11/16/2016

2017 Legislative Priorities

Behavioral Health Coalition of the Mid Shore

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Closure of Adventist Behavioral Health Eastern Shore

Problem: Adventist Behavioral Health Eastern Shore will be closing November 30, 2016 creating a loss of services for Mid-Shore children, youth and families seeking behavioral health treatment in an acute, residential or partial hospitalization setting and in a Level V Non-Public school placement.

Immediately, this impacts 12 children or youth who are current residents or day school participants who will soon be moved across the Bay to attain the level of services that they require. Some of these families have been able to have their child attend the Level V day school while living at home, but will have to consider admitting their child into a Residential Treatment program in order to get the level of support to access their education.

The burden of seeking acute treatment for their child impacts the family's ability to work, provide emotional support to other children in the family, and impacts the overall structure of the family. If Peninsula Regional Medical Center is approved to provide Acute and Partial Hospitalization Programs on the Lower Shore, this will lessen the burden for families in that geographic region. But, the families in the Mid and Upper Shore will spend more time traveling, additional funds in gas and travel expenses, and less time with their family, in order to be an active part of their child's treatment.

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

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

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

Chesapeake Voyagers, Inc. Transportation Barriers

Problem: Currently Chesapeake Voyagers, Inc. (CVI) provides Peer Support services to those with mental health and substance use issues who live within the five county mid-shore region. However, we are financially only able to have one physical location, which is in Talbot County. The 5 counties we serve are both Federal and State designated rural jurisdictions. There are only 10 in the state that are deemed both, and we serve half of them. The total area that we, as an organization cover, is a stifling 1,778 sq. miles.

As stated in multiple Maryland State reports through DHMH and University of Maryland, the two major access barriers facing residents of rural areas are access to health insurance and transportation limitations. All of our support groups, social activities, one-on-one peer support, educational forums, and access to computers and other various resources, are free of charge. Since CVI does not charge for the services we provide, having limited or no insurance is not an issue. However, transportation has been, and continues to be, a major issue. Our Peer Support services cannot be effective if the individuals in need of them cannot access them.

At this time, we offer limited transportation to and from our Wellness & Recovery Center only to those who live within the town of Easton. In order to do this, Peer Support staff and volunteers must use their own vehicles. Staff that are in other surrounding counties are also using their own vehicles to help transport people to support groups when possible. This becomes increasingly difficult when looking to help bring people to other activities or events. Requests for increased transportation have been key findings of the last two Maryland Consumer Quality Team reports. Inquiries and requests for transportation from both individuals and referring agencies, is ever increasing. Over the past year, CVI has done multiple marketing events as well as increased media presence to expand our name recognition and spread awareness of the services we offer. Yet those living in, for instance, Greensboro or Millington are 30-45 minutes away from our Easton center. For those without transportation options, accessing our services is near impossible.

Public transportation is helpful, but inadequate. Facing the same problems of long distances across the 5 county area, public buses attempt to offer a multitude of pick up and drop off stops, in as few routes as possible as stated in the 2007 Maryland Rural Health Plan (in regards to adequacy of transportation to health care services) 'routes often do not cover the entire rural jurisdiction and run infrequently'. This creates scheduling conflicts for those wishing to utilize the services at CVI, creating long rides, early boarding times and less time available to receive the support services we provide. As an example of the significance that we have made to some we see, in the fiscal year of 2016 we were able to divert 11 people from going to the ER for a behavioral health evaluation through having a one-on-one peer support session. Based on the Healthcare bluebook, a visit to the ER for a behavioral health evaluation costs approximately $2,189 per visit. Based on that amount, that is a savings of $24,079.

Solution/Support: We are seeking support in our efforts to obtain additional funding, either through BHA, or through grants we apply for and seek out on our own. We request the support of this panel through possible letters of support, or reference if needed, for possible grants, as well as encouragement, assistance, and participation in possible fundraising and awareness efforts.

Behavioral Health Rates for Medical Inflation

Problem: For twenty years, Maryland's Medicaid reimbursement rates for behavioral health services have stagnated, and access to community-based treatment has withered. Today, the overwhelming majority of Maryland residents needing mental health or addiction treatment do not receive it and, for too many individuals, access to behavioral health treatment only occurs after expensive hospitalization or incarceration.

Maryland must change its behavioral health funding policies. Achieving reduced hospital readmissions, reducing lethal heroin overdoses, and reducing avoidable incarceration are all dependent on expanding access to community-based mental health and addiction treatment.

Since 1997, medical inflation has increased providers' costs by 86%, but reimbursement for mental health providers have been increased for inflation by 13% -- leaving providers with a growing gulf between what they're paid and what it costs to do business. In other words, a provider paid $100 in 1997 would be paid $113 under Medicaid reimbursement today, but medical inflation has driven costs up to $191. Thus, behavioral health providers stretch to cover rising expenses with reimbursement rates that don't keep up.

Solution/Support: Potential Legislation for the 2017 Session is still in the early planning stages, however, we expect legislation similar to the 2016 Keep the Door Open Act will be put forth next year and we ask for your **support**. We believe that smart and effective spending will ensure stability for community based clinics who will then be open and available to meet the needs in our rural communities. Further, addressing mental health challenges and substance abuse in the early stages is most certainly more cost-effective then ER visits, hospitalizations and incarcerations.

Transfer of Grant Funds for Inpatient/Residential Substance Use Disorder Treatment

Problem: The Behavioral Health Administration has spent a number of years planning and now implementing the transfer of grant funds for ambulatory/outpatient treatment to the ASO/Medicaid for fee for service reimbursement. This transfer began last July 1st for some counties, and will happen for the rest on January 1st, 2017. It has been and continues to be a complex process to implement.

Recently the BHA has announced that grant funds for inpatient detox/residential treatment will transfer to the ASO/Medicaid July 1st, 2017 for fee for service reimbursement. This will create benefits in that there will be federal matching funds, and it could potentially expand the availability of these services. A reimbursement rate will be established between now and then.

One concern is that the reimbursement rate will be too low for grant funded programs, such as the Whitsitt Center, or possibly for some current private providers, to be able to operate. This could affect the availability of these services as of 7/1/17. There is already a waiting list of 1-2 weeks for this service, so disruption to services would have an impact on overdoses and missed opportunities for individuals to begin their recovery.

Another concern is how this transfer would impact the uninsured or underinsured in obtaining this service. Would the uninsured Medicaid eligibility and the exceptions be extended to this level of service, as it is currently for the outpatient benefits?

Solution/Support: In order to provide a continuum of services for substance use disorder treatment on the Eastern Shore, it will take adequate funding and planning for the transfer of grant funds for inpatient treatment to the fee for service reimbursement system. Adequate rates will need to be established in a timely manner to avoid disruptions. This is an opportunity to increase the availability of detox and residential services at a time when it is critically needed. We ask your support to be aware of this process and to provide the funding needed to make this transition a success.

Behavioral Health Service Delivery Expansion to Meet Increased Demand

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SAMPLE

Program Application Chronology Table – Corsica River Mental Health Services

Program	Health Home	SUD Level 1	Mobile Treatment	SUD Additional Sites	SUD Level 2
Date Application Received by OHCQ	11/4/2013	1/20/2015	12/??/2015	3/4/2016	8/30/2016
Date of OHCQ Site Visit	Not Required	4/27/2015	No Record	5/20/2016 Chestertown 6/22/2016 Denton 6/24/2016 Easton	Pending
Date Additional information Request Received by OHCQ	None Received	5/6/2015	None Received	3/9/2016 (prior to site visit and submitted as received while visits were being conducted)	Pending
Date BHA Approval Letter	12/11/2013 K&QA 3/21/2014 Dorchester	5/18/2015	3/10/2016	7/7/2016 Chestertown 7/7/2016 Denton 7/12/2016 Easton	Pending
Date MA Application Received by Provider Enrollment (Mailed Upon Receipt of NPI)	11/14/2013 Dorchester	7/28/2015 8/31/2016	4/6/2016 Returned 5/2/2016 Resubmitted	8/28/2016 Chestertown 8/28/2016 Denton 9/21/2016 Easton	Pending
Date of MA Site Visit	12/20/2013 Dorchester	9/10/2015	7/18/2016	10/19/2016	Pending
Date of MA Letter	1/2/2013	10/30/2015	8/5/2016	Pending	Pending
Date of Beacon Registration	Not Required	11/5/2015	8/25/2016	Pending	Pending
Total Months	K&QA **2** Dorchester **4**	**9.5**	**8**	Current **7.5**	

PROVIDER ALERT

APPLICATION PROCESS STEPS FOR ACCREDITATION-BASED LICENSES

AUGUST 19, 2016

Introduction:
New and existing providers are required to follow multiple steps when opening a new program, a new location, and/or a new service line or ASAM level of care. BHA has mapped the application process steps for accreditation-based licenses under recently promulgated COMAR 10.63. While the application itself will be amended to reflect the requirements in COMAR 10.63, process steps 2-5 reflect the same processes that are currently in effect under COMAR 10.21 and COMAR 10.47. This information will allow programs to mindfully plan when opening new locations or adding to their existing array of services.

Step 1:
Become accredited through an approved accrediting body, using the appropriate crosswalk grid as a guide.

- Crosswalk grids can be found at http://bha.dhmh.maryland.gov/Pages/Accreditation-Information.aspx.

Step 2:
Apply for licensure through OHCQ (based on type of accreditation), using the approved application and submitting all required information – it is anticipated this step may take up to 3 months.

Step 3 (new providers/services/locations only):
Apply for NPI number (NPPES - https://npiregistry.cms.hhs.gov/).

Step 4 (new providers/services/locations only):
Apply for Medicaid provider number(s) (based on license issued by OHCQ, NPI number, and an unannounced Medicaid site visit to each location) – this step can take 4-6 weeks.

- Download the application from the Medicaid Web site: https://mmcp.dhmh.maryland.gov/Pages/Provider-Information.aspx.

- Once the application with the NPI number is submitted to Provider Enrollment, the application is "pended" and then routed through the Medicaid enrollment process. This may include an unannounced site visit, depending on provider type. After the Medicaid enrollment process is complete, a recommendation either to enroll or reject is made.

- Assuming the recommendation is to enroll, Provider Enrollment changes the application status from “pended” to “activated” and a letter to the provider is generated with their MA number(s).

- For behavioral health Medicaid enrollment questions, providers can e-mail dhmh.bhenrollment@maryland.gov.

- FYI – All providers are required to be re-validated every 5 years. To be re-validated the provider will download and complete the same application as above, but select "Re-validation" as the Type of Request and include their MA#.

Step 5 (new providers/services/locations only):
Register as a provider with Beacon Health Options (BHO), based on the NPI and Medicaid provider numbers – since BHO files are uploaded from Medicaid weekly, this step may take 1-2 weeks.

- Providers should call the BHO Customer Service Department at (800) 888-1965 and a Provider Relations Representative will begin the registration process.

Behavioral Health Coalition of the Mid Shore

2017 Legislative Priorities

Behavioral Health Workforce Crisis

Recommendations to Streamline the Professional Counselor Licensing Process

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

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

The following timeline outlines the LGPC licensing process:

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

Solution/Support: Require the Board to amend its application process to mirror that of the Board of Social Work Examiners (BSWE). The BSWE allows for its application to be submitted prior to graduation. Its website includes the information needed to obtain the Criminal Background Check which is submitted simultaneously with the application.

Transcripts can be submitted prior to graduation along with a letter from the Registrar or Dean certifying the student is scheduled to graduate. The student is allowed to take the Social Work test immediately upon graduation. There is no 2 step testing process which Professional Counselor applicants could simultaneously schedule & complete. The social work student subsequently submits the final semester transcript with the date the degree was conferred to obtain their license number which is posted electronically.

Mirroring the BSWE process could reduce the licensure wait time from 6 or more months to approximately 1 month. An employer may be much more likely to retain the student as an employee even though they cannot provide billable services for 1 month vs. 6+ months. The employer may also be just as likely to utilize Professional Counselor interns as it would Social Work interns which would also help to increase the workforce.

Private Insurance Credentialing

Recommendations to Streamline the Credentialing Process

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

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

When credentialed staff leave, the agency typically cannot replace that staff person with another qualified staff in order to maintain (never mind increase) its capacity to continue services for clients of that insurance company or serve others that may be on the agency waiting list. This is counterintuitive to the "any willing provider" approach that Maryland purports to provide.

Some insurance companies require submitting written vs. online applications and/or rarely respond to an application within their own processing timeline(s). With CareFirst, it takes 120 days for it to credential the agency and then another 120 days for the behavioral health staff to be credentialed by Magellan. That delays the agency staff (assuming the application is not denied) for 6+ months before they could provide services to a CareFirst insured client.

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

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

Solution/Support: For true parity for client access and client choice, require all private insurance companies to credential the agency vs. every individual provider within the agency. The agency could report on its internal credentialing process to ensure its staff meet the necessary requirements.

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

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

The agency cannot "bilk" the system. At the end of the day, the client gets to choose where they want to go and who they want to see. After all, the client is the one paying the insurance premium.

COMPANY	USES CAQH?	APPLICATION PROCESS	CONTACT	BARRIERS
Aetna	Yes	https://www.aetna.com/health-care-professionals.html Apply to join network – choose Behavioral Health – Complete online application	Credentialing or re-credentialing status: 1-800-451-7715	Specific geographic area considered when reviewing applications
Carefirst BC/BS	Yes	Apply through CAQH if participating with multiple insurance companies	Rep: Karen Hudson Karen.hudson@carefirst.com 410-872-3570	
Cigna		Submit Health Care Professional Screening Form: Email: BehavioralHCPEnrollment@cigna.com or Fax: 855-300-6162		Accept limited # of providers in geographic area
Magellan (HMO for BC/BS)	Yes	Credential with BC/BS first. Apply online: https://www.magellanprovider.com Complete short application.		
Medicare		Submit both CMS-855I and CMS-855R		Lengthy application. Must be mailed. 4-6 weeks for response. Often want additional info.
MHN (In Network Tricare)		https://www.mhn.com/provider/content.do?mainResource=pracJoin&category=JoinNetwork Complete MHN Participation Request Form on line Should respond within 15 business days	Provider Relations Representative: Trish Redding pdredding@	
Onenet PPO (subsidiary of United Health)		https://www.onenetppo.com/providers/index.html Providers - Join network – Complete provider nomination form	Member services: 1-800-342-3289	Need by region or specialty is considered
Optum – United Behavioral Health	Yes	www.providerexpress.com Download Clinician Add/Change Application Form, complete with original signature. Fax to number in next column.	1-877-614-0484 Fax 1-215-832-4707	Limited to 5 providers
Tricare North		https://www.mytricare.com/internet/tric/tri/mtc_nprov.nsf/sectionmap/Frms_PrvdrCrtfctn Complete applicable application online and mail or fax.	Customer Service: 1-877-874-2273	
Beacon Health private insurances. MD Health Advantage Medicare, Evergreen and commercial Beacon Health		Credential as a facility. Must do an application to then be considered for the credentialing process. Need to be accredited, if not a site visit is required.		Long and involved application form.

Recovery Support for Youth on the Eastern Shore

Problem: According to the Maryland Dept. of Health and Hygiene report titled "Drug- and Alcohol-Related Intoxication Deaths in Maryland 2015" (Revised Sept 2016), there were 1259 drug and alcohol related deaths in 2015, a 20% increase over 2014. Access to treatment and the follow up recovery supports has been an ongoing challenge for Eastern Shore residents particularly as related to youth and young adults.

There is a growing movement across the country in support of youth that have become opioid dependent. The two most predominant factors are Recovery High Schools and Collegiate Recovery Centers.

A movie from the creator of the groundbreaking documentary "The Anonymous People" has highlighted the success of a recovery high school in Huston, Texas. "Generation Found" is being shown across the country to bring awareness to communities that there is help and hope for youth that have become caught up in heroin or opioid dependence or other addictions.

Solution/Support: This film was recently shown on the Shore in Salisbury and generated much interest in the feasibility of starting a recovery high school locally. Please set this concept on your radar as we continue to explore ways in which we can build further recovery capacity to support and protect our vulnerable youth.

Behavioral Health Coalition of the Mid Shore

2017 Legislative Priorities

Enhancing Crisis Services – Adequate Funding

Problem: Support adequate funding for access to quality crisis services on demand establishing walk-in and mobile crisis capacity in every jurisdiction, ensuring that 24/7 walk-in crisis capacity, behavioral health mobile crisis services, law enforcement training are available in every jurisdiction statewide. We thank you for your support of the 2016 legislative session's passing of SB551/HB682.

On the Shore, we are blessed to have the framework of a robust crisis response system, but it is by no means complete.

- ✓ **Our Current Framework**
  - ✓ 24/7 Crisis Referral Services Hotline
  - ✓ Co-Occurring capable Mobile Crisis Teams available in 8 counties
  - ✓ Urgent Care Services in every county
  - ✓ Growing Law Enforcement and Corrections Crisis Intervention Team (CIT) training program
  - ✓ Crisis Beds in Kent and Wicomico
  - ✓ Care Coordination and Stabilization Services
  - ✓ Referrals and Linkages to long term services and resources

- ➢ **What we still need**
  - ➢ Fully funded 24/7 Crisis Referral Services Hotline
  - ➢ 24/7 co-occurring enhanced Mobile Crisis Team in every county
  - ➢ 24/7 Walk-In Urgent Care in every county
  - ➢ 24/7 Law Enforcement and Corrections Crisis Intervention Team (CIT) officers every shift every county/detention center
  - ➢ Expanded Crisis Beds
  - ➢ 23 hour beds
  - ➢ Regional crisis centers for enhanced ED and Jail diversions

Affiliated Santé Group's Eastern Shore Crisis Response Mobile Crisis Teams – 9a-12a/7/365

% of Diversions	FY13	FY14	FY15	FY16	Totals
% of Diversions	86%	79%	81%	88%	84%
ED Diversions	602	516	912	1221	3251
Voluntary ED Admissions	52	58	99	73	282
EP's	54	80	109	98	341

According to the healthcare blue book, which rates emergency room visits on a scale of 1-5, an average psychiatric emergency room visit would be a level 3 visit which is $2189.

- **$2,672,790 is the potential savings we helped achieve with our 1221 diversions in FY16.**
- **$7,116,439 is the potential savings we helped achieve with our 3251diversions since FY13.**
- **The savings would be even higher if any of the individuals served were admitted to an inpatient unit from the emergency room…….**

Solution/Support: Forward movement of the strategic planning process outlined in SB551/HB682. The first part of the plan is due 12/16. The final plan is due 12/17. Increased funding is needed. As you can see above, the return on the investment can be significant. Without adequate funding having the capacity needed to meet the growing demands isn't available. Additionally, without adequate funding attracting and retaining quality staff for our citizens when they are at their most vulnerable really can be the difference between life and death. Currently, crisis services are only funded through the Behavioral Health Administration of DHMH. Exploring funding diversification for these services is essential. If folks are being diverted from higher levels of services like emergency departments and hospitalizations, exploring public/private partnerships with hospital systems, insurers, etc. Collaborative funding to meet the growing demands makes sense and can save lives.

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

Contact Erica Horney at ehorney@midshorebehavioralhealth.org for more information or visit: www.midshorebehavioralhealth.org/advocacy.