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HEALTH MANAGEMENT ASSOCIATES

## *Post-Acute Discharge Planning Workgroup*

PREPARED FOR THE SECRETARY OF THE MARYLAND DEPARTMENT OF HEALTH

BY HEALTH MANAGEMENT ASSOCIATES

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## **Acknowledgements**

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## Executive Summary

The Secretary of the Maryland Department of Health and the Secretary's Strategic Vision Group (SVG), comprised of health care leaders across sectors, have identified challenges with hospital discharges for complex and sometimes repeat patients to both the cost containment pressures relative to the current Total Cost of Care Waiver and to population health outcomes. Dr. Jinlene Chan, Assistant Secretary at the Maryland Department of Health led this work for the Secretary's office and was supported by two Health Management Associates staff, Uma Ahluwalia, Principal and Samantha Di Paola, Research Assistant.

This work was commissioned to address discharge challenges for patients in acute care settings. However, as our work evolved it became clear that strategies for prevention and diversion from acute care settings for complex and high utilizer patients was equally critical to prevent log jams from occurring across the continuum especially if the community-based infrastructure was weak. It is for this reason that many of the recommendations reflect this reality and reach beyond step down from acute care. However, in many instances, strengthening the community-based capacity serves not only to prevent but also to enhance the ability to place individuals in the least restrictive environments.

It is also important to note that this report is not a comprehensive and total capture of all the opportunities, but rather a compilation of a few targeted conversations, review of business flow documents and a review of available data. It is our belief that while this report offers significant insight into the problem of post-acute discharge challenges from the emergency department and from in-patient beds, it is by no means inclusive of all sources of information and all possible recommendations. More can be done, and we recommend that periodic reviews to identify additional strategies by the SVG occur.

At the kick-off meeting on March 27, 2019, the SVG was charged to develop recommendations for addressing post-acute discharge barriers from hospitals and to build a system of care for Maryland's residents with complex health and behavioral healthcare needs. The development of recommendations resulted in two distinct tracks of activities - one clustered around children and transition age youth and the other around adults. The original, by invitation only, kick off group spun off into two workgroups focused on these two population tracks. This report fully lays out the methodology for arriving at the tiered recommendations to address the challenges around post-acute discharge and a blueprint to begin implementation on recommended and prioritized strategies. It is ultimately up to the Secretary of the Maryland Department of Health in consultation with the SVG to make the final decisions on which recommendations will move forward.

The researchers gathered considerable data to define the scope of the problem. Data came from the Maryland Hospital Association, and the Health Services Cost Review Commission. It is important to note that the data is still being refined and revised to sharpen the analytics around patient outcomes and apply a stronger data driven decision-making frame. This analysis remains a work in progress.

At the kickoff meeting, SVG participants acknowledged that while the vast majority of patients are successfully discharged from hospitals, a core group of patients present with complex and challenging issues that require a multi-sectoral response. These patients often have three common indicators in

combination or in isolation: 1) Lack of financial resources to support the patient's care needs out of the hospital; 2) Lack of a caregiver who can step up and help assume, coordinate and manage care outside of hospital on an ongoing basis; 3) Diminished decision-making capacity and mental competence; and 4) in the case of children there could be many social determinants of health factors in play - from poor housing conditions, parental struggles with behavioral management of a child with behavioral issues, child abuse and neglect, to drug abuse and domestic violence. These indicators combined with chronic health and behavioral health conditions, adverse social determinants of health outputs, poor access to care and inequitable place-based health and well-being outcomes have led to a crisis of placement for a sub-group of Maryland's residents. This report attempts to capture the high-level challenges and proposed recommendations to address these barriers.

Recommendations for Adults include but are not limited to the following:

- Build a clearly articulated referral protocol for hospital discharges
- Develop a care re-design program that allows long term care facilities to manage residents with behavioral needs with additional services (e.g., hire sitters – one on one supervision of a patient with behavioral health issues, or other behavioral management resources)
- Develop facility or transportation financing strategies for safe care and transport of bariatric patients with end stage renal dialysis
- Maintain fully funded 24/7 crisis response services
- Develop a well-resourced community-based continuum of care for individuals with serious emotional disturbances
- Identify additional options for assisted living and congregate/group care for adults

Recommendations for Children and Transition Age Youth include but are not limited to the following:

- Building a clearly articulated referral protocol for hospital discharges and preventing hospitalization by leveraging the structure of the Local Care Team (LCT) and strengthening LCTs across all 24 jurisdictions
- Develop a well-designed 24/7 crisis response system of care for children and youth that supports families
- Address the shortage of providers offering evidence informed Residential Treatment, Specialized Group Care and Treatment Foster Care to meet the needs of specialty populations such as Runaway and Human Trafficked Youth, Pregnant and Parenting teens, Physically Aggressive Youth often on the Autism Spectrum, Sexual Offenders and Fire Setters
- Align federal Families First Prevention Services Act affecting the Department of Human Services with Medicaid services to maximize revenue opportunities for clinical services to children both outside of foster care and in state custody
- Build in home and out of home respite options for parents and caregivers of children with serious emotional illnesses

The full report and Tier 1 and Tier 2 recommendations will be reviewed by the Secretary of the Maryland Department of Health and the Secretary's Vision Group upon receipt of the report by July 31, 2019.

They will then provide further direction to:

- i) Build out certain recommendations with an eye towards better understanding the feasibility of a policy or financing strategy, or
- ii) Develop an implementation plan to address selected recommendations.

## Background

The State of Maryland has been undergoing a transformation in its healthcare system to achieve better health for Marylanders, higher quality of health care, and decreased costs. The new Total Cost of Care (TCOC) model with the Centers for Medicare and Medicaid Services (CMS) builds on the prior All-Payer model that realigned hospital-based care and reimbursement structures to a global budgeting approach. The TCOC has placed greater attention on enhancing community-based care, including work with primary care practices and the prevention of disease and related complications.

As the system evolves, the Department of Health recognizes that there are challenges to identify appropriate community placements for individuals who have more complex medical and behavioral health conditions, creating significant issues for timely patient discharges from both hospitals' emergency departments and inpatient acute care. The challenges are not solely centered on individual health conditions, but also are related to the availability and coordination of resources and services across multiple sectors necessary to support these individuals.

This report was commissioned to address post-acute discharge challenges for patients in acute care settings. However, as our work evolved it became clear that strategies for prevention and diversion from acute care settings for complex and high utilizer patients was equally critical to prevent log jams from occurring across the continuum of care especially if the community-based infrastructure was weak. It is for this reason that many of the recommendations reflect this reality and reach beyond only addressing step down from acute care. However, in many instances, strengthening the community-based capacity serves not only to prevent but also to enhance the ability to place individuals in the least restrictive environments.

To focus additional attention to this key issue, the Department of Health convened two Post-Acute-Care (PAC) workgroups, focused on adults and children and transition age youth, to develop solutions to address financing, policy, practice, and resource development options. Qualitative and quantitative data were gathered but the granularity and specificity of data remains a challenge and the work is continuing. However, the workgroups proceeded using available data reports and sources to keep the momentum moving forward recognizing that this initial phase of the work has further defined which data points need to be connected and analyzed by all stakeholders in the system.

### **PAC Planning Workgroup Goals:**

1. Identify barriers to appropriate and least restrictive placements for individuals with complex acute and sub-acute health and behavioral health needs.
2. Develop protocols for discharging patients with complex health and behavioral health needs as demonstrated by successful post-acute discharges to appropriate and least restrictive placements in the community.
3. Identify resource needs and take an innovative approach about how to build out an appropriate multi-disciplinary system of care and continuum of placement options for people in acute care settings ready for discharge.

**Target population:** Adults and youth in acute care settings (inpatient acute care or hospital emergency departments) with complex health conditions that challenge lower level of care placements. Complex health conditions can include behavioral health, developmental disabilities, and/or somatic diagnoses that may result in behavioral manifestations.

## Workgroup Membership

### Adults

Name	Title	Organization
Alexandra Wykowski	Clinical Services Coordinator	Behavioral Health System Baltimore
Celeste Boykins	Associate Director Clinical Services	Behavioral Health System Baltimore
Chris Peterson	Principal Deputy Director	Health Services Cost Review Commission
Cynthia A. Kelleher	President & CEO	University of Maryland Medical Center
Donald List	SW Patient and Family Services	Kimmel Cancer Center Johns Hopkins
Dorinda Adams	Director of the Office of Adult Services	Department of Human Services, Social Services Administration
Erin Dorrien	Director of Policy	Maryland Hospital Association
Gregory James	Deputy Secretary for Operations	Department of Human Services
Jeff Bracken	Director Social Work in Psychiatry	Johns Hopkins Hospital
Jennifer Wilkerson	Vice President & Chief Strategy Officer	Sheppard Pratt Health System
Joe Demattos	President	Health Facilities Association of Maryland
Linda Cole	Chief, Long Term Care	Maryland Healthcare Commission
Lisa Hovermale	Psychiatrist	Maryland Department of Health, Developmental Disabilities Administration
Liz Woodward	LTS Division Manager	Department of Aging
Louise Knight	Director of Patient Family Services	Kimmel Cancer Center Johns Hopkins
Nicki McCann	Chief of Staff	Johns Hopkins Hospital
Nora Hoban	Senior Vice President of Strategic Analytics	Maryland Hospital Association
Stacy Howes	Chief, Long Term Care Quality	Maryland Healthcare Commission
Steve Whitefield	Medical Director	Behavioral Health Administration
Tequila Terry	Deputy Director	Health Services Cost Review Commission



**Children and Transition Age Youth**

<b>Name</b>	<b>Title</b>	<b>Organization</b>
Caroline Jones	Child & Adolescent Program Administrator	Behavioral Health Administration
Deborah Harburger	Clinical Instructor & Co-Director	UMD School of Social Work Institute for Innovation and Implementation
Erin Dorrien	Director of Policy	Maryland Hospital Association
Janet Furman	Director of Children's Services	Developmental Disabilities Administration
Jennifer Wilkerson	Vice President & Chief Strategy Officer	Sheppard Pratt Health System
Kim Malat	Assistant Deputy Director	Governor's Office for Children
Kevin Keegan	Division Director	Catholic Charities of Baltimore
Nicki McCann	Chief of Staff	Johns Hopkins Hospital
Nora Hoban	Senior Vice President of Strategic Analytics	Maryland Hospital Association
Robert Basler	Associate Vice President of Residential Services	Arrow Child and Family Ministries
Tennille Thomas	Contracts and Monitoring Manager	Department of Human Resources
Tiffany Hiob	Section Chief, Autism Waiver and Health Related Services	Maryland State Department of Education
Todd Peters	Medical Director, Child and Adolescent Services; Chief Medical Information Officer	Sheppard Pratt Health System
Tom Andrews	Chief of Staff to the Secretary	Maryland Department of Health

## Methodology

The PAC Planning Workgroup scope of work began with the formulation of a workgroup document outlining the goals and issue area needs, which all members agreed upon. These goals were presented at a March 2019 kick-off meeting where presentations on data and case studies were shared with key stakeholders and state leaders. After the kick-off meeting, the two work groups were created – the first focusing on the adult (Adult PAC) target population and the second on children and transition age youth (CTAY PAC). The two workgroups met once a month, at a minimum, from April through July to discuss key findings and recommendations.

Fact finding meetings and interviews were conducted with various stakeholder groups (see Appendix A). A total of 15 stakeholder conversations including focus groups, three full workgroup meetings for the child and youth population and three full workgroup meetings for the adult populations - for a total of 21 meetings in addition to the kick-off meeting were held leading up to the framing of this report. We also reached out to other states in which we identified best practices. As a result, we spoke with Vanderbilt University's (TN) Center for Excellence on their clinical consultation model for children in custody with behavioral health challenges. We also spoke with the State of Massachusetts about their children's crisis response model called BEST and with Oregon Health Sciences University about long term care practices. The details of these conversations can be found in the appendices section of the report.

These conversations led to the identification of the major barriers facing individuals with complex medical and/or behavioral needs and a clear articulation of a multi-faceted problem statement for children and youth and a similar statement for adults. From these barriers and challenges, high-level solutions emerged that largely fell under the following categories:

- Providers – Capacity and Practice
- Payers
- Patient Populations
- Multiple Categories

Details on the proposed solutions are outlined in the Recommendations section and the matrices can be found in the Appendices Section. Each recommendation was further developed to determine if the fix was related to:

1. A policy or a regulatory response
2. Financial modeling and resource infusion
3. Clinical Practice Management strategies
4. Infrastructure development and
5. Development of strategic and intentional partnerships

The recommendation matrices (see Appendix C) were reviewed and edited by each respective workgroup, culminating with a prioritization exercise. Each recommendation was voted upon as a group, for the Adult PAC and the CTAY PAC separately, using a polling system. Members were given the option to vote A (high feasibility, high impact), B (low feasibility, high impact), C (high feasibility, low impact), or D (low feasibility, low impact) (see grid in Appendix C).

Each recommendation was placed into one of three tiers based on vote outcomes – tier 1, high priority; tier 2, mid-priority; or tier 3, low priority. The high and mid-priority recommendations are outlined in this report to be reviewed by the Secretary of the Maryland Department of Health and the Secretary’s Vision Group.

## Key Findings and Recommendations: Adult

Below are the key findings and **Tier 1 – High Priority** and **Tier 2 – Mid-Priority** consensus recommendations for adults resulting from the Post-Acute Discharge Planning Workgroup Adult PAC meetings. They are organized by the categories identified above. For each category, we first summarize key findings that informed the group's recommendations.

### 1. Providers – Capacity and Practice

Key findings identified the following core barriers and challenges related to hospital discharge of adults with complex needs:

- Absence of discharge protocols to support discharge planner's ability to effectively identify process to secure post-discharge placements. Information needed includes entity and individuals to contact, paperwork needed to facilitate and secure placements and timelines for making level of care decisions. This was particularly acute for transition age youth over adults, including seniors.
- There is not a way to allow confidential sharing of key patient information with multiple providers of care treating the same patient (e.g. behavioral health case management, behavioral health providers, DHS)
- Inability to include community providers previously engaged with patients in discharge planning. Hospitals do not notify community providers in a timely way to enable planning and engagement prior to discharge. Further, community provider participation in discharge planning is not a reimbursable service.
- Shortage of behavioral health services and other services in the community for needed interventions. There is a need to increase the number of (?) Assertive Community Treatment (ACT) teams, support expansion of behavioral health homes, create greater capacity to provide Medication Assisted Treatment (MAT) in nursing facilities and improve approaches to divert bariatric and non-compliant dialysis patients from emergency department to the community.
- Insufficient bed capacity including specialized residential and treatment beds across the continuum of care. They include: traumatic brain injury rehabilitation beds, secure Alzheimer's beds, residential rehabilitation provider beds, medical shelter beds, geriatric psychiatric beds, assisted living facility beds for individuals with behavioral health issues, crisis beds, Autism spectrum beds which include neurobehavioral beds for adults and transition age youth, and skilled nursing facility beds with capacity to provide specialized care for behavioral health patients, particularly those who are aging.
- Need for crisis or mobile services 24/7 throughout the state outside of emergency departments.
- Need for residential care for individuals with high behavioral health and medical needs.
- Need for provider training and capacity related to trauma informed care and additional behavioral health workforce to manage individuals with complex behavioral conditions.

**Recommendation 1a (Tier 1-High Priority, High Feasibility/High Impact) Build a clearly articulated referral protocol for hospital discharges** with timeliness/responsiveness accountability measures that

thread the entire continuum of care - primary care physicians, hospital emergency departments, skilled nursing facilities, assisted living, community based organizations (e.g. Area Agencies on Aging or AAAs) and care coordinators with Department of Human Services (DHS), and local Behavioral Health Authorities (LBHA)/Core Service Agencies (CSA).

Lead Entities: State-local infrastructure across Area Agencies on Aging (AAA), Department of Human Services (DHS) and Maryland Department of Health (MDH)

**Recommendation 1b (Tier 1-High Priority, High Feasibility/High Impact) Build a care transition model partnership** between a local AAA and hospital to coordinate care management – use pilots already underway as models (e.g. Maintaining Active Citizens (MAC) and Peninsula Regional Medical Center (PRMC)). Make recommendations for spreading to scale.

Lead Entities: Department on Aging (DOA) and Department of Human Services (DHS)

**Recommendation 1c (Tier 1-High Priority, High Feasibility/High Impact) Include individuals' current community service providers in the discharge planning process.**

Lead Entity: Maryland Hospital Association (MHA)

**Recommendation 1d (Tier 1-High Priority, High Feasibility/High Impact) Improve Local Behavioral Health Agency (LBHA)/Core Services Agency (CSA) coordination** for community behavioral health services including pre-authorization for services and CSA processes across the state.

Lead Entities: Behavioral Health Administration (BHA)/Medicaid and Maryland Association of Behavioral Health Authorities (MABHA)

**Recommendation 1e (Tier 2-Mid-Priority, Even votes across A,B and D) Establish cross-system care coordination for inpatient high utilizers** that supports proactive communication and facilitates identification of and linkages to care; consider use of high intensity utilizer case managers to work closely with discharge planners, community providers and patients.

Lead Entities: Behavioral Health Administration (BHA)/Medicaid and Maryland Association of Behavioral Health Authorities (MABHA)

**Recommendation 1f (Tier 2-Mid-Priority, Low Feasibility, High Impact) Build out a high intensity utilizer care redesign program with a PMPM** (per member per month) payment care management approach.

Lead Entities: Department of Human Services (DHS), Maryland Department of Health Medicaid (MDH), Department of Aging (DOA), Health Services Cost Review Commission (HSCRC)

**Recommendation 1g (Tier 1-High Priority, High Feasibility/High Impact) Evaluate standardization and efficiency of guardianship protocols across all counties.** Lead Entities: Department on Aging (DOA) and Legal Services

**Recommendation 2 (Tier 2-Mid-Priority, Low Feasibility, High Impact)** Establish data sharing for coordinating treatment across multi-disciplinary and multi-agency teams to ensure and monitor for optimal outcomes - consider a data sharing platform across hospitals, community providers and state/local agencies to track high inpatient utilizers and coordinate discharges.

Lead Entities: Chesapeake Regional Information System for our Patients (CRISP) and Maryland's Total Human services Integrated Network (MD THINK)

**Recommendation 5 (Tier 1-High Priority, High Feasibility/High Impact)** Increase all ACT teams including forensic and non-forensic psychiatric ACT teams beyond the current 17 counties.

Lead Entities: Behavioral Health Administration (BHA), Medicaid

**Recommendation 6 (Tier 1-High Priority, High Feasibility/High Impact)** Establish certified community behavioral health clinics (CCBHCs) to manage individuals with mental illness.

Lead Entity: Behavioral Health Administration (BHA)

**Recommendation 7 (Tier 2-Mid-Priority, A and B tied in votes)** Expand Maryland behavioral health home provider eligibility to include outpatient mental health clinics (OMHCs) and certified substance use treatment providers (in addition to psychiatric rehabilitation programs (PRPs), assertive crisis treatment (ACTs) and outpatient treatment programs (OTPs)) to increase ability to manage people with complex behavioral and somatic conditions.

Lead Entities: Behavioral Health Administration (BHA), Medicaid

**Recommendation 8 (Tier 1-High Priority, High Feasibility/High Impact)** Establish outpatient behavioral health urgent care clinics with walk-in capacity for people across the lifespan throughout Baltimore City—and beyond. Lead Entity: Behavioral Health Administration (BHA)

**Recommendation 9 (Tier 1-High Priority, High Feasibility/High Impact)** Address compliance and regulatory needs of nursing facilities offering MAT. This is currently allowable, so the issue is more around the perceived regulatory risks for LTC facilities admitting people with substance use disorders.

Lead Entities: Behavioral Health Administration (BHA)/Medicaid, Maryland Health Care Commission (MHCC) and Office of Healthcare Quality (OHCQ)

**Recommendation 13a (Tier 1-High Priority, High Feasibility/High Impact)** Establish strong emergency diversion practices to avoid non-emergent use of ED by dialysis patients, bariatric patients weighing over 400 pounds with a diagnosis of End Stage Renal Disease, with and without dialysis issues, and after discharge from inpatient and rehab centers. This would require building out viable alternative avenues for dialysis treatment and stabilization of patients. Transportation needs would also need to be met.

Lead Entity: Maryland Department of Health (MDH) and Maryland Hospital Association (MHA)

**Recommendation 13b (Tier 2-Mid-Priority, Low Feasibility/High Impact)** Establish mobile integrated health across fire and rescue services, primary care and hospitals to support ED diversion. (Baltimore City and Montgomery County pilots) Lead Entity: Maryland Department of Health (MDH)

## 2. Payer

Key findings identified the following post-acute discharge barriers and challenges under the payer category:

- Undocumented residents have no payer source if there is a need for ongoing care after acute care
- Challenges in parity in health services coverage between public and private payers. Some of these services are not perceived as medical or clinical in nature by employers so are not covered benefits.
  - Behavioral health services: residential, ACT, crisis beds are not covered services
  - Pediatric home health care (long-term) and ancillary services (e.g. DME, supplies)
- Medicaid
  - Delays in the Adult Evaluation and Review Services (AERS) and Pre-Admission Screening and Resident Review (PASRR) evaluations can result in additional unnecessary hospital days
  - Need for community behavioral health provider capacity to be able to serve as consultants/care coordinators with the hospital team for individuals well-known to the community provider
- Medicare
  - Nursing home bundled payment structure includes the cost of medications resulting in denied admissions for individuals who need nursing home level of care for rehabilitation who are on high cost medications (e.g., transplant or oncology related). A new Medicare Patient Driven Payment Model (PDPM) will begin in October 2019, though the impact on this issue is still to be seen.
  - Little to no behavioral health coverage under Medicare means that individuals with only Medicare coverage are often lacking access to a continuum of care
  - Lack of reimbursement for behavioral health sitters and other resources to safely maintain individuals in a skilled nursing facility or other non-acute level of care

**Recommendation 14a (Tier 1-High Priority, High Feasibility/High Impact) Review and propose regulations and payment approaches that address chemical restraints, sitters and integrated medication management** to include behavioral health and somatic medications in nursing facilities.

Lead Entities: Office of Healthcare Quality (OHCQ) and Health Services Cost Review Commission (HSCRC)

**Recommendation 15 (Tier 2-Mid-Priority, (vote count is missing) Expedite AERS and PASRR determination timeframes** to relieve staffing pressures within authorizing agency. Expand AERS nurses and adjust reimbursement rates for services.

Lead Entity: Telligen with oversight from Maryland Department of Health (MDH)

**Recommendation 16 (Tier 2-Mid-Priority, Low Feasibility/High Impact) Incentivize shared problem solving around patient discharge** (especially on Friday afternoons) to ensure that both commercial insurance and Medicare are available until Saturday for preauthorization determinations. Ensure Medicaid MCOs/Telligen mirror the pre-authorization practices with marketplace health insurance plans/payers.

Lead entities: Medicaid with participating Managed Care Organizations (MCOs) and Maryland Hospital Association (MHA)

**Recommendation 17a (Tier 2-Mid-Priority, Low Feasibility/High Impact) Address parity between Medicaid and private insurance for behavioral health services** - (e.g. ACT) and explore options to allow behavioral health treatment facilities (versus individual providers) to be credentialed by third party insurance providers and payers, similar to FQHCs.

Lead Entity: Insurance carriers and CBHA discussions. Explore possible alignment with Lt. Governor's commission on behavioral health.

**Recommendation 19 (Tier 2-Mid-Priority, Low Feasibility/High Impact) Address cost burden to nursing homes under Medicare bundled payment** and disincentive to accept patients with high cost medications such as oral chemotherapy and transplant medications through exploring: 1) group purchasing for pharmaceuticals, and 2) behavioral health as part of care redesign team.

Lead Entities: Medicaid/Health Services Cost Review Commission (HSCRC)

### 3. Patient Population

Key findings identified the following post-acute discharge barriers and challenges identified by patient population

- Dialysis with additional health or medical needs
  - Bariatric
  - Behavioral issues
- Bariatric patients >400 lbs.
- Behavioral health issues
  - Needing nursing facility level of care
    - Older
    - Younger patients may pose a safety risk
  - Aging population have increasing somatic care needs along with dementia
- Autism Spectrum Disorder
- Brain injury—associated impulsivity and behavioral issues present challenges for longer term rehabilitation and care in the community.
- Individuals who are homeless. Stable housing is key to prevent cycling of patients, and when combined with adult day mental health services). Adequacy of housing options was a repeat challenge.

**Recommendation 20a (Tier 2-Mid-Priority, Low Feasibility/High Impact) Build medical beds in homeless shelters to address home oxygen needs, patients with IV ports for antibiotics that can be managed outside hospital or colostomy bags.**

Lead Entities – Need partnership with Department of Housing and Community Development (DHCD), hospitals, and other providers

**Recommendation 21 (Tier 1-High Priority, High Feasibility/High Impact) Secure more TBI rehabilitation beds.** Lead Entity – Dr. Jinlene Chan with healthcare partners



**Recommendation 22 (Tier 1-High Priority, High Feasibility/High Impact) Develop more Autism spectrum beds** – State should consider an expansion of the current autism waiver. Evaluate service continuum for the small sub-population of assaultive/aggressive autistic youth.

Lead Entities: Behavioral Health Administration (BHA)/ Developmental Disabilities Administration (DDA)/ Department of Human Services (DHS) (given the crossover between Homeless service systems and Adult Protective Services)

**Recommendation 23 (Tier 1-High Priority, High Feasibility/High Impact) Establish more “secure” Alzheimer’s (and other dementia) beds.** As the population ages, this will be a greater need, in particular for Medicaid and uninsured populations. Long Term Care Facility related policy and financing discussion around patient safety and restraints

Lead Entities: Medicaid and Office of Healthcare Quality (OHCQ)

**Recommendation 24 (Tier 2-Mid-Priority, Low Feasibility/High Impact) Develop a system to address placement needs of uninsured and undocumented residents.** – consider MHIP like coverage.

Lead Entity: The Maryland Insurance Administration with multi-state agency engagement

#### **4. Multi-Category and Partnership Driven:**

Key findings identified the following post-acute discharge barriers and challenges:

- LBHAs’ responsiveness to coordination needs of individuals in their jurisdictions varies across the state and can present challenges for facilities that need to work with multiple LBHAs to find placement.
- Consensus that the State Medicaid Plan had a very small menu of approved EBPs. Furthermore, besides expanding the menu, criteria for selection of evidence-based practices (EBPs), implementation approaches, and fidelity monitoring were all incredibly challenging and were often perceived as disincentives for EBP adoption by provider partners.
- The creation of a robust 24/7 crisis response system for adults and seniors is critical. This gap also points to gaps in respite services and the need for a bed registry to track availability of alternative short term and rehabilitative placement and treatment options.

**Recommendation 25a (Tier 1-High Priority, High Feasibility/High Impact) Increase residential rehabilitation program (RRP) bed capacity** (currently paid for by state only funds). Effective July 1, 2019 for ages 21-64, psychiatric IMD is allowable if primary diagnoses is of SUD origin). Consider ways to expand the availability of increased nursing support in RRP for the care of individuals with both behavioral health and somatic illness.

Lead Entities: Medicaid, Behavioral Health Administration (BHA) and Health Services Cost Review Commission (HSCRC)

**Recommendation 25b (Tier 1-High Priority, High Feasibility/High Impact) Increase crisis bed capacity in local communities.** Consider feasibility of building a real time capacity tracking tool such as a bed registry (there is lack of capacity universally). Lt. Governor’s commission has a crisis workgroup; Ensure that this recommendation is picked up by the Lt. Governor’s Behavioral Health Commission.

Lead Entity: Behavioral Health Administration (BHA)

**Recommendation 25c (Tier 1-High Priority, High Feasibility/High Impact) Implement 24/7 mobile crisis team availability statewide** – support for current RFP and then evaluate in 12 months post implementation to assess for adequacy and effectiveness, and to address gaps; monitor implementation and 18-month evaluation to strengthen the model as it is being rolled out.

Lead Entity: Behavioral Health Administration (BHA)

**Recommendation 25d (Tier 1-High Priority, High Feasibility/High Impact) Look at standards for involuntary placements.** Tied to 24/7 mobile crisis recommendations.

Lead Entity: Maryland Institute for Emergency Medical Services Systems (MIEMSS) and Behavioral Health Administration (BHA)

**Recommendation 25e (Tier 2-Mid-Priority, Low Feasibility/High Impact) Develop standard protocols across the behavioral health crisis system** to 1) ensure consistent risk screening (e.g., suicide, overdose (OD), homelessness, violence and abuse/neglect) and 2) follow-up. Lead Entity: Behavioral Health Administration (BHA)

**Recommendation 26 (Tier 1-High Priority, High Feasibility/High Impact) Build a stronger community-based system of care and a larger menu of evidence-based practices.** Infuse the same with training and capacity building as well as fidelity monitoring the state’s fidelity monitoring practices are cumbersome and many providers struggle to meet requirements and abandon program. Consider ways to simplify. Engage the CBHA as partners in this effort.

Lead Entity: Behavioral Health Administration (BHA) and Department of Human Services (DHS)

### Adult Recommendation Summary Table

Legend: REC # - Recommendation Number; AIP – Already in Progress; SR – Shovel Ready; ND – Needs Development

REC #	RECOMMENDATIONS FOR ADULTS	TIER	AIP	SR	ND
<b>HIGH PRIORITY</b>					
1a	Build a clearly articulated referral protocol for hospital discharges	1		✓	
1b	Build a care transition model partnership (Dept. on Aging)	1	✓		
1c	Include individuals’ current community service providers in the discharge planning process	1		✓	
1d	Improve Local Behavioral Health Agency (LBHA)/Core Services Agency (CSA) coordination	1		✓	
1g	Evaluate standardization and efficiency of guardianship protocols across all counties	1	✓		
5	Increase all ACT teams including forensic and non-forensic psychiatric ACT teams	1			✓

REC #	RECOMMENDATIONS FOR ADULTS	TIER	AIP	SR	ND
6	Establish certified community behavioral health clinics (CCBHCs) (partial approach in place)	1			✓
8	Establish outpatient behavioral health urgent care clinics with walk-in capacity	1			✓
9	Address compliance and regulatory needs of nursing facilities offering MAT	1	✓		
13a	Establish strong non-emergent care for bariatric patients both with or without a diagnosis of ESRD and needing dialysis	1	✓		
14a	Review and propose regulations and payment approaches that address chemical restraints, sitters and integrated medication management	1			✓
21	Secure more TBI Beds	1			✓
22	Develop more Autism spectrum beds	1			✓
23	Establish more "secure" Alzheimer's beds	1			✓
25a	Increase RRP Bed Capacity (Expand)	1			✓
25b	Increase Crisis Bed Capacity in local communities (Expand)	1			✓
25c	Implement 24/7 mobile crisis team availability statewide	1	✓		
25d	Look at standards for involuntary placements	1	✓		
26	Build a stronger community- based system of care and a larger menu of evidence-based practices	1		✓	
<b>MID PRIORITY</b>					
1e	Establish cross-system care coordination for inpatient high utilizers	2			
1f	Build out a high intensity utilizer care redesign program with a PMPM	2			✓
2	Establish data sharing for coordinating treatment across the multi-disciplinary and multi-agency team (CRISP/MDTHINK/DoIT)	2	✓		
7	Expand Maryland behavioral health home provider eligibility to include outpatient mental health clinics (OMHCs) and certified substance use treatment providers (in addition to PRPs, ACTs and OTPs)	2		✓	
13b	Establish mobile integrated health across fire and rescue services, primary care and hospitals to support ED diversion	2	✓		
15	Expedite AERS and PASRR determination timeframes	2		✓	
16	Incentivize shared problem solving around patient discharge	2			✓
17a	Address parity between Medicaid and private insurance for behavioral health services	2			✓
19	Address cost burden to nursing homes under Medicare bundled payment	2			✓
20a	Build medical beds in homeless shelters to address home oxygen needs, patients with IV ports for antibiotics that can be managed outside hospital or colostomy bags	2			✓
24	Develop a system to address placement needs of uninsured and undocumented residents	2			✓
25e	Develop standard protocols across the behavioral health crisis system	2		✓	

## Key Findings and Recommendations: Children and Transition Age Youth

Below are the key findings and **Tier 1 – High Priority** and **Tier 2 – Mid-Priority** consensus recommendations for youth resulting from the Post-Acute Discharge Planning Workgroup Children and Transition Age Youth PAC meetings. They are organized by the categories identified above. For each category, we first summarize key findings that informed the group’s recommendations.

### 1. Providers – Capacity and Practice

Key findings identified the following core barriers and challenges related to hospital discharge of youth with complex needs:

- Lack of a tight referral protocol when a child or youth is admitted to ER or hospital and needs more services in the home to be safely maintained or a higher level of placement (e.g., inpatient psychiatric unit, RTC).
- Need to reaffirm the Governor’s Office for Children role in this collaborative space. GOC, which currently staffs the Children’s Sub-Cabinet and administered grants has an evolved role and scope of work from when the Office of Children, Youth and Families was created.
- Between Place Matters and the effort over last three years to bring children back from “out of state Residential Treatment Center (RTC) placements” to “in-state placements” and closing of beds for poor quality performance has led to a crisis of placements for children and youth with serious mental illness (SMI) and for autism spectrum aggressive youth. This has led to an over-reliance on therapeutic treatment foster care and therapeutic group care and sometimes this level of intervention is inadequate if staff are not well trained at these facilities in evidence-based and evidence informed practices. This can result in hospital admission churn and trauma to children. At the same time this reduction in reliance on residential placements positions the state well for federal Family First Prevention Services Act implementation.
- Critical need to create a robust 24/7 crisis response system for children and youth and their families. This gap also points to gaps in respite services and the need for a bed registry to track availability of alternative short term and rehabilitative placement and treatment options.
- Consensus that the State Medicaid Plan has a limited menu of approved Evidence Based/Informed Programs and Interventions. Furthermore, besides expanding the menu, criteria for selection of EBPs, implementation approaches, and fidelity monitoring were all incredibly challenging and were often perceived as disincentives for EBP adoptions by provider partners. The University of Maryland School of Social Work Institute for Innovation functions as a trusted partner for the Department of Human Services and some member agencies of the Children’s subcabinet in identifying and building capacity around evidence-based practices.
- Lack of physical plant and staffing capacity and competence were often cited as provider limitations in repurposing existing beds to become more responsive to presenting needs of children and youth.
- Lack of understanding in the community around the rules for Voluntary Placement Agreements (VPA), referral and approval of levels of care protocols and the role of the interagency placement council.

- The Certificate of Need application and award processes are often monolithic and not responsive to the changing needs of the population or the shifts in the provider market and therefore there is continuing dispute about the need for more RTC beds between providers, state agencies and the MHCC which is responsible for issuing these CONs
- A need for specialized services along a continuum of care and provider training and capacity.

**Recommendation 1a (Tier 1-High Priority, High Feasibility/High Impact) Build out and approve referral protocol** and timeliness/responsiveness accountability measures that thread the entire continuum of care – Primary Care Physician/Psychiatrist - Hospital ED and Admission to Residential Treatment/Treatment Foster Care/Group Home/Day Program – Community Based Organization – DSS/DDA/LEA/LBHA and Local Care Team – Parent or guardian.

Lead Entity: Governor’s Office for Children (GOC)

**Recommendation 1b (Tier 2-Mid-Priority, Low Feasibility/High Impact) Infrastructure to support a real time capacity inventory tool or a bed registry.**

Lead Entity: Governor’s Office for Children (GOC) with support from the Children’s Subcabinet, Behavioral Health Administration (BHA)

**Recommendation 2 (Tier 1-High Priority, High Feasibility/High Impact) Implement 24/7 crisis response system including mobile crisis** team availability statewide with the capability to manage children and adolescents.

Lead Entities: Behavioral Health Administration (BHA) and Medicaid

**Recommendation 3a (Tier 1-High Priority, High Feasibility/High Impact) Evaluate effectiveness of available in home and out of home respite** to land on the most effective model to consider for spread and scale to address inappropriate hospitalization and to provide relief to caregivers for the under 18 population and expand as appropriate.

Lead Entities: Behavioral Health Administration (BHA) and Department of Human Services (DHS)

**Recommendation 3b (Tier 2-Mid-Priority, Low Feasibility/High Impact) Develop and implement a peer supported respite program for the 18-26-year old transition age youth.**

Lead Entities: Behavioral Health Administration (BHA) and Department of Human Services (DHS)

**Recommendation 4 (Tier 1-High Priority, High Feasibility/High Impact) Build intensive community-based outpatient services for children** – build into Medicaid State Plan with expanded services – including Wrap Around.

Lead Entities: Behavioral Health Administration (BHA), Medicaid and Department of Human Services (DHS)

**Recommendation 6 (Tier 2-Mid-Priority, votes vary) Increase capacity of high quality and responsiveness to current needs RRP beds to serve the TAY population**—currently there are not enough providers in the state. While there are statewide vacancies in beds, there is a shortage of placement resources because the available beds do not meet the presenting needs of the TAY. Most TAY do not meet the medical necessity criteria for RRP because what they need is housing with therapeutic support. Statewide there are 80 TAY RRP beds.

Lead Entities: Department of Human Services (DHS), Behavioral Health Administration (BHA), Governor’s Office for Children (GOC)

**Recommendation 7 (Tier 2-Mid-Priority, Low Feasibility/High Impact) The state needs more in-state RTC and therapeutic foster care beds including high intensity treatment foster care and therapeutic group home beds.** Access to these resources has been limited to children in the Department of Juvenile Services (DIS) or Department of Social Services (DSS) which presents a challenge for Medicaid youth with SMI . VPA is limited in what it can do to support non-DSS or DJS-involved children. Data (as of 6/2019) – 240 operational RTC beds, 238 are occupied. Congregate Care – 600 beds, 460 are occupied.

Lead Entities: Department of Human Services (DHS), Behavioral Health Administration (BHA), Governor’s Office for Children (GOC), Maryland Healthcare Commission (MHCC)

## 2. Partnership

Key findings identified related to partnerships to serve hospital discharged youth with complex needs:

- The infrastructure that has been built in all 24 jurisdictions to support Local Care Teams (LCT) and the vision are both on target but they are operating with great variability across jurisdictions; there is confusion as to who is the lead about the referral protocols. Often barriers include poor communication across team members, timeliness of response, “who’s on first” with arguments over ownership of the case across multiple agencies and lack of adequate resources that inhibit collaboration and creative problem solving.
- There is a need to engage around data sharing across provider and agency partners to prevent children and youth falling through the cracks and/or receiving duplicate or inappropriate services as the full picture is not known.
- There is a need for the role of the Governor’s Office for Children as a convener and facilitator of the policy leadership agenda of multiple state departments.

**Recommendation 8 (i) (Tier 1-High Priority, High Feasibility/High Impact) Evaluate the effectiveness of the Local Care Team and make improvements.** LCT members should be trained in prevention and diversion of kids from RTC through strong community-based treatment continuum and support RTC placements when needed.

Lead Entity: Governor’s Office for Children (GOC)

**Recommendation 8(ii) (Tier 2-Mid-Priority, Low Feasibility/High Impact) Data sharing is critical across all child serving systems and providers who are coordinating to treat the child and best serve the family.**

Lead Entities: Department of Information Technology (DoIT) and Chesapeake Regional Information Services Platform (CRISP)

### 3. Payer

Key findings identified the following barriers and challenges under the payer category to serve hospital discharged youth with complex need:

- Lack of parity between Medicaid and private payers for behavioral health – this is particularly acute for children in families whose parents are over income and do not qualify for Medicaid. They often have employer-based marketplace health insurance and find that these plans fall short in covering a more comprehensive set of needed services for their child, as these services may be perceived as non-medical or non-clinical in nature by employers. Often, they are encouraged to disassociate the child from their health insurance as a household of one so that the child can qualify for Medicaid and be placed in a more robust system of care. This may involve voluntary placement into foster-care. These are all traumatic responses of a failing system on the child and the family.
- Hospitals expressed significant frustration with the pre-authorization timeframes and protocols of Medicaid MCOs, especially from noon on Friday into the weekend.
- Activation of the child and adolescent case management charge codes prior to discharge from RTC (or inpatient) is a necessary tool for care coordinators. This was also mentioned as a recourse for community behavioral health providers to be able to serve as consultants/care coordinators with the hospital team for individuals well-known to the community provider.
- Frustration among community-based providers that the hospitals were starting discharge planning too late as opposed to starting on day one of admission and thereby making discharge an urgent activity. These providers have not been invited in to discharge planning meetings held by the hospital if one of their clients is involved.
- The Medicaid State Plan does not have an adequate menu of effective evidence-based and evidence informed practices and the few that are there are not reimbursed adequately to account for increased training, fidelity monitoring and outcomes delivered.
- Medical necessity criteria for TAY and young adults needs to be updated. It is leaving too many TAY without services.
- Family First Prevention Services Act was signed into law in 2018 and will change the way that states are able to use federal child welfare funds beginning on October 1, 2019 for children in or at risk of entering the child welfare system. Funding will be made available for services such as in-home parenting services, substance abuse prevention and treatment as well as mental health treatment. Prevention services that qualify must be on a DHHS approved list of promising, supported or well-supported treatment.
- Early Childhood Mental Health practices and resources are inadequate and must be built out as early intervention has shown positive results for older children.

**Recommendation 9 (Tier 1-High Priority, High Feasibility/High Impact)** All stakeholders need a clear understanding of VPA and how they operate. If rules around VPA placements are being tightened, then the new expectations should be shared with partner agencies. Post RTC discharge into a group home



should be permissible even in situations where parents have custody – this is where VPA is most useful. The DHS JCR Report is available from 2018.

Lead Entities: Department of Human Services (DHS) and Department of Juvenile Services (DJS)

**Recommendation 10 (Tier 1-High Priority, High Feasibility/High Impact) Extend Medicaid service preauthorization reviews until close of business (COB) on Friday.** Telligen often do not review preauthorization requests from Friday at noon until the next business day, which backs up hospital beds.

Lead Entities: Medicaid and Managed Care Organizations (MCOs)

**Recommendation 12 (Tier 2-Mid-Priority, Low Feasibility/High Impact) Address parity between Medicaid and private insurance.** Add staffing and service capacity to Targeted Case Management Plus and Family Navigator/Peer Support Specialist roles in the CBO sector to address needs of SMI children and their families.

Lead Entity: Behavioral Health Association (BHA) and Medicaid

**Recommendation 13 (Tier 2-Mid-Priority, Low Feasibility/High Impact) Evaluate effectiveness of current offerings of Therapeutic Behavioral Services (TBS) and Applied Behavioral Analysis (ABA) for Autism Spectrum Kids;** tighten monitoring and expand recruitment of providers who offer high quality TBS and ABA services.

Lead Entities: Behavioral Health Administration (BHA) and Medicaid

**Recommendation 14a (Tier 1-High Priority, High Feasibility/High Impact) Build a stronger menu of evidence based and evidence informed practices** into the children and youth system of care and add these where possible to the Medicaid State Plan. Evaluate how the federal FFPSA list of evidence-based practices may be leveraged to expand the service continuum in the state.

Lead Entities: Behavioral Health Administration (BHA), Medicaid, Department of Human Services (DHS), University of Maryland School of Social Work (UMD SSW)

**Recommendation 14b (Tier 1-High Priority, High Feasibility/High Impact) Recreate an improved version of the EBP workgroup in state government** involving all children’s sub-cabinet agencies. This group would reinforce the framework for applying evidence-based practices for children, review, approve and support implementation of identified practices on a rolling schedule.

Leading Entity: Governor’s Office for Children (GOC) with agency partners

**Recommendation 14c (Tier 2-Mid-Priority, Split Vote - High Feasibility/High Impact & Low Feasibility/High Impact) Require training, capacity building and fidelity monitoring for providers to offer a larger menu of reimbursable EBPs.** Budget these costs into the EBPs.

Lead Entities: Behavioral Health Administration (BHA), Department of Human Services (DHS), University of Maryland School of Social Work (UMD SSW)



**Recommendation 15 (Tier 2-Mid-Priority, Low Feasibility/High Impact)** Consider use of a single agent as the authorization agent/gatekeeper with access to all fund sources supporting behavioral health services from all state agencies.

Lead Entities: Medicaid, Behavioral Health Administration (BHA), and the Behavioral Health Administrative Services Organization (BHASO)

**Recommendation 16 (Tier 2-Mid-Priority, Low Feasibility/High Impact)** Expand medical necessity criteria for 18-26-year-old population within Adult Targeted Case Management for Residential Rehabilitation Program and the Psychiatric Rehabilitation Program services.

Lead Entity: Behavioral Health Administration (BHA)

#### **4. Patient Population**

Key findings identified the following barriers and challenges identified by patient population to serve hospital discharged youth with complex needs:

Some of the characteristics among youth who have challenges with timely, appropriate placements include:

- Autism spectrum disorder diagnoses
- Youth in state custody with a history of:
  - Highly aggressive behaviors
  - Victims of human trafficking
  - Sex offender charges
  - Fire-setting behavior

**Recommendation 17a (Tier 2-Mid-Priority, Split Vote - High Feasibility/High Impact & Low Feasibility/High Impact)** Early Childhood Mental Health system of care in Maryland is weak and needs capacity building and adoption of evidence-based practices to prevent and mitigate the potential negative impacts of childhood trauma. For example, Head Start should have social workers available on site to address child behavioral health needs. Extend 1915(i) for the 0-5 age group. (A 0-3 early childhood committee just submitted a finalized report with recommendations to expand care and treatment options for this population. We recommend that there be a review of that report to determine where there may be alignment and an ability to move the recommendations forward collaboratively.

Lead Entities: Maryland State Department of Education (MSDE) and Behavioral Health Administration (BHA)

**Recommendation 17b (Tier 1-High Priority, High Feasibility/High Impact)** Expand and publicize the Infant and Early Childhood Mental Health Consultation Project.

Lead Entity: Maryland State Department of Education (MSDE)

**Recommendation 18 (Tier 2-Mid-Priority, Low Feasibility/High Impact)** Build out centers of excellence around Evidence Informed collaborative clinical practice for autism spectrum youth.

Lead Entities: Behavioral Health Administration (BHA), Developmental Disabilities Administration (DDA), and Maryland State Department of Education (MSDE)

### Children and Transition Age Youth Recommendation Summary Table

Legend: REC # - Recommendation Number; AIP – Already in Progress; SR – Shovel Ready; ND – Needs Development

REC #	RECOMMENDATIONS FOR CTAY	TIER	AIP	SR	ND
<b>HIGH PRIORITY</b>					
1a	Build out and approve referral protocol	1		✓	
2	Implement 24/7 crisis response system including mobile crisis team	1			✓
3a	Evaluate effectiveness of available in home and out of home respite	1			✓
4	Build intensive community-based outpatient services for children	1			✓
8 (i)	Evaluate the effectiveness of the Local Care Team and make improvements	1			✓
9	All stakeholders need a clear understanding of Voluntary Placement Agreements	1		✓	
10	Extend Medicaid service preauthorization reviews until close of business (COB) on Friday	1		✓	
14a	Build a stronger menu of evidence based and evidence informed practices	1			✓
14b	Recreate an improved version of the EBP workgroup in state government	1		✓	
17b	Expand and publicize the Infant and Early Childhood Mental Health Consultation Project	1		✓	
<b>MID-PRIORITY</b>					
1b	Infrastructure to support a real time capacity inventory tool or a bed registry	2			✓
3b	Develop and implement a peer supported respite program for the 18-26-year old transition age youth	2			✓
6	Increase capacity of high quality and responsiveness to current needs RRP beds to serve the TAY population	2		✓	
7	The state needs more in-state RTC and therapeutic foster care beds including high intensity treatment foster care and therapeutic group home beds	2		✓	
8(ii)	Data sharing is critical across all child serving systems and providers who are coordinating to treat the child and best serve the family – CRISP/MDTHINK/DoIT	2			✓
12	Address parity between Medicaid and private insurance	2			✓
13	Evaluate effectiveness of current offerings of Therapeutic Behavioral Services (TBS) and Applied Behavioral Analysis (ABA) for Autism Spectrum Kids	2		✓	
14c	Require training, capacity building and fidelity monitoring for providers to offer a larger menu of reimbursable EBPs	2			✓

REC #	RECOMMENDATIONS FOR CTAY	TIER	AIP	SR	ND
15	Consider use of a single agent as the authorization agent/gatekeeper with access to all fund sources supporting behavioral health services from all state agencies	2			✓
16	Expand medical necessity criteria for 18-26-year-old population within Adult Targeted Case Management for Residential Rehabilitation Program and the Psychiatric Rehabilitation Program services	2			✓
17a	Early Childhood Mental Health system of care in Maryland is weak and needs capacity building and adoption of evidence-based practices	2			✓
18	Build out centers of excellence around Evidence Informed collaborative clinical practice for autism spectrum youth	2			✓

## Conclusion and Next Steps

The State of Maryland has a national reputation for being an innovator and an experimenter in healthcare. The transition from the old All Payer Medicare Waiver to the new Total Cost of Care Medicare contract and Medicaid Expansion over the past six plus years have positioned the State well to undertake the next generation of work to push forward additional care system change and alignment beyond the walls of the hospital. This involves having the state:

- Ensure that population health and well-being are at the center of all of its health improvement efforts
- Build out a strong community-based continuum of care where acute care is brief and non-recurring where appropriate
- Build stronger business processes to transition patients between levels of care
- Build a stronger evidence informed menu of clinical treatment and placement resources
- Resource the system adequately to ensure financial sustainability of innovative approaches
- Maximize federal revenue wherever possible
- Build a true public-private supported system of care

This report, commissioned by the Secretary of the Maryland Department of Health and chartered by the Secretary's Strategic Vision Group, provides a fairly holistic, high-level summary of the major pain points involved in admitting and discharging patients to and from hospitals and long-term care facilities. It then goes on to develop recommendations for improving care experiences and outcomes for adults and for children and youth who come into contact with the acute care and long-term care systems. This report, while an attempt at capturing a comprehensive view of the challenges and solutions, is by no means complete. The authors of this report anticipate that there are other barriers and solutions that have not been captured or inadvertently left out and that will be uncovered in ongoing stakeholder discussions. While this entire issue area is highly complex and the development of solutions will be a work in progress, it is reassuring that the Maryland Department of Health has committed to this work with partner agencies, both public and private, to improve outcomes for adults, children, youth and families.

This report will be reviewed by the Secretary and the Secretary's Strategic Vision Group and they will then provide direction on next steps to either build out an implementation framework for certain recommendations or direct identified leads to proceed with implementation.