

Commission to Study Mental & Behavioral Health

October 6, 2020

4:00-6:00PM

Meeting Minutes

I. Call to order

Lieutenant Governor Rutherford called to order a virtual meeting for the Commission to Study Mental and Behavioral Health on October 6 at 4:00PM.

II. Roll Call/Attendees

Commission Members Participating: Lt. Governor Rutherford, Senator Adelaide Eckardt, Senator Katie Fry Hester, Delegate Lewis Young, Delegate Ariana Kelly, Richard Abbott, Dennis Schrader, Dr. Aliya Jones, Lt. Col. Roland Butler, Christian Miele, Dr. Lynda Bonieskie, Tiffany Rexrode, Director Steve Schuh, Mary Gable, Barbara Allen, Patricia Miedusiewski, Dr. Bhaskara Tripuraneni, Cari Cho, Serina Eckwood & Kimberlee Watts

Designees: Tricia Roddy, Joy Hatchett

Absent: Commissioner Birrane

III. Sub-Committee Update:

a) Crisis Services - *Director Steve Schuh, Chair:*

- Standing goal of developing a comprehensive crisis coordination system
- The Opioid Operational Command Center, (O OCC) Second Quarter Report was released on September 26, 2020 and illustrates an increase of total intoxication deaths of over 9% during the first half of 2020 as compared to the first half of 2019
- We are also seeing an acceleration of those deaths. During Jan – March, fatalities were up about 1% but during the second quarter, April – June, they were up 18%
- The report shows an increase of intoxication deaths related to both opioids and non-opioid substances
- Looking at implementing ACT Teams across Maryland
- Next meeting is November 4 at 10:30am

- b) Youth & Families - *Co-Chairs Deputy Secretary Christian Miele & Asst. Secretary Tiffany Rexrode:*
- Last meeting was held on September 14
 - Will meet second Monday every other month
 - Broke up our subcommittee into workgroups to focus our goals
 - (1) Licensure and Reciprocity – looking at regulatory reform
 - (2) Maryland Behavioral Health Report Card Assessment – strengthening training efforts
 - (3) Substance Use Services for Youth & Adolescents – Medicaid reimbursements
 - (4) Looking at adding workgroups for senior citizens and adult caregivers
 - Next meeting is November 9 at 1:00pm
- c) Financing & Funding - *Co-Chairs Tricia Roddy & Commissioner Birrane:*
- Continuing to work on the network adequacy and relations which includes adequacy of mental health providers
 - Developing regulations related to the reporting obligations on mental health parity.
 - MD IMD Waiver history highlights –
 - (1) Originally applied for IMD Waiver in 1997 and we had one in place until 2006 because we were told by Centers for Medicare and Medicaid Services that they would no longer support psych IMD Waivers and it was completely phased out by 2006.
 - (2) During the Affordable Care Act, there was monies in there to apply for the Emergency Psychiatric Demonstrations Program and MD was one of the states that was selected for the program. That ran from 2012-2015. There were questionable evaluation results of the program that Dept. of Health and Human Services presented to Congress and they elected to not to move forward or continue with the demonstration.
 - (3) We do have an IMD coverage for the Substance Use Disorder, (SUD) population and we have expanded that to cover individuals with a primary SUD diagnosis in a psych IMD and we have had the ability to bill for those services since 2018.
 - (4) Our 1115 waiver comes up for renewal next year. We would be considering putting this ask back into the renewal process and assuming CMS doesn't change its policy and continues to support these waivers, then we would expect to have this waiver into effect Jan 2022.
 - (5) Our next meeting is scheduled for October 28 at 1:00pm

d) Public Safety & Justice System - *Co-Chairs Senator Katie Fry Hester & Dr.*

Lynda Bonieskie:

- Since our last Commission meeting, we have met twice to move forward with planning of our SIM Summit to take place on November 17 and November 18.
- We have spoken to the Forensic Director of Michigan, Dr. Deborah Pinals. Michigan is 1 of 2 states that has done this so far
- We have heard from local examples – Katherine Dilley, Executive Director of Mid-Shore Behavioral Health and Belinda Frankel, Forensic Mental Health Program Manager on Mid-Shore’s experience with SIM
- Goals of SIM Summit (3)
 - (1) Facilitate discussions to identify the resources and gaps and opportunities at each intercept
 - (2) Hold county workgroups to identify local opportunities to strengthen existing efforts
 - (3) Compile recommendations informed by those discussions and outline a report for the next state
- Next meeting is October 20 at 3:00pm

IV. Special Presentations – *Please see additional materials on our webpage*

a) Briefing: Governor's Challenge to Prevent Service Member, Veteran and Families (SMVF) Suicide/Ask the Question Campaign

Presenters:

- Joy Ashcraft, Director, Maryland's Commitment to Veterans, MDH Behavioral Health Administration, Lead, Governor's Challenge to Prevent SMVF Suicide
- Dana Burl, Director, Outreach and Advocacy Program, MD Department of Veterans Affairs, Co-Lead, Governor's Challenge to Prevent SMVF Suicide

b) The Path Forward for Mental Health & Substance Use | 2020 Milliman Report

Presenters:

- John Miller, CEO of MidAtlantic Business Group on Health
- Henry Harbin, National Health Care Consultant and MHAMD Board Member

V. Commission Discussion – Assisted Outpatient Treatment, (AOT)

Lt. Governor: People who have had a frequency with the ER rooms and law enforcement are the target populations for AOT.

Dr. Jones: Original implementation was a complete Involuntary process – the patients had to have inpatient involuntarily hospitalization in order to meet criteria for program admission. 2018 Legislation made a slight change that people can volunteer to be a part of the program; you didn't have to have an involuntary hospitalization since referrals were so low. AOT is fairly new and a different way of thinking about care for people with psychiatric conditions. Historically, in MD, people have had autonomy about their care and treatment so this is a shift of care.

Lt. Governor: It seems that the person who is frequently in crisis and is in the ER because law enforcement has brought them to the ER. This is typically an involuntary commitment to treatment. This person may need some type of oversight. Not that we keep them somewhere but that the Health Department can check in on them at their homes.

Dr. Jones: Bon Secours was the pilot program. The providers are the ones that have to state that “this person needs this type of care”. The number of referrals were low. When you are speaking about the people that are frequently brought into the ER by law enforcement, you have two types: people that are intoxicated and will not be referred to the psychiatric unit and then you have individuals who are exhibiting some sort of manic or psychotic behavior who are going to be committed into a psychiatric or in patient setting where there is an opportunity to make the AOT referrals. The program works well when you can get someone into the program.

Lt. Governor: The report does say there was a lot of success but not a lot of people and therefore SAMHSA's funding didn't continue. In regards to law enforcement, sometimes families will call law enforcement on a family member that is in crisis and needs help. The police that respond will usually take that person to a hospital to address the crisis and therefore are involuntarily committed. It's something worth exploring.

Cari Cho: Dr. Jones described perfectly the challenges in Maryland. MD is very pro-individual rights and this is a cultural shift. An administrator in the Montgomery County Behavioral Health Department, years ago, told me “I would never have supported AOT in all the years I worked in government until I had this job and saw how much money some of these individuals cost the tax payers. I have completely changed my mind just to get them the care they need”. It is a tough transition. It's a part of the continuum of care that we need in place.

Dr. Bonieskie: I work for the Department of Public Safety and Correctional Services, I researched it. We are one of three states that don't have this. I have 45% of my prison population that is seriously mentally ill. This could prevent people going to prison. Corrections is the default and I think this program could reduce the prison population.

Lt. Governor: When you get law enforcement involved it causes escalation. There needs to be a way to work with these individuals and have some oversight. For example, the woman who was cast out of the University of Maryland Medical on the coldest day of the year, she clearly could not care for herself. At some point she may have needed that AOT where there are still some oversight and monitoring of what is going on.

Senator Eckardt: The longer people are not able to respond to treatment the more brain damage there is. It leads to treatment resistance. I truly believe it is time to revisit this and think it through. Folks need this structure and support to prevent further deterioration of the brain.

Lt. Governor: I know Senator Hester's committee is looking into this on October 20.

VI. Verbal Testimony:

- Dr. Renee Desmarais, *Eastern Group Trustee, MedChi, The Maryland State Medical Society*:
*Please see additional materials for testimony
- Adrienne Breidenstine, *Behavioral Health System Baltimore*:
I would like to quickly comment on AOT and as you've heard during your discussion, it is a very controversial topic, the idea of legally mandated or forced treatment. My organization has the responsibility with overseeing and implementing in MD the Outpatient Civil Commitment, (OCC) pilot program that you all heard about today. We know that the forced treatment doesn't necessarily result in better health outcomes for this population. A part of the puzzle I think is missing from today's conversation, is how much social determinants of health play a role in a person's ability to succeed in an OCC program; whether it's of a pilot program that we have in MD or one that uses more of the civil legal system to mandate a type of treatment. Those are things like housing and public safety and how those can support someone's overall recovery. I am looking forward to Senator Hester's subcommittee's discussion but would encourage you to consider how social detriments of health support someone's overall recovery. Again, whether it's in a more legally mandated program or if it's one like we have in MD. We do think the one we have is

working; you heard about that from Dr. Jones. What makes MD's unique is that it holds our system accountable to the person whereas other states are holding the person accountable for their own treatment. That is really important when you are working with individuals with severe mental illnesses, comorbidities and all these other complex social determinants of health challenges. I encourage you to look at what we have in MD and build upon the strengths of the current pilot program.

Commission discussion: Yes, we have an opportunity to look at those existing programs. I guess you can say AOT is forced treatment but so is involuntary commitment at least in this way, it appears that it can be seen as oversight. It is the least restrictive. The person has freedom and are not being kept in a facility. It is something worth exploring and discussions that need to be had. We are aware that this is a controversial subject and it is important that we hear from both our experience here in MD and other states with slightly different approaches. We should not shy away from this, we just need to explore what will be best.

VII. Closing Remarks:

Next Meeting November 6 at 4:00-6:00pm

Please visit our webpage: Ltgovernor.maryland.gov/mbhcommission