act (IDEA). MHA and MSDE collaborate to provide services to children and youth and to recruit qualified mental health providers for schools and the community. There has been a considerable increase in school-based mental health services over the past several years. For example, mental health services are available in over 120 public schools in Baltimore City and in six schools in Baltimore County. There are currently 61 school-based health centers across the state, each of which provides somatic services. Approximately half of the centers also provide mental and behavioral health services

Early Childhood Mental Health - The strategy for early childhood mental health is to integrate mental health services into existing early childhood programs (children 0 to 5 years), to incorporate supports into existing early childhood programs, and to promote and support the integration of early childhood mental health services within other settings. The mental health component of the Maryland Infant and Toddler Program, which provides services for young children governed by IDEA, is strengthened by the activities of the Early Childhood Mental Health Initiative. Additionally, the Initiative supports the provision of mental health services in day care services as well as federally-funded Head Start programs.

A new SAMHSA grant, Maryland Project LAUNCH, targets a comprehensive early childhood intervention strategy in Prince George's County, located in the Washington DC suburbs. This demonstration is in the earliest stages of implementation at this time and will feature mental health consultation and other specialized services to early childhood service providers, young children and their families across Prince George's County.

Juvenile Services – The Mental Hygiene Administration (MHA) consults and collaborates with the Department of Juvenile Services (DJS) to coordinate mental health services within their juvenile detention centers. The mental health programs focus on the needs of youth in the care of DJS prior to adjudication and disposition by the juvenile court.

The MHA Child and Adolescent staff provide training for DJS direct care staff on an as needed basis. In FY 2010, the Director of Child and Adolescent Services began a Psychopharmacology Learning Collaborative consisting of psychiatrists who provide services to youth in the juvenile justice system. The focus of the Collaborative is to examine the use and administration of psychotropic medication to youth in custody.

FY 2014 – 2015 MARYLAND MENTAL HEALTH BLOCK GRANT

Substance Abuse Services Including Co-occurring Disorders - In the past, Maryland has emphasized cross training of staff and coordination of services as a means of providing access to services by individuals needing both mental health and substance abuse services. A number of existing mental health treatment and rehabilitation programs, as well as programs established through the DHMH Alcohol and Drug Abuse Administration (ADAA), have developed dual diagnosis capability and are able to offer substance abuse treatment services to individuals with mental illnesses.

Maryland is poised to move forward in developing an integrated system of care for youth with mental health and substance abuse issues through the process of Behavioral Health Integration which is described elsewhere in this plan. This structure will also allow for coordinated behavioral health workforce development and integrated service delivery. The Office of Child & Adolescent Behavioral Health will support more effective access to services and improved outcomes for youth and young adults with behavioral health needs and their families.

Health and Mental Health Services - Our efforts to improve coordination of somatic and behavioral health care under the CHIPRA Demonstration grant have been described in a prior section. In addition, because DHMH is the agency responsible for mental health, substance abuse, developmental disabilities, AIDS, child and maternal health, and all the programs offered through the State Medical Assistance Plan, there is an ongoing need for coordinating mechanisms within the Department itself in order for DHMH to fulfill its role as an interagency partner with the other Departments of the Children's Cabinet. The coordination of services for substance abuse, as well as developmental disabilities, with services offered to children and youth for mental health problems, is a critical issue within the DHMH coordination process. These needs all fall under the category of youth with special health care needs, and the primary systemic coordinating effort is DHMH's Special Needs Advisory Committee. Staff coordinators from MHA and ADAA work with the special needs coordinator from the child's HealthChoice MCO when a child with co-occurring diagnoses requires enhanced coordination efforts. Efforts are also implemented at the county level to promote the Integrated Systems of Care for Consumers with Co-Occurring Mental Health and Substance Use Disorders model of best and evidence-based practices and the State's involvement in the SAMHSA National Policy Academy.

Targeted Services

The exact number of children and youth in Maryland who are homeless and who have mental health problems is unknown. MHA has been participating in the efforts of the Maryland Department of Human Resources (DHR) and local communities to implement the Homeless Management Information System statewide. All of the Maryland counties have established a system and most of the counties have trained shelters' staff and providers on utilizing the Homeless Management Information System. Some counties are still working to resolve issues regarding providers' resistance to using this System due to concerns about client confidentiality. Data are not broken out by age as a part of the survey. Efforts are also underway to develop a statewide data warehouse so that local homeless data may be accessed at the state level.

FY 2014 – 2015 MARYLAND MENTAL HEALTH BLOCK GRANT

DHR gathers and reports information only on people and families who have stayed in emergency shelters, transitional housing programs or who have received emergency motel placements. The data reflects the extent of shelter services provided to people who are homeless as reported by emergency shelter and transitional housing providers on a Homelessness Services Survey form. The data in DHR's report does not include an absolute count of the number of homeless people in Maryland.

Services for Runaway and Homeless Youth - The unmet needs of youth that are homeless are extensive, particularly the needs of the runaway and homeless adolescents with serious emotional disturbance. A special project, for runaway and homeless youth, continues in Ocean City, Maryland, the state's major beach resort area. Located in Worcester County on the Eastern Shore, Ocean City increases from a relatively small community to a population of close to 400,000 in the summer. Many runaway and homeless youth frequent the resort, some experiencing serious psychiatric disorders, almost all involved, in some way, in drug and alcohol abuse. The agencies in the community have formed a successful collaborative consortium to coordinate shelter, primary health, substance abuse, mental health, and other human services for this population. The project serves youth from all areas of the rest of the Maryland and large numbers of youth from other surrounding states in the region. Federal community mental health block grant funds have been allocated for mobile crisis services in Worcester County. This project is intensively staffed.

Services for Children in Homeless Families - MHA has funded and provided technical assistance to a project for young children who are homeless because their mothers and other family members live in family shelters throughout Baltimore City. The Parents and Children Together (PACT) program provides a therapeutic nursery at the YWCA shelter in Baltimore City, and extensive consultation at The Ark, a day care program that serves many of the children who reside in family shelters across the entire city. This population is reported to experience significant developmental delays, particularly in language acquisition.

FY 2014 – 2015 MARYLAND MENTAL HEALTH BLOCK GRANT

Adult Services

MHA's Offices of Adult Services, Consumer Affairs, Special Needs Population and Forensic Services ensures that a comprehensive system of mental health services and supports are available and accessible for adults from age 18 throughout the life-span. These offices oversee the statewide planning, design, development, implementation, administration and monitoring of community-based mental health programs and services for adults, transition-age youth, and older adults. Additionally services are offered to individuals who are homeless, individuals who are deaf or hard of hearing, individuals with mental illness and/or substance abuse disorders and trauma-related effects, as well as individuals with mental illnesses who are court –involved. In addition, these offices formulate policy, protocols, regulations, and practice guidelines to support systems transformation for improved consumer outcomes; promotes evidence-based, consumer-directed and recovery-oriented rehabilitation, treatment and supports that have demonstrated effectiveness and are responsive to consumer needs and preferences.

Olmstead Related Activities

Maryland has been selected to participate in SAMHSA's 2013 *Olmstead Policy Academy on Housing, Employment and Recovery*. The Maryland Olmstead PA team is part of a larger effort sponsored by SAMHSA involving multiple states and bringing to bear the efforts of subject matter experts in the topic areas of recovery, housing and employment. The hope is to see measurable improvements in policies, practices and numbers of people making successful transitions from institution to community. The Maryland Olmstead Policy Academy will be convened as an ad hoc workgroup of the Maryland Affordable Housing Partnership, a long-standing cross-disability housing advisory group to include all members of that group, as well as additional members representing key mental health stakeholders and constituencies. Efforts in Maryland will build on the state's success in developing and targeting housing resources to people with disabilities, and take that success to the next level. Specifically, there is interest in crafting a statewide, coordinated approach to helping people with disabilities move into affordable housing. This might include:

- Standardized assessment of needs and preferences of prospective tenants, and creation of a method for matching needs and preferences with available units and supports. This could result in *system change* that becomes the Maryland approach to the housing needs of people with disabilities, across systems and applicable to all sorts of institutionalized situations.
- Staff and prospective tenant training and support: This might include efforts across systems to standardize outreach and 'in reach' to prospective tenants with disabilities; offer a set of tools and approaches designed to improve successful transitions; train staff and prospective tenants on step by step methods of matching housing needs and preferences to available units and available supports as well as finding and securing housing. These efforts are targeted to the people doing the work – the prospective tenants and caseworkers from all systems.

FY 2014 – 2015 MARYLAND MENTAL HEALTH BLOCK GRANT

Services for Individuals with Mental Illness and Substance Use - Over the past 18 months, the Mental Hygiene Administration (MHA) has worked toward the implementation of a work plan designed to increase the number of programs that are dual diagnosis capable (DDC). Six county jurisdictions which have chosen to adopt the implementation of the Comprehensive, Continuous Integrated System of Care model (CCISC) are in various stages of development. Assertive Community Treatment (ACT) teams are receiving training on interacting with substance abuse to improve the Dual Diagnosis Capability of each of the 10 ACT teams, on an individualized basis.

As stated earlier, plans are underway to integrate Maryland's Mental Hygiene Administration (MHA) and the Alcohol and Drug Abuse Administration (ADAA) systems. This behavioral health integration effort will foster a seamless service system for individuals with these co-occurring disorders. To further enhance collaboration, MHA, ADAA and the Developmental Disabilities Administration (DDA) have formed a Co-Occurring Disorders (COD) Workgroup to address the training, consultation and technical assistance providers need in order to deliver quality services to this population. Following several meetings, and consultation with provider representatives, it was determined the most pressing initial need was for a way for agencies to self-assess their dual diagnosis capability. Through a contract between DHMH and the University of Maryland's Evidence-Based Practice Center, the COD Consultant/Trainer has developed expertise in administering three validated tools for agencies to measure this. The tools are the Dual Diagnosis Capability in Mental Health Treatment (DDMHT), the Dual Diagnosis Capability in Addiction Treatment (DDCAT) and the Comorbidity Program Audit and Self Survey for Behavioral Health Services (COMPASS). Additionally, there is the COMPASS-ID which can be used for programs providing services to those with cognitive impairments. These self-assessment instruments are able to provide practical measures of program level dual diagnosis capability (DDC). These are user friendly tools designed to enable agencies to honestly discuss their progress in achieving competencies necessary to become DDC. Agencies will be able to self assess, identify steps needed to improve DDC, and develop an action plan to move forward. Training, supervision and top leadership support are all vital components in the achievement of DDC (or DDE – Dual Diagnosis Enhanced).

The COD Workgroup is currently in the process of developing strategies for training and consultation which will enable providers in all three disciplines to complete a self-assessment with one of the three tools mentioned above. Through this process training needs will then be identified. It is anticipated that the COD Workgroup will collect information regarding the training needs, and will then design strategies to provide the necessary training, using a variety of modalities. These may include face to face trainings, teleconferences, web—based information, and dissemination of no or low-cost training that is already archived and available on the web. Using the resources of OETAS (Office of Education and Training in Addiction Services) at ADAA, of DDA and of the MHA-funded University of Maryland's Evidence-Based Practice and Training Centers, DHMH is well-positioned to make significant inroads into the large training needs to help programs achieve dual diagnosis capability.

FY 2014 – 2015 MARYLAND MENTAL HEALTH BLOCK GRANT

Another important development in the provision of co-occurring services to individuals with mental illnesses and substance disorders was the Substance Abuse and Mental Health Services Administration (SAMHSA) grant awarded to provide substance abuse and mental health services for people who are homeless. The grant enables communities to expand and strengthen their treatment services for individuals who are homeless with substance abuse disorders, mental illness, or co-occurring (in this plan co-occurring refers to individuals who have mental illness and substance abuse disorders).

MHA also provides \$440,000 in State general funds for the Trauma, Addictions, Mental Health, and Recovery (T.A.M.A.R.) Project which provides treatment for incarcerated men and women who have histories of trauma and have been diagnosed with a mental illness and/or co-occurring substance abuse disorder. The project is available in nine county detention centers: Anne Arundel, Baltimore, Caroline, Dorchester, Frederick, Garrett, Prince George's, and Washington Counties; and at Springfield Hospital Center.

Maryland Commitment to Veterans (MCV)

Maryland's Commitment to Veterans (MCV) is a program under the Maryland Department of Health and Mental Hygiene that collaborates with the United States Department of Veterans Affairs; Maryland Department of Veterans Affairs; Maryland Department of Labor, Licensing and Regulation, Maryland Department of Higher Education and Maryland Department of Housing and Community Development. Maryland's Commitment to Veterans assists veterans and their families with coordinating behavioral health services, including mental health and substance abuse services- either with the VA Maryland Health Care System or Maryland's public health system. MCV facilitates and covers transportation costs to behavioral health appointments. MCV also provides information and referrals related to VA benefits, employment, education, housing and outreach to educate veterans, residents, and community groups about MCV.

FY 2013 MCV Updates:

- New MCV website, posters and brochures distributed - veterans.dhmv.maryland.gov
 - MCV Facebook Fan Page active – 2,282 fans (started with 1,000 fans June 2013)
347 people share MCV updates which is 200% increase from last week; 4 veteran referrals via Facebook
- FY 2013 Top call needs: 19.89% Housing, 19.5% VA Benefits, Info/Ref 16.1%, Behavioral Health 13.18% (9.98% MH, 3.2% SA)
- FY 2103 average 111 calls per month, total 1,342 for FY 2013
 - Oftentimes RRC speak to same veteran up to 6 times in one week because of multiple needs

FY 2014 – 2015 MARYLAND MENTAL HEALTH BLOCK GRANT

MCV Testimonial – from mother of a US Marine

“I am grateful every day that I found MCV. Trying to negotiate the red tape and bureaucracy of everything related to the VA, mental health and available resources was insurmountable. I believed that once my son was out of combat he would be safe, but I was wrong and if I hadn’t been connected to MCV, I’m not sure where we would be today or if my son would even be alive and working on becoming mentally healthy.

MCV was the first direct contact I found. Our MCV RRC was not only accessible, but also knowledgeable and personable. We were in a crisis situation and I was beginning to think that no one knew where to go, who to contact or what to do until I spoke with MCV. Just the fact that I was able to speak directly with a person was comforting and when I realized the RRC not only was compassionate and helpful but also very knowledgeable I realized I had found a gold mine. MCV was able to direct us to valuable resources without delay and maintained contact with us during and after our family crisis. I feel that MCV is our key to a system that may not be broken but is sadly in need to repair. Without a doubt, MCV is a very valuable resource.”

MCV Memorandum of Understanding (MOU) FY 2013 Updates:

University of Maryland School of Public Health

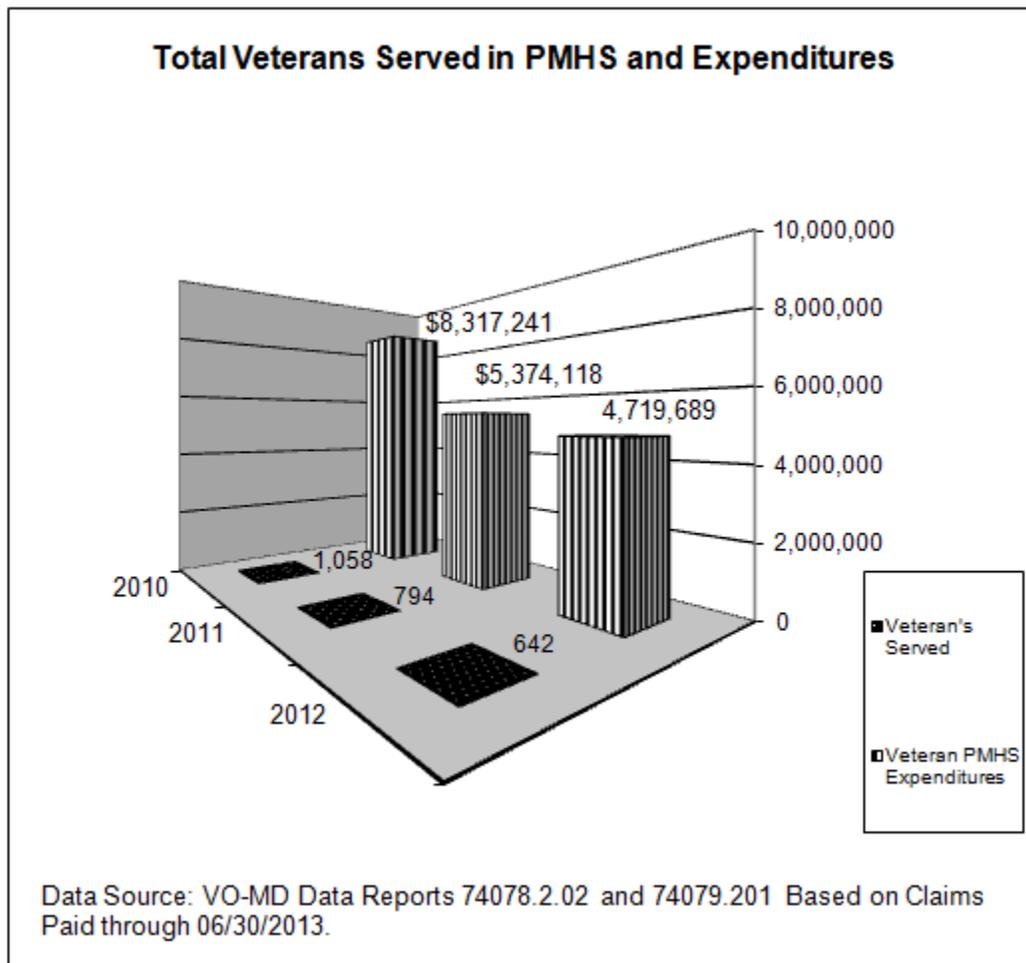
- Fall 2012 nearly 3,300 behavioral health and primary care providers completed an online needs assessment survey; analyzed data to plan targeted provider trainings in 2013 and 2014.
- Hosted first training for behavioral health providers on March 22, 2013; the University of Maryland, College Park primary site with Harford Community College and Hagerstown Community College serving as distance education sites – 416 attendees – Topics included Military Culture and Impacts of Deployment, Child and Family Relationship Issues, PTSD/TBI and Mental Health Co-morbidities, Sleep disorders and Women veterans’ health
 - Center for Deployment Psychology leading clinical follow on training 26-27 September 2013 – Prolonged Exposure Therapy to Treat PTSD – The Gathering Place Clarksville MD
- FY 2014 4 new campuses and 4 new veteran peer facilitators - currently determining where to host
 - Howard County Community College – 1 veteran member September 2012 to 25 by May 2013 –DragonVets name of club, has Facebook page, member tee shirts, developed template for “spotlights” highlighting military experience and achievement of student veterans that can be posted at student unions
 - UMBC – Vets2Vets not as well attended because 3 student veteran groups already on campus competition – SVA, campus group and 6th Branch
- New MOU with UMD for FY 2014– project called “Enhancing the behavioral health and successful reintegration of women veterans in Maryland” Submitted to Institutional Review Board (IRB) anticipate approval mid-August. Interviewing women veteran health

FY 2014 – 2015 MARYLAND MENTAL HEALTH BLOCK GRANT

experts, holding focus groups with post-911 women veterans, and organizing training on this topic to improve civilian clinicians' ability to work effectively with this population.

MCV MOU with US Veterans Health Administration (VISN 5)

- Provide outreach to veterans and their families in rural Maryland to increase veteran enrollment in VA services and enhance provision of care – MCV coordinates monthly conference calls to share challenges RRCs are experiencing with veterans accessing behavioral health services through the VA. VISN 5 shares veteran stats and responds to challenges



FY 2014 – 2015 MARYLAND MENTAL HEALTH BLOCK GRANT

Maryland's HIV Prevention and Intravenous Drug Users -

The Prevention and Health Promotion Administration (PHPA) at the DHMH is the lead state agency in Maryland for coordination of care and prevention services to address the HIV/AIDS epidemic. Over 34,000 people are living with HIV/AIDS in the state of Maryland. The epidemic remains a major public health challenge in the state, as the number of persons living with HIV/AIDS continues to grow and the state must continue to find the resources to provide ongoing systems of care to meet the needs of their citizens.¹ The Maryland Community Planning Group (CPG) develops a set of statewide HIV prevention priorities. Representatives from the Maryland Department of Health and Mental Hygiene (DHMH) Alcohol and Drug Abuse and Mental Hygiene Administrations (ADAA and MHA) serve on the CPG. The CPG's priorities are based on evidence including HIV and AIDS statistics, injection drug use trends, behavioral science, and input from affected communities. The CPG's Plan is used by the DHMH Infectious Disease and Environmental Health Administration (IDEHA) in writing the state's application to the CDC for funding to support HIV prevention programs across the state.

Injection drug use ranks among the top five priorities for the CPG. The CPG approved Maryland's 2010-2011 HIV prevention priorities were ranked as follows:

1. HIV Positive Persons
2. Men who have Sex with Men (72% African American)*
3. Heterosexual (83% African American)*
4. Injection Drug Users (IDU) (86% African American)*
5. Special Populations (Deaf, Hispanic, African Immigrants, and Transgender persons)

*These priority populations reflect CDC requirements and the risks associated with new HIV infections in the state. Within all transmission categories, high risk persons (as defined by HIV prevalence or individual risk behaviors) are prioritized. Within each risk group, African Americans are emphasized, given the disproportionate impact of HIV in this group. When aggregated, the HIV prevention projects targeting each risk group serve mostly African Americans. Individual projects do not have to meet these racial goals (e.g., when client level data from all injection drug users (IDU) projects are added together, 86% of the IDU served should be African American IDU).

SOAR Initiative

Supplemental Security Income (SSI)/ Social Security Disability Insurance (SSDI) Outreach, Access, and Recovery (SOAR) - Individuals who are homeless can benefit from Medicaid enrollment to obtain needed services. The purpose of SOAR is to expedite and increase the number of successful SSI/SSDI applications for all eligible applicants. Typically only 10 – 15 percent of all homeless adults who apply for SSI or SSDI programs through the Social Security Administration (SSA) are approved on the initial application. Access to these benefits can be

¹ Prevention and Health Promotion, 2012-2014 Maryland HIV Plan

FY 2014 – 2015 MARYLAND MENTAL HEALTH BLOCK GRANT

very challenging for individuals who are homeless with mental health problems due to the complex process.

Since September 2009, MHA has been collecting data on success of SOAR in Maryland. Since then, data has been collected on over 530 claims. The approval rate for claims across the state is 81% and the average processing time for initial claims is 71 days. A number of jurisdictions including Baltimore City, Montgomery County and Carroll County have approval rates over 90%. Each month MHA reports data on the SOAR initiative as part of Maryland's state stat program which is tracked by the Governor's Office.

In SFY 2013, MHA continued to expand the SOAR initiative. In addition to the existing work groups in Baltimore City, Anne Arundel, Baltimore, Frederick, Harford, Howard, Montgomery, Prince George's, St Mary's, Washington, and the Lower Eastern Shore counties (Somerset, Wicomico, and Worcester), MHA supported Cecil and Garrett Counties to establish their Work Groups and complete their work plans. Providers in these counties have undergone SOAR training and are now participating in the SOAR Initiative. Allegany County is currently developing its work group and plan.

Four 2-day Stepping Stones to Recovery SOAR trainings were held in FY 2013, training over 110 case managers, mental health professionals and social workers. Additionally, MHA, in conjunction with representatives from community providers and Disability Determination Services, gave presentations about SOAR at six conferences in FY 2013.

During FY2013, the newly developed Certification pilot program continued to be implemented in Baltimore City and Montgomery County. The purpose of the program is to ensure high quality applications and provide recognition for all the hard work that goes into completing SOAR applications. As of the end of June 2013, nine providers have gained provisional status and eight people hold Full Certification Status.

In FY 2013, through the use of PATH funding, MHA was able to fund two SOAR Outreach positions, two SOAR coordinators and a part time Data and Evaluation coordinator. Additionally, as part of the Homeless ID Project that is being funded through Maryland's Alcohol Tax Appropriation, five dedicated SOAR case manager positions were created in FY2013. Each of the dedicated SOAR Outreach/Case Management positions provides outreach, assistance with applying for SSI/SSDI using SOAR components and assistance with applying for other entitlements.

It is anticipated that the focus in FY 2014 will be to continue to strengthen those counties that are currently implementing SOAR, or who have already actively begun the planning process, as well as to explore the feasibility of extending SOAR into additional counties.

Peer Run Services for Lesbian, Gay, Bi-sexual, Transgendered and Questioning (LGBTQ) - The Office of Consumer Affairs (OCA) works to gradually increase the sustainability and accountability of the 25 Wellness & Recovery Centers (formerly known as drop-in centers) currently established across the state. The LGBTQ Wellness & Recovery Center has offered

FY 2014 – 2015 MARYLAND MENTAL HEALTH BLOCK GRANT

several outreach sessions during the fiscal year on topics such as: “The Gay Community and Stereotypes”; Mental Health First Aid; and a workshop on community resources for the LGBTQ consumer for individuals who are homeless with mental illness. There will be an increased focus on the involvement of the Wellness and Recovery centers in surrounding community organizations and activities to allow the centers and their members to become active members of the greater community. In FY 2012, an annual meeting of the CSA directors and the directors of Wellness & Recovery centers was held to re-establish effective communication and continue to develop cohesive strategies to enhance the recovery process through collaborative leadership training. Many other consumer-run support groups are held in the centers on a regular basis. Many of these centers address issues of co-occurring disorders of mental illness and substance abuse within their programming.

Services for the Deaf or Hard of Hearing - The Director of MHA’s Office of Special Needs Populations, in collaboration with CSAs, works with community-based programs, the state hospital and the Governor’s Office of the Deaf & Hard of Hearing (ODHH) Advisory Council to coordinate community and inpatient services for persons who have a serious mental illness (SMI) and are deaf or hard of hearing. MHA currently operates a separate unit at a State hospital for individuals who are deaf and hard of hearing. The unit provides full accommodations and employs a full complement of mental health professionals who are fluent in American Sign Language. MHA also provides funding to CSAs to contract with providers in order for individuals who are deaf or hard of hearing to access outpatient treatment, psychiatric rehabilitation services, case management, and residential rehabilitation services which have interpreters and/or staff fluent in American Sign Language and provide technical assistance and consultation. Additionally, limited outpatient clinic and residential rehabilitation services are available to individuals who have a SMI who are deaf or hard of hearing through the fee-for-service system.

In FY 2011, MHA hosted and participated on a behavioral health subcommittee, comprised of representatives from MHA, the Alcohol and Drug Abuse Administration, the Developmental Disabilities Administration, behavioral health providers, the Maryland State Department of Education, consumers, family members, and advocates. In FY 2010 the behavioral health subcommittee drafted minimum criteria for providing behavioral health care for Marylanders who are deaf or hard of hearing. Additionally in FY 2010, the subcommittee drafted recommendations to MHA’s ASO regarding standards for public mental health providers certifying proficiency and cultural competency in serving consumers who are deaf or hard of hearing. In FY 2011, the behavioral health subcommittee revised and resubmitted its recommendations to the Deputy Director of Behavioral Health and Disabilities for review and approval. MHA served as the lead bringing together the partners at MHA, ADAA, and DDA and also served as the Department of Health and Mental Hygiene’s representative on the Maryland Advisory Council for Individuals who are Deaf or Hard of Hearing. The behavioral health subcommittee also drafted informational materials on American with Disabilities Act, as well as tips for local hospitals (emergency departments) on assessing the needs of individuals who are deaf or hard of hearing that are seeking services and providing timely access to culturally sensitive and appropriate linguistic and communication services.

FY 2014 – 2015 MARYLAND MENTAL HEALTH BLOCK GRANT

Also in FY 2011, MHA worked with Springfield Hospital Center (SHC) to re-institute the service providers review board, comprised of SHC social work staff, ADAA, DDA, and MHA funded residential programs, and staff from the three state behavioral health authorities. The service providers review board discussed the community needs of specific patients and coordinated a service plan which consisted of housing and services to facilitate a successful re-entry into the community for patients leaving the hospital. MHA continued to work with the Office of Deaf or Hard of Hearing (ODHH) Advisory Council and the CSAs to develop strategies to improve access to outpatient treatment and improving the competencies of outpatient providers working with consumers who are deaf or hard of hearing. In March 2011, MHA's Office of Special Needs Populations held a one-day conference "Helping Individuals to Lead Better Lives". The Governor's Office of Deaf or hard of hearing presented two afternoon workshops on cultural sensitivity and awareness for providers working with individuals who are deaf or hard of hearing, which was well received. Additionally, in May 2010, MHA hosted a cultural sensitivity and awareness training for behavioral health providers, CSAs, consumers, and advocates on understanding issues faced by consumers who are deaf or hard of hearing, and will offer future trainings in collaboration with the Governor's Office of Deaf or Hard of Hearing to increase awareness and understanding of providers in working with individuals who are deaf or hard of hearing and have a serious mental illness.

IV: Narrative Plan

P. Consultation with Tribes

Narrative Question:

SAMHSA is required by the 2009 Memorandum on Tribal Consultation to submit plans on how it will engage in regular and meaningful consultation and collaboration with tribal officials in the development of federal policies that have tribal implications.

Consultation is an enhanced form of communication, which emphasizes trust, respect, and shared responsibility. It is an open and free exchange of information and opinions between parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process that results in effective collaboration and informed decision making with the ultimate goal of reaching consensus on issues.

For the context of the Block Grants awarded to tribes, SAMHSA views consultation as a government-to-government interaction and should be distinguished from input provided by individual tribal members or services provided for tribal members whether on or off tribal lands. Therefore, the interaction should be attended by elected officials of the tribe or their designees. SAMHSA is requesting that states provide a description of how they consulted with tribes in their state, which should indicate how concerns of the tribes were addressed in the State Block Grant plan(s). States shall not require any tribe to waive its sovereign immunity in order to receive funds or in order for services to be provided for tribal members on tribal lands. If a state does not have any federally-recognized tribal governments or tribal lands within its borders, the state should make a declarative statement to that effect. For states that are currently working with tribes, a description of these activities must be provided in the area below. States seeking technical assistance for conducting tribal consultation may contact the SAMHSA project officer prior to or during the Block Grant planning cycle.

Footnotes:

IV: Narrative Plan

Q. Data and Information Technology

Narrative Question:

In the FY 2012/2013 Block Grant application, SAMHSA asked each state to:

- Describe its plan, process, and resources needed and timeline for developing the capacity to provide unique client-level data;
- List and briefly describe all unique information technology systems maintained and/or utilized by the state agency;
- Provide information regarding its current efforts to assist providers with developing and using EHRs;
- Identify the barriers that the state would encounter when moving to an encounter/claims based approach to payment; and
- Identify the specific technical assistance needs the state may have regarding data and information technology.

Please provide an update of your progress since that time.

Footnotes:

IV: Narrative Plan

R. Quality Improvement Plan

Narrative Question:

In the FY 2012/2013 Block Grant application, SAMHSA asked states to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures, based on valid and reliable data, that will describe the health of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that services, to the extent possible, continue reflect this evidence of effectiveness. The state's CQI process should also track programmatic improvements and garner and use stakeholder input, including individuals in recovery and their families. In addition, the CQI plan should include a description of the process for responding to emergencies, critical incidents, complaints and grievances. In an attachment, states must submit a CQI plan for FY 2014/2015.

Footnotes:

IV: Narrative Plan

S. Suicide Prevention

Narrative Question:

In the FY 2012/2013 Block Grant application, SAMHSA asked states to:

- Provide the most recent copy of your state's suicide prevention plan; or
- Describe when your state will create or update your plan.

States shall include a new plan as an attachment to the Block Grant Application(s) to provide a progress update since that time. Please follow the format outlined in the new SAMHSA document [Guidance for State Suicide Prevention Leadership and Plans](#) available on the SAMHSA website at [here](#).

Footnotes:

FY 2014 – 2015 MARYLAND MENTAL HEALTH BLOCK GRANT

S. SUICIDE PREVENTION

Suicide is a serious public health problem that causes immeasurable pain, suffering, and loss to individuals, families, and communities nationwide. Many people may be surprised to learn that suicide was one of the top 10 causes of death in the United States in 2009. And death is only the tip of the iceberg. For every person who dies by suicide, more than 30 others attempt suicide. Every suicide attempt and death affects countless other individuals. Family members, friends, coworkers, and others in the community all suffer the long-lasting consequences of suicidal behaviors (p. 10).

- U.S. Department of Health and Human Services (HHS) Office of the Surgeon General and National Action Alliance for Suicide Prevention. *2012 National Strategy for Suicide Prevention: Goals and Objectives for Action*. Washington, DC: HHS, September 2012.

On October 7, 2009, Governor Martin O'Malley issued Executive Order 01.01.2009.13, establishing the Governor's Commission on Suicide Prevention (the Commission). Over the course of three years, 21 Commissioners brought their professional expertise and personal experiences with suicide and its consequences to bear in crafting their recommendations.

The work of the Commission is aligned with national suicide prevention efforts, especially in the State's historic and continuing emphasis on youth suicide prevention. The Commissioner's Plan (the Plan) also puts forth a strengthened focus on preventing suicide not only with high risk groups like veterans, lesbian, gay, bisexual, transgender and questioning individuals, and persons who are unemployed but also at critical high-risk periods, such as following an unsuccessful suicide attempt. Additionally, based on the Public Health Model, the Plan's three overarching goals and eight related strategies operate at three levels:

- Universal: prevention efforts applicable to all members of a population;
- Selected: more focused education and skill-building applicable to selected sub-groups who are at-risk for a preventable occurrence; and
- Indicated: focused interventions providing intense education and skill development related to specific risks of an indicated subpopulation.

The Plan's three Goals are:

1. Increase and broaden the public's awareness of suicide, its risk factors, and its place as a serious and preventable public health concern.
 - i. Increase evidence-based or best practice training opportunities for professionals;
 - ii. Increase awareness through community education; and
 - iii. Increase State policy and leadership efforts.
2. Enhance culturally competent, effective, and accessible community-based services and programs;
3. Assure effective services to those who have attempted suicide or others affected by suicide attempt or completion.

FY 2014 – 2015 MARYLAND MENTAL HEALTH BLOCK GRANT

In order to achieve these Goals, the Commissioners propose the following eight strategies, ranked in order of priority. Specific tasks related to each strategy are described in the body of this report:

1. Establish a baseline listing of existing services and supports across prevention, intervention and post-vention (attempters and survivors);
2. Enhance the use and capacity of suicide prevention hotlines;
3. Identify, plan for and implement Evidence-based and Promising Practices to address unmet needs across prevention, intervention and post-vention as well as professional and community training in awareness of suicide risk and education in accessing resources.
4. Develop and execute an effective suicide prevention community education campaign to increase awareness and knowledge and decrease risk across the age span;
5. Recognize and address the needs of high-risk populations, such as:
 - a) Returning veterans of the armed services;
 - b) Persons who have made suicide attempts
 - c) Lesbian, gay, bisexual, transgender and questioning individuals (LGBTQ);
 - d) Persons who are unemployed; and
 - e) Youth and adults who have been victims of bullying and/or harassment.
6. Recommend to the Maryland State Department of Education that they work with the local school systems' personnel to discuss best practices that are considered post-vention strategies related to student deaths that are the result of suicide.
7. Suicide prevention efforts should be planned and implemented with strong ties to the Maryland Public Health System. Staffing dedicated to the implementation of this Plan, as well as coordination and leadership in all State suicide prevention efforts, should be well defined within the Maryland Mental Hygiene Administration structure.
8. Continue the work of the Governor's Suicide Prevention Commission by extending the Commission's authority to assist and advise the Mental Hygiene Administration in the implementation of these recommendations; to identify emerging issues in suicide prevention and intervention; and to focus attention and recommend action on these emerging issues.

By defining three primary goals, each emphasizing the science base of suicide prevention, as well as the cultural competence, effectiveness and accessible nature of all outreach, services, and supports, the Commission has set the future direction of Maryland's suicide prevention efforts. The Commission's work provides clear priorities and achievable strategies for the organization, delivery, and funding of State suicide prevention, intervention and post-vention (suicide) services for years to come.

IV: Narrative Plan

T. Use of Technology

Narrative Question:

In the FY 2012/2013 Block Grant application, SAMHSA asked states to describe:

- What strategies the state has deployed to support recovery in ways that leverage ICT;
- What specific application of ICTs the State BG Plans to promote over the next two years;
- What incentives the state is planning to put in place to encourage their use;
- What support system the State BG Plans to provide to encourage their use;
- Whether there are barriers to implementing these strategies and how the State BG Plans to address them;
- How the State BG Plans to work with organizations such as FQHCs, hospitals, community-based organizations, and other local service providers to identify ways ICTs can support the integration of mental health services and addiction treatment with primary care and emergency medicine;
- How the state will use ICTs for collecting data for program evaluation at both the client and provider levels; and
- What measures and data collection the state will promote to evaluate use and effectiveness of such ICTs.

States must provide an update of any progress since that time.

Footnotes:

IV: Narrative Plan

U. Technical Assistance Needs

Narrative Question:

States shall describe the data and technical assistance needs identified during the process of developing this plan that will facilitate the implementation of the proposed plan. The technical assistance needs identified may include the needs of the state, providers, other systems, persons receiving services, persons in recovery, or their families. Technical assistance includes, but is not limited to, assistance with assessing needs; capacity building at the state, community and provider level; planning; implementation of programs, policies, practices, services, and/or activities; evaluation of programs, policies, practices, services, and/or activities; cultural competence and sensitivity including how to consult with tribes; and sustainability, especially in the area of sustaining positive outcomes. The state should indicate what efforts have been or are being undertaken to address or find resources to address these needs, and what data or technical assistance needs will remain unaddressed without additional action steps or resources.

1. What areas of technical assistance is the state currently receiving?
2. What are the sources of technical assistance?
3. What technical assistance is most needed by state staff?
4. What technical assistance is most needed by behavioral health providers?

Footnotes:

IV: Narrative Plan

V. Support of State Partners

Narrative Question:

The success of a state's MHBG and SABG will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, and education providers, as well as other state, local, and tribal governmental entities. States should identify these partners in the space below and describe how the partners will support them in implementing the priorities identified in the planning process. In addition, the state should provide a letter of support indicating agreement with the description of their role and collaboration with the SSA and/or SMHA, including the state education authority(ies), the State Medicaid Agency, entity(ies) responsible for health insurance and health information marketplaces (if applicable), adult and juvenile correctional authority(ies), public health authority (including the maternal and child health agency), and child welfare agency. SAMHSA will provide technical assistance and support for SMHAs and SSAs in their efforts to obtain this collaboration. These letters should provide specific activities that the partner will undertake to assist the SMHA or SSA with implanting its plan.⁴⁵ This could include, but is not limited to:

- The State Medicaid Agency agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to the expanded Medicaid population.
- The state justice system authorities that will work with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with mental and substance use disorders who come in contact with the criminal and juvenile justice systems, promote strategies for appropriate diversion and alternatives to incarceration, provide screening and treatment, and implement transition services for those individuals reentering the community, including efforts focused on enrollment.
- The state education agency examining current regulations, policies, programs, and key data-points in local and tribal school districts to ensure that children are safe, supported in their social/emotional development, exposed to initiatives that target risk and protective actors for mental and substance use disorders, and, for those youth with or at-risk of emotional behavioral and substance use disorders, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements.
- The state child welfare/human services department, in response to state child and family services reviews, working with local and tribal child welfare agencies to address the trauma and mental and substance use disorders in children, youth, and family members that often put children and youth at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system. Specific service issues, such as the appropriate use of psychotropic medication, can also be addressed for children and youth involved in child welfare.
- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities.

⁴⁵ SAMHSA will inform the federal agencies that are responsible for other health, social services, and education

Footnotes:

FY 2014 – 2015 MARYLAND MENTAL HEALTH BLOCK GRANT

V. SUPPORT OF STATE PARTNERS

Collaborations with Other State Agencies - MHA continues to interface with other agencies and administrations to support a comprehensive system of mental health, somatic health, substance abuse, and other services and community supports. Under the Deputy Secretary for Behavioral Health and Disabilities, the MHA and the Alcohol and Drug Abuse (ADAA) administrations will merge to become a Behavioral Health Administration. The development of the State Mental Health Plan is a result of the collaborative efforts existing interagency cooperation, and public and private partnerships. Alliances have been strengthened and new partnerships have been formed to further build upon the infrastructure, to coordinate care, and improve service systems.

Collaboration with the other State agencies include, but is not limited to: Maryland Medicaid Office of Health Services, Maryland Department of Disabilities, Governor's Office for Children, Maryland State Department of Education, Department of Juvenile Services, Department of Human Resources, Department of Public Safety and Correction Services, Developmental Disabilities, Department of Housing and Community Development, Department of Rehabilitation Services, Office of the Deaf and Hard of Hearing, Maryland National Guard and Department of Veterans Affairs.

A chart of State Partners and MHA Liaisons are appended.

FY 2014 – 2015 MARYLAND MENTAL HEALTH BLOCK GRANT

Appendix A

Mental Hygiene Administration Liaisons to Maryland State Government Agencies

Maryland Department of Disabilities (MDOD)	Governor's Office for Children (GOC)	Governor's Office of the Deaf and Hard of Hearing (ODHH)	Maryland State Department of Education (MSDE)	Division of Rehabilitation Services (DORS)	Department of Human Resources (DHR)	Department of Housing and Community Development (DHCD)	Maryland Department of Aging (MDoA)	Department of Public Safety and Correctional Services (DPPS)	Department of Juvenile Services (DJS)	Department of Veterans Affairs	Judiciary of Maryland
Brian Hepburn, M.D.	Al Zachik, M.D. Tom Merrick	Marian Bland	Al Zachik, M.D. Cyntrice Bellamy	Marian Bland and Steve Reeder	Daryl Plevy, Al Zachik, M.D. and Marian Bland	Steve Reeder and Marian Bland	Marian Bland and Steve Reeder	Office of Forensic Services and Marian Bland	Al Zachik, M.D., Cyntrice Bellamy and Office of Forensic Services	Shauna Donahue, DHMH, Director, Maryland's Commitment to Veterans	Darrell Nearon, Ph.D., J.D., LCSW-C, DHMH, Office of Forensic Services

Mental Hygiene Administration Liaisons to Maryland State Government Agencies

DHMH Alcohol and Drug Abuse Administration (ADAA)	DHMH Family Health Administration (FHA)	DHMH Developmental Disabilities Administration (DDA)	Maryland Health Care Commission (MHCC)	Health Services Cost Review Commission (HSCRC)	The Children's Cabinet	DHMH Medical Care Programs (Medicaid)	DHMH Office of Health Care Quality (OHCQ)	DHMH Office of Capital Planning, Budgeting, and Engineering Services	DHMH AIDS Administration	Maryland Emergency Management Administration (MEMA)	
Lisa Hadley, M.D., J.D., Cynthia Petion and Carole Frank	Al Zachik, M.D.	Stefani O'Dea, Lisa Hovermale, M.D., DDA, and Darrell Nearon, Ph.D., J.D., LCSW-C, DHMH, Office of Forensic Services	Brian Hepburn, M.D.	Brian Hepburn, M.D.	Al Zachik, M.D.	Brian Hepburn, M.D., Daryl Plevy, Lisa Hadley, M.D., J.D., and Melissa Schober	Sharon Ohlhaber And Audrey Chase	Cynthia Petion and Robin Poponne	Marian Bland	Mary Sheperd	

IV: Narrative Plan

W. State Behavioral Health Advisory Council

Narrative Question:

Each state is required to establish and maintain a state Behavioral Health Advisory Council (Council) for services for individuals with a mental disorder. While many states have established a similar Council for individuals with a substance use disorders, that is not required. SAMHSA encourages states to expand their required Council's comprehensive approach by designing and use the same Council to review issues and services for persons with, or at risk of, substance abuse and substance use disorders. In addition to the duties specified under the MHBG statute, a primary duty of this newly formed Council will be to advise, consult with, and make recommendations to SMHAs and SSAs regarding their activities. The Council must participate in the development of the MHBG state plan and is encouraged to participate in monitoring, reviewing, and evaluating the adequacy of services for individuals with substance abuse and mental disorders within the state. SAMHSA's expectation is that the State will provide adequate guidance to the Council to perform their review consistent with the expertise of the members on the Council. States are strongly encouraged to include American Indians and/or Alaska Natives in the Council; however, their inclusion does not suffice as tribal consultation. In the space below describe how the state's Council was actively involved in the plan. Provide supporting documentation regarding this involvement (e.g., meeting minutes, letters of support, etc.)

Additionally, please complete the following forms regarding the membership of your state's Council. The first form is a list of the Council members for the state and second form is a description of each member of the Council.

There are strict state Council membership guidelines. States must demonstrate (1) that the ratio of parents of children with SED to other Council members is sufficient to provide adequate representation of that constituency in deliberations on the Council and (2) that no less than 50 percent of the members of the Council are individuals who are not state employees or providers of mental health services. States must consider the following questions:

- What planning mechanism does the state use to plan and implement substance abuse services?
- How do these efforts coordinate with the SMHA and its advisory body for substance abuse prevention and treatment services?
- Was the Council actively involved in developing the State BG Plan? If so, please describe how it was involved.
- Has the Council successfully integrated substance abuse prevention and treatment or co-occurring disorder issues, concerns, and activities into the work of the Council?
- Is the membership representative of the service area population (e.g., ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)?
- Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families and other important stakeholders.

Footnotes:

FY 2014 – 2015 MARYLAND MENTAL HEALTH BLOCK GRANT

W. State Behavioral Health Advisory Council

The Maryland Advisory Council on Mental Hygiene/P.L. 102-321 Planning Council, often referred to as the Joint Council, was created to serve in an advisory and advocacy capacity in addressing mental health issues in Maryland. Its mandated duties are to advise the Mental Hygiene Administration (MHA) and “be a strong advocate of a comprehensive, broad-based approach to the social, economic, and medical problems of mental hygiene”.

The Joint Council is composed of consumers, family members of persons with psychiatric disabilities, mental health professionals, representatives of other state agencies that serve individuals with psychiatric disorders, and other citizens interested in the state’s mental health delivery system. The membership also includes representation from a broad range of groups that are concerned either directly or indirectly with mental health (e.g. clergy, labor, courts, medical profession, mental health advocacy organizations, parents of children with emotional disabilities, etc.). Also included are various socio-economic and ethnic groups.

Maryland’s Planning Process for the State Mental Health Plan and Mental Health Block Grant Application

MHA’s Office of Planning and Training is responsible for the oversight, development, and implementation of the state, local, and federal planning activities. Each year, coordinated efforts begin with the submission to MHA of local plans and budgets from the Core Service Agencies (CSAs) that oversee behavioral health services in the local jurisdictions. CSAs work with their local boards and mental health advisory committees to develop and approve these plans, according to guidelines developed through the Office of Planning and Training, prior to submission. These Plans identify local needs and gaps that help to further inform the development of the State Mental Health Plan.

MHA develops a State Mental Health Plan annually that strategically outlines the goals and initiatives of Maryland’s behavioral health system of care in alignment with SAMHSA’s Eight Strategic Initiatives. The production of this plan begins with the outlining of goals and priorities of the behavioral health system through the meeting of the Mental Hygiene Administration leadership and continues as a process that includes a broad participation of stakeholders (consumers, family members, mental health advocacy organizations, behavioral health providers, CSAs, local entities, agency representatives, among others) coming together with MHA leadership to further develop strategies that reflect the direction and the elements of a “*Good and Modern Mental Health and Addictions Service System*”. The final stages of the Plan development include feedback and approval from the MHA leadership, staff, and the Joint Council. Additionally, the State Mental Health Plan includes specific priority areas and strategies that are presented in the FY 2014 – 2015 MHBG Application.

FY 2014 – 2015 MARYLAND MENTAL HEALTH BLOCK GRANT

The Joint Council's Planning Role

The Joint Council maintains an active involvement in MHA's planning process through its participation in the development of the State Mental Health Plan and the Federal Mental Health Block Grant (MHBG) Application. The Joint Council operates under by-laws that set forth a committee structure to enhance its ability to monitor the system of care and to gather and share information that helps to inform the planning process and policy making decisions of MHA. The Planning Committee of the Council monitors behavioral health system data and participates in the planning processes year round. In FY 2013, a series of Planning Committee meetings were held to develop and review these key documents:

The Planning Committee, which meets as needed after the full Council meeting, discussed priorities and prepared for the MHA public meeting on April 26, 2013 to develop the State Mental Health Plan. The meeting was formatted to include six breakout groups, with each focused on one of six goal areas, reflective of SAMHSA's Strategic Initiatives in the State Mental Health Plan, to develop strategy concepts for the FY 2014 Mental Health Plan. This inclusive group generated robust dialogue and many recommendations were submitted to further cultivate strategies. Although all ideas/recommendations were not able to become part of the Plan, areas incorporated included: strengthening of health and wellness programs across the lifespan, enhancement of community supports, expansion of Mental Health First Aid, increase system capacity for addressing workforce development and co-occurring substance use issues across the life span, strategies that addressed continuum of care issues for children and adolescents such as engagement of pediatricians as partners in early intervention efforts, and strategies that further supported individuals who are veterans, and/or members of the LGBTQ community.

On June 18, 2013, the Planning Committee of the Joint Council met, after the full Council meeting, with the MHA Office of Planning and Training staff to review, discuss, and offer feedback on objectives and strategies in the draft FY 2014 State Mental Health Plan and elements of the FY 2014-15 Mental Health Block Grant application. The Committee modified, expanded, and strengthened the strategies as appropriate. The full Maryland Advisory Council on Mental Hygiene/ PL 102–321 Planning Council received the report of the Planning Council's recommendation for adoption of the FY 2014 State Mental Health Plan along with the following comments:

- The strategies in the Plan: promote collaborative efforts among MHA and the Alcohol and Drug Abuse Administration (ADAA), as well as partnerships with consumers, advocacy

FY 2014 – 2015 MARYLAND MENTAL HEALTH BLOCK GRANT

groups, providers, state agencies, and academia; and are reflective of the movement toward behavioral health integration.

- Strategies address the needs of individuals with co-occurring issues across the lifespan including a systems planning grant for children and adolescents.
- The Plan is reader-friendly and it's suggested that additional language/discussion be included to enhance the accuracy and scope of specific projects in areas such as community education, early intervention, and health home implementation.
- The inclusion of peer support efforts is valued. In addition to other activities and outcomes of the MHA Office of Consumer Affairs, the Council looks forward to the *Bringing Recovery Supports to Scale Technical Assistance Center Strategy* (BRSS TACS) Policy Academy efforts to expand and strengthen the role of Peer Support Specialists and Recovery Support Specialists.

The Committee was pleased to read of efforts that promote behavioral health integration and wellness and prevention activities. Year-round, the Council monitors MHBG-funded activities such as crisis response systems and services for children and adolescent. This year there was focus on the Consumer Quality Team (CQT), a block grant funded quality improvement initiative, which will expand site visits and confidential quality of life interviews to consumers served in mental health programs and to additional facilities across the State. This initiative will expand to include programs that serve children and adolescents.

Other Committees of the Joint Council that enhance its ability to monitor progress towards goals incorporated in MHA's State Mental Health Plan and the federal Block Grant include the Interagency Forensic Services Committee (IFSC) which monitors and makes recommendations to improve behavioral health services in the justice/corrections system and the Cultural and Linguistic Competency Committee which monitors the system and informs the Plan on strategies that address issues of cultural competency. Additionally, the Maryland BluePrint Committee monitors closely the child and adolescent system of care and shares information through a statewide network of youth providers and programs.

The Council stays informed of Maryland's implementation of Health Care Reform/ACA as well as other federal grants that promote behavioral health integration. These include presentations on Maryland's SAMHSA-funded planning grants: MDCARES, RURAL CARES - System of Care (SOC) grants; Projects LAUNCH and LIFT - focusing on children and adolescents with co-occurring issues; the five year CHIPRA Quality Demonstration - an anchor in the sustainability planning for the SOC efforts; and the Bureau of Justice Second Chance grant which will provide in-reach and re-entry supports to individuals over a two year period who have co-occurring disorders and are transitioning from prison to the community.

FY 2014 – 2015 MARYLAND MENTAL HEALTH BLOCK GRANT

Additionally, the Council has been kept abreast of Maryland's efforts to address co-occurring disorders through a variety of areas. One of the activities of the Council is to promote dialogue and updates from agency representatives. The Alcohol and Drug Abuse Administration (ADAA) representatives have always provided updates on collaborative efforts with MHA on training and workforce development in the area of co-occurring issues. Additionally, the current substance use representative collaborated with MHA's Office of Consumer Affairs in the areas of: Recovery and Peer Specialists; Recovery Oriented System Of Care (ROSC), a strength-based model that utilizes a network of formal and informal services to sustain long-term recovery for individuals and families impacted by substance use disorders; and other efforts.

The Behavioral Health Council Workgroup

In light of the Maryland Department of Health and Mental Hygiene (DHMH) efforts towards implementation of behavioral health integration, the Councils for mental health and substance use disorders thought it was important to explore discussions to facilitate movement on creating a "Behavioral Health Council". After an initial meeting of the Councils' support staff and the DHMH Deputy Secretary of Behavioral Health and Disabilities, the Maryland Advisory Council on Mental Hygiene/P.L. 102-321 Planning Council (Joint Council) and the State Drug and Alcohol Abuse Council (SDAAC) formed a Behavioral Health Council Workgroup to:

- Clarify what a Behavioral Health Council should look like
- Eliminate duplication in design/structure and in membership
- Define a model to present to both Councils
- Repeal prior state statutes and replace with statute that would delineate the parameters for one Behavioral Health Council

Additionally, the SDAAC, which develops a Strategic Plan for the Maryland State Drug and Alcohol Abuse Council, prioritized a goal in that Plan to move toward a Behavioral Health Council.

Leading participants in the Joint Council (including the Chair, Vice Chair, and Coordinator) and the SDAAC were invited to represent their memberships. The ADAA representative to the Joint Council also participates in this Workgroup. Prior to the first Workgroup meeting, support staff from MHA and ADAA developed a matrix that highlights/crosswalks information on the state/federal legislation of both councils, and compares the roles/duties/bylaws, membership, meeting frequency, appointments/terms as well as other key issues. This has become a useful resource as the Workgroup moves toward its goals. The Workgroup has continued to meet over the past several months. Discussion has focused on, but not been limited to, the inclusion of county advisory councils as important components of the current system and the desire to

FY 2014 – 2015 MARYLAND MENTAL HEALTH BLOCK GRANT

maintain their involvement in the planning process as well as the consideration of establishing a supportive committee structure that would address themes that would assist the progress of the new council in addressing key areas.

In early 2013, The Workgroup, through a joint effort between MHA's Joint Council and the State Drug and Alcohol Abuse Council, submitted an application on February 14, 2013 to join the State Planning Council National Learning Community Technical Assistance Project. Maryland was among eight states' Planning Councils awarded this grant which allows the group to share ideas with other states that are making similar changes in the structure of their mental health advisory councils and to receive technical assistance in the following areas:

- Further examination of existing models and best practices in the area of integrated behavioral health councils in other states including focus on membership/composition and committee structures
- Continual exploration/awareness of areas of agreement and common strengths between the Joint Council and the SDAAC; i.e. comparison of what already exists in Maryland to lay the groundwork for change
- Sharing ideas, model concepts with decision makers and leadership from DHMH, both councils/administrations, and local stakeholders to report on progress and solidify foundation for change
- Continuous enhancement of communication efforts - telecommunications/video conferencing; increase utilization of Web-based efforts
- Legislative review and revision to support the new integrated Council
- Develop an implementation plan

Efforts continue with expectations that recommendations toward a combined council will be made in FY 2014-15.

IV: Narrative Plan

Behavioral Health Advisory Council Members

Start Year:

End Year:

Name	Type of Membership	Agency or Organization Represented	Address, Phone, and Fax	Email (if available)
Michael Finkle	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	On Our Own of Maryland, Inc.	1521 S. Edgewood Street Baltimore, MD 21227 PH: 410-646-0262 FAX: 410-646-0264	mikef@onourownmd.org
Lynn Albizo	Others (Not State employees or providers)	Maryland Addictions Director's Council (Behavioral Health) MADC	11869 Bright Passage Columbia, MD 21044 PH: 410-733-1098	LALBIZO@VERIZON.NET
Sarah Burns	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	On Our Own of Maryland, Inc.	1247 Newfield Road Baltimore, MD 21207 PH: 443-682-5012	SEB21228@AOL.COM
Herb Cromwell	Providers	Community Behavioral Health Association of Maryland	18 Egges Lane Catonsville, MD 21228 PH: 410-788-1865	MDCBH@VERIZON.NET
Joshana Goga	Providers	Medical Profession	1158 East MacPhal Road Bel Air, MD 21015 PH: 410-441-9999	JGOGA@SHEPPARDPRATT.ORG
Jan Desper	Others (Not State employees or providers)	Black Mental Health Alliance, Inc.	733 West 40th Street, Suite 10 Baltimore, MD 21215 PH: 410-338-2642	
Eugenia Conolly	State Employees	Alcohol and Drug Abuse Administration	55 Wade Avenue Catonsville, MD 21228 FAX: 410-402-8601	Eugenia.Conolly@maryland.gov
Robert Anderson	State Employees	Maryland Department of Juvenile Services	One Center Plaza, 120 West Fayette Street Baltimore, MD 21201 PH: 410-230-3147	ANDERSR@DJS.STATE.MD.US
Terry Farrell	Others (Not State employees or providers)	Maryland Association of Core Service Agencies	125 North Main Street/Rear Bel Air, MD 21014 PH: 410-803-8726 FAX: 410-803-8732	CSATFARRELL@MEGAPATHDSL.NET
Michelle Stewart	State Employees	Maryland Division of Rehabilitation Services	2301 Argonne Drive, Suite A304 Baltimore, MD 21218 PH: 410-554-9109 FAX: 410-554-9412	MSTEWART@DORS.STATE.MD.US

10630 Little

Kate Farinholt	Family Members of Individuals in Recovery (to include family members of adults with SMI)	National Alliance on Mental Illness-Maryland	Patuxent Pkwy., Suite 475 Columbia, MD 21044 PH: 410-884-8691	KFARINHOLT@NAMIMD.ORG
Vira Froehlinger	Others (Not State employees or providers)	Advocate	One Southerly Court, #608 Towson, MD 21286 PH: 410-828-8608	
Adrienne Hollimon	State Employees	Maryland Medicaid	201 W Preston Street, 2nd Floor Baltimore, MD 21201 PH: 410-767-1690 FAX: 410-333-5154	ADRIENNE.HOLLIMON@MARYLAND.GOV
William Manahan	State Employees	Maryland Department of Housing and Community Development	100 Community Place Crownsville, MD 21032 PH: 410-514-7508 FAX: 410-729-3721	MANAHAN@MDHOUSING.ORG
Dan Martin	Others (Not State employees or providers)	Mental Health Association of Maryland, Inc.	Suite 505, 1301 York Road Lutherville, MD 21093 PH: 410-235-1178	DMARTIN@MHAMD.ORG
Cynthia Petion	State Employees	Maryland Mental Hygiene Administration	55 Wade Avenue, Dix Bldg Catonsville, MD 21228 PH: 410-402-8473 FAX: 410-402-8309	CYNTHIA.PETION@MARYLAND.GOV
Linda Raines	Others (Not State employees or providers)	Mental Health Association	Suite 505, 1301 York Road Lutherville, MD 21093 PH: 410-235-1178 FAX: 410-235-1180	LRAINES@MHAMD.ORG
Sarah Rhine	Others (Not State employees or providers)	Maryland Disability Law Center	Suite 2000, 1500 Union Avenue Baltimore, MD 21211 PH: 410-727-6352 FAX: 410-727-6389	SARAHR@MDLCLAW.ORG
Jane Walker	Parents of children with SED	Maryland Coalition of Families for Children's Mental Health	10632 Little Patuxent Pkwy., Suite 234 Columbia, MD 21044 PH: 410-730-8267 FAX: 410-730-8331	JWALKER@MDCOALITION.ORG
Kathleen Ward	State Employees	Social Services	Room 597, 311 W Saratoga Street Baltimore, MD 21201 PH: 410-767-7422 FAX: 410-333-0127	KWARD2@DHR.STATE.MD.US
M. Sue Diehl	Others (Not State employees or providers)	Mental Health	6005 Lake Manor Drive Baltimore, MD 21210 PH: 410-377-4446	SUEDIEHLSW@COMCAST.NET

Livia Pazourek	Providers	Mental Health	Astern Way Annapolis, MD 21401 PH: 410-768-6777 FAX: 410-760-6811	LIVIAP@OMNIHOUSE.ORG
Robert Pender	Others (Not State employees or providers)	Mental Health	Box 294, Terry Drive Port Tobacco, MD 20677 PH: 301-934-3145	RPENDER@CROSSLINK.NET
Charles Reifsnider	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	Mental Health	Unit F, 500 Heather Ridge Drive Frederick, MD 21702-1409 PH: 301-898-3044	
John Scharf	Others (Not State employees or providers)	Mental Health	PO Box 15320 Middle River, MD 21220 PH: 443-841-2111	JJOHN2509@AOL.COM
Anita Solomon	State Employees	Mental Health	7517 Holiday Terrace Bethesda, MD 20817-6611 PH: 301-340-0999 FAX: 301-229-0833	SOLOANITA@AOL.COM
Phoenix Woody	State Employees	Maryland Department of Aging	301 W Preston Street, Suite 1007 Baltimore, MD 21201 PH: 410-767-4665 FAX: 410-333-7943	PLISS@OOA.STATE.MD.US
Chicquita Crawford	Family Members of Individuals in Recovery (to include family members of adults with SMI)	Mental Health	5501 Summerfield Avenue Baltimore, MD 21206-4313 PH: 410-448-2232	KEE-KEE10@HOTMAIL.COM
A. Scott Gibson	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	Mental Health	PO Box 561 Frostburg, MD 21532-0561 PH: 301-777-2346 FAX: 301-777-2364	GODFATHER21532@HOTMAIL.COM
Victor Henderson	State Employees	Maryland Department of Disabilities	217 East Redwood Street, Suite 1300 Baltimore, MD 21202 PH: 410-767-3635	VHENDERSON@MDOD.STATE.MD.US
Geraldine Gray	Family Members of Individuals in Recovery (to include family members of adults with SMI)	Mental Health	Apt 2302, 8820 Walther Blvd Parkville, MD 21234 PH: 410-513-7313	GERRY.GRAY@GMAIL.COM
Julia Jerscheid	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	Mental Health	201 Federal Street, #33 Easton, MD 21601 PH: 410-822-4917	
Cathy Marshall	State Employees	Developmental Disabilities Administration	1360 Marshall Street Hagerstown, MD 21740 PH: 301-791-4670	CATHY.MARSHALL@MARYLAND.GOV
Sharon Lipford	Others (Not State employees or providers)	Mental Health	319 S Main Street Bel Air, MD 21014 PH: 410-638-3389 FAX: 410-803-0433	SMLIPFORD@HARFORDCOUNTYM.D.GOV

George Lipman	State Employees	Maryland Courts	Avenue Baltimore, MD 21133 PH: 410-878- 8963 FAX: 410-878- 8319	GEORGE.LIPMAN@MDCOURTS.GOV
Sheryl Lynn Sparer	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	Mental Health	1612 Hill Top Road Edgewater, MD 21037 PH: 443-716- 5322 FAX: 410-956- 8695	LUV2SING29@GMAIL.COM
Gerald Beemer	Providers	Mental Health	6013 Newton Road Preston, MD 21655 PH: 410-228-5511	GBEEMER@SHOREHEALTH.ORG
Jacqueline Powell	State Employees	Maryland Department of Human Resources	311 W Saratoga Street Baltimore, MD 21201 PH: 410-767-6948	JPOWELL@DHR.STATE.MD.US
Nancy Feeley	State Employees	Maryland State Department of Education	200 West Baltimore Street Baltimore, MD 21201 PH: 410-767-0738	NFFEELEY@MSDE.STATE.MD.US
Joanne Meekins	Others (Not State employees or providers)	Mental Health	1301 York Road, Suite 505 Lutherville, MD 21093 PH: 410-235- 1314 FAX: 410-235- 5102	JMEEKINS@CQTMD.ORG
Thomas E. Arthur	Others (Not State employees or providers)	Mental Health	98 Dewey Drive Annapolis, MD 21401 PH: 410-269- 5263 FAX: 410-269- 5263	ARTHURHOME98@COMCAST.NET
Naomi Booker	Others (Not State employees or providers)	Mental Health	2611 Manhattan Avenue Baltimore, MD 21215 PH: 410-207- 3173 FAX: 410-367- 6166	NAOMIBOOKERASSOC@YAHOO.COM
Dennis McDowell	Others (Not State employees or providers)	Mental Health	24308 Hipsley Mill Road Laytonsville, MD 20882 PH: 240-888- 5649 FAX: 301-253- 8839	STARKS4343@AOL.COM
John Turner	Others (Not State employees or providers)	Mental Health	225 Autumn Lane Centreville, MD 21617 PH: 410-739-1910	JOHN.TURNER225@GMAIL.COM
Frank Kolb	State Employees	Maryland Health Benefit Exchange	750 East Pratt Street, 16th Floor Baltimore, MD 21202	

Footnotes:

IV: Narrative Plan

Behavioral Health Council Composition by Member Type

Start Year:

End Year:

Type of Membership	Number	Percentage
Total Membership	45	
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)	6	
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	3	
Parents of children with SED*	1	
Vacancies (Individuals and Family Members)	<input type="text" value="0"/>	
Others (Not State employees or providers)	16	
Total Individuals in Recovery, Family Members & Others	26	57.78%
State Employees	15	
Providers	4	
Federally Recognized Tribe Representatives	0	
Vacancies	<input type="text" value="0"/>	
Total State Employees & Providers	19	42.22%
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	<input type="text" value="0"/>	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	<input type="text" value="0"/>	
Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Persons in recovery from or providing treatment for or advocating for substance abuse services	<input type="text" value="0"/>	

* States are encouraged to select these representatives from state Family/Consumer organizations.

Indicate how the Planning Council was involved in the review of the application. Did the Planning Council make any recommendations to modify the application?

Footnotes:

IV: Narrative Plan

X. Enrollment and Provider Business Practices, Including Billing Systems

Narrative Question:

Each state is asked to set-aside three percent each of their SABG and MHBG allocations to support mental and substance use service providers in improving their capacity to bill public and private insurance and to support enrollment into health insurance for eligible individuals served in the public mental and substance use disorder service system. The state should indicate how it intends to utilize the three percent to impact enrollment and business practices taking into account the identified needs, including:

- Outreach and enrollment support for individuals in need of behavioral health services.
- Business plan redesign responsive to the changing market under the Affordable Care Act and MHPAEA.
- Development, redesign and/or implementation of practice management and accounts receivable systems that address billing, collection, risk management and compliance.
- Third-party contract negotiation.
- Coordination of benefits among multiple funding sources.
- Adoption of health information technology that meets meaningful use standards.

Footnotes:

FY 2014 – 2015 MARYLAND MENTAL HEALTH BLOCK GRANT

X. Enrollment and provider business practices, including Billing Systems

Each state is asked to set-aside three percent each of their SABG and MHBG allocations to support mental and substance use service providers in improving their capacity to bill public and private insurance and to support enrollment into health insurance for eligible individuals served in the public mental health and substance use disorder service system.

Maryland intends to use the three percent of the mental health block grant application (MHBG) to identify efforts necessary to aid providers in the transition process to the new integrated system. This would include a plan to provide technical assistance (TA) to providers on electronic billing systems and use of electronic health records (EHRs). Also TA efforts would be provided to promote outreach and enrollment support as well as promotion of prevention/wellness activities.

As discussed earlier in this document, the “next steps” in the Behavioral Health Integration (BHI) process include the development of the Request for Proposal (RFP) to select an Administrative Services Organization (ASO) to administer the new MA financing model, as well as collaborative process with stakeholders to develop performance measures, shared savings models, quality and access to care standards and a financing approach that complements emerging clinical models of integration. MHA, in collaboration with the Department, will work with stakeholders, which includes providers, to address the above issues, including mechanisms to address billing and billing disputes.

IV: Narrative Plan

Y. Comment on the State BG Plan

Narrative Question:

Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. 300x-51) requires that, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the State BG Plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to the Secretary of HHS.

Footnotes:

FY 2014 – 2015 MARYLAND MENTAL HEALTH BLOCK GRANT

Y. PUBLIC COMMENT ON THE STATE PLAN

Each year, official public notice of the State Mental Health Plan, Block Grant application, and Implementation Report is published in the Maryland Register for citizen review. The Register is published two times per month and provides information on state government activities. The notice in the Register also provides information regarding the availability of the documents. Due dates for the application and the implementation report are noted. Comments are requested in writing. Any responses received prior to finalization of documents are considered and incorporated, as appropriate. Comments are also accepted after submission of documents to the federal government. The notice provides the name of a Mental Hygiene Administration contact person and phone number.

The opportunity to comment on the plan is provided at different stages in the state planning process. The most critical stages of this planning process involve the work of the Joint Council discussed in Section W, State Advisory Council. The development of the goals, objectives, and strategies for the annual state plan involves a series of meetings with active participation from key PMHS stakeholders including representatives of consumer and family advocacy organizations, mental health advocacy groups, advisory council for special needs populations, (such as the deaf or hard of hearing, traumatic brain injury), provider organizations, Core Service Agencies, and a wide range of groups, agencies, and individuals serving on the Joint Council. The annual Joint Council review and recommendation is also summarized in Section W. of the application.

During this public process, draft copies of the State Plan and key sections of the Block Grant application are distributed, through the Joint Council mailing and e-mail lists, for review and comment. The Planning Committee reviews the final draft of the State Plan and key Block Grant documents during two separate meetings with MHA staff.

Each year, following the adoption of the State Plan, the document is distributed through the Joint Council mailing list consisting of over 200 members, stakeholders, interested parties, Core Service Agencies, and local mental health advisory committee chairmen. Throughout the year, MHA's Division of Planning provides copies of the State Mental Health Plan to interested parties upon request. The review and comment on the annual Block Grant Implementation Report follows a somewhat similar process prior to the December submission deadline.

MHA's Division of Planning, in collaboration with the Division of Health Management Information Systems, places the approved State Plan on the Department of Health and Mental Hygiene-Mental Hygiene Administration Web site as a vehicle for notification of the availability and/or for wider distribution of the document. We expect this process to engender questions during the year, which will assist with the development of the Plan for the following year.