



BEHAVIORAL HEALTH

Surfacing the Issues Facing Baltimore's Behavioral Health Landscape

Recommendations from the
Half-Day Summit

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GLOSSARY OF KEY TERMS

Beacon Health Options Maryland (Beacon) – a behavioral health management company, often referred to as an ‘administrative services organization’ (ASO), that delivers administrative services to Maryland such as claims processing and billing for Medicaid populations.

Behavioral Health System Baltimore (BHSB) – a non-profit organization in Baltimore with a mission to enhance the behavioral health and wellness of individuals, families and communities through the promotion of behavioral health and wellness, prevention, early intervention, treatment and recovery.

Consumer – an individual utilizing the services of behavioral health providers.

Electronic Health Record (EHR) – an electronic version of a patient’s medical and health history, maintained by a provider over time.

Medication Assisted Treatment (MAT) – the use of FDA approved medication for the treatment of opiate/opioid addiction and substance abuse. Well known medications include buprenorphine, methadone, and naltrexone.

National Alliance on Mental Illness (NAMI) – a grassroots mental health organization that provides advocacy, education, support, and public awareness so that all individuals and families affected by mental illness can build better lives.

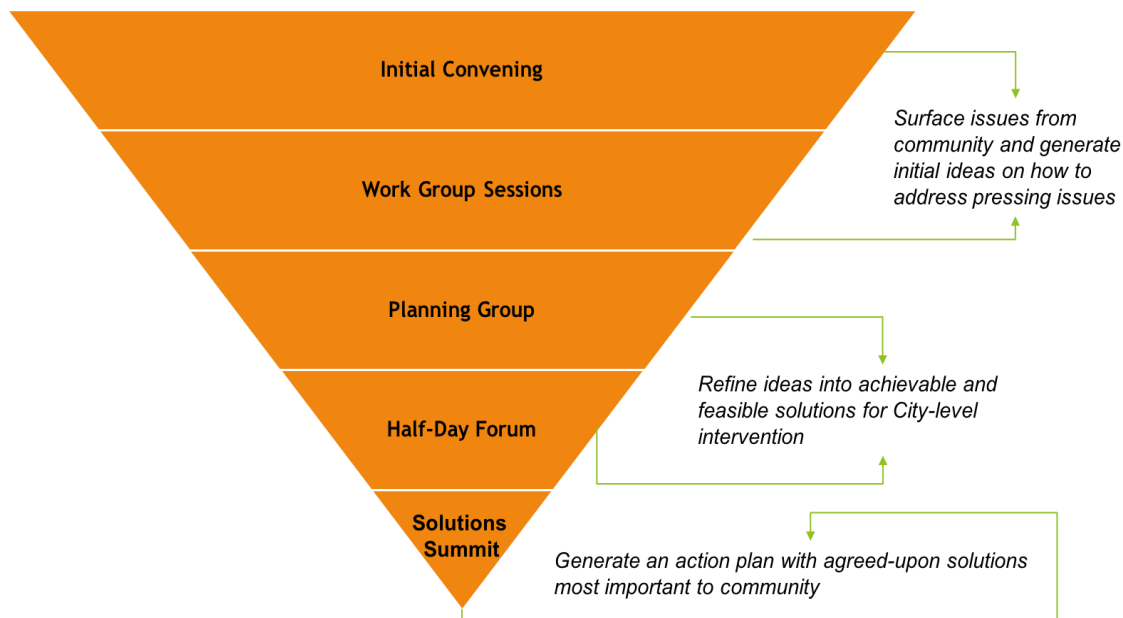
Screening, Brief Intervention, and Referral to Treatment (SBIRT) – an evidence-based practice used to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs.

Substance Use Disorders (SUD) – the recurrent use of alcohol and/or drugs leading to clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home.

EXECUTIVE SUMMARY

The behavioral health landscape in Baltimore City has undergone significant change and transition over the last several years. Given these transitions, Open Society Institute-Baltimore (OSI-Baltimore), in early 2016, recognized a need to gather voices of community-based behavioral health providers, consumers, and advocates to surface critical issues they face in their work in the field of behavioral health in Baltimore, as well as identify solutions to address those issues. With changes in leadership at multiple levels – from a new mayor and city council soon to take office, as well as relatively new leadership at Behavioral Health Systems Baltimore – OSI-Baltimore has focused its attention on designing and implementing a process to not only identify issues for behavioral health, but also to create momentum toward addressing the issues.

This white paper describes the multi-step process used to surface the key issues facing Baltimore’s behavioral health system; to give voice to the community; and to generate achievable and feasible solutions for City-level intervention.



The paper reflects discussions about how to address provider capacity and consumer access; billing/funding; care coordination and integration; and stigma reduction. These topic areas emerged from a series of meetings and work group sessions with behavioral health providers, consumers, and advocates that took place between March and June 2016 (See Appendices A and B). A planning group was convened in summer 2016 to refine the potential solutions developed by the work groups before presentation and discussion with participants at a half-day, public forum that took place October 1, 2016. The Solutions Summit in December 2016 will serve as a culminating event where recommendations that came out of the half-day forum will be discussed and debated. Those in attendance will collectively vote on the solutions most important to the Baltimore community and upon which new city leadership will be expected to act.

DEVELOPING SOLUTIONS TO IMPROVE THE BEHAVIORAL HEALTH SYSTEM IN BALTIMORE

In July 2016, OSI-Baltimore announced a full-day public event, the Solutions Summit, planned for December 10, 2016. The event is “an effort to bring together community leaders, elected officials, issue-area experts, on-the-ground activists and concerned residents in order to come up with practical solutions to some of Baltimore’s most intractable issues.”¹ The purpose of the Summit is to discuss and agree on an action plan to present to the new mayor and city council of Baltimore. The Solutions Summit will be a time to discuss, debate, and, using mobile technology, vote on 10 to 15 key priorities for the newly elected mayor and city council.

In preparation for the Solutions Summit, OSI-Baltimore hosted half-day forums, open to the public, focused on three key issues: Jobs, Criminal and Juvenile Justice, and Behavioral Health. OSI-Baltimore identified planning groups for each of the three key areas, including co-chairs to head the planning groups. For Behavioral Health, the co-chairs are Susan Leviton, a University of Maryland Law School professor emeritus and founder of the statewide child advocacy group Advocates for Children and Youth and Scott Nolen, Director of the Drug Addiction Treatment program at OSI-Baltimore. The Behavioral Health Planning Group members are a cross-section of providers, advocates, and consumers, and include:

- Adrienne Breidenstine, Vice President of Policy and Communications, Behavioral Health System Baltimore
- Adrienne Ellis, Director of Healthcare Reform and Community Engagement, Mental Health Association of Maryland
- Ronald Fountain, Peer Recovery Specialist, New Hope Treatment Center
- Carlos Hardy, Founder and CEO, Maryland Recovery Organization Connecting Communities (MROCC)
- Dr. Aliya Jones, Chair, Department of Behavioral Health, Bon Secours Hospital Baltimore
- Susan Leviton, Founder, Advocates for Children and Youth; Professor Emeritus, University of Maryland Francis King Carey School of Law
- Carin Miller, Founder, Save Our Children Peer Family Support Groups
- David Nelson, Board Chair, National Council on Alcoholism and Drug Dependency – Maryland
- Scott Nolen, Director, Drug Addiction Treatment Program, Open Society Institute-Baltimore
- Amanda Owens, Program Officer, Criminal Justice and Addiction, The Abell Foundation
- Vickie Walters, Director, Institutes for Behavior Research’s Recovery Enhanced by Access to Comprehensive Healthcare (REACH) Program
- Ellen Weber, Professor of Law, University of Maryland Francis King Carey School of Law; Founder, Drug Policy Clinic

The Behavioral Health Planning Group began their work in August 2016, which included reviewing the themes that emerged from earlier work group sessions to help shape the half-day forum. After a rich discussion about the key issues and potential solutions generated by work group participants, planning group members voted to determine which of the ideas they considered the most pressing priorities and what would be achievable and feasible for city-level intervention. The issues identified fell fairly neatly into four areas: Care Coordination and Integration, Stigma Reduction, Provider Capacity and Consumer Access, and Housing and Recovery Support Services. After

¹ OSI-Baltimore. Solutions Summit, www.solutionssummitbaltimore.org/. Accessed on 16 September 2016.

reviewing the data from the work group sessions, the planning group identified a list of 17 potential solutions.

OSI-Baltimore convened a behavioral health half-day forum on October 1. Forum participants explored the 17 solutions and used mobile technology to vote on the top ten priorities that should be discussed at the Solutions Summit on December 10th. The recommendations that come out of the half-day forum will be discussed and debated at the Solutions Summit and refined into achievable solutions for city-level intervention, and those in attendance will collectively vote on their most important priorities. The action plan generated at the conclusion of the Solutions Summit will outline the agreed-upon solutions most important to the Baltimore community and upon which new city leadership will be expected to act. The following list of represents the solutions that were identified as the “Top 10”² priorities at the half-day forum:

Behavioral Health Recommendations Highest Vote Recipients

Care Coordination and Integration

1. Conduct a full landscape scan of treatment and service providers throughout the city, including eligibility requirements, insurance types accepted, levels of care, services available, and number of people served annually. Include in this landscape scan service gaps by provider type, level of care, and geography. Publish this inventory in print and online, and create a mechanism to ensure that information in the inventory is verified and updated regularly. Ideally, create an online platform with live, continuously updated data on available treatment slots and program capacity.
2. Create a funding model that uses discretionary funds to support case management and peer recovery specialist services in order to provide wraparound and care coordination services to meet consumers’ needs.

Stigma Reduction

3. Behavioral Health System Baltimore should develop a training program to train local behavioral health providers on: (1) how to reduce bias and stigma within their programs and (2) how to effectively advocate to decision-makers about the needs of those in or in need of treatment.
4. Coordinate and launch a communications and public awareness campaign aimed at normalizing substance use disorders, changing public perception of people dealing with addiction to reduce stigma, and educating the public about treatment and recovery options.
5. Advocate for fair, non-discriminatory zoning standards that permit outpatient and residential programs to locate in communities under the same standards as other medical services.

Provider Capacity and Consumer Access

6. Increase the efficacy of the city’s Crisis, Information, and Referral (CI&R) helpline by: (1) staffing the line with peer specialists with lived experience, (2) training helpline staff in

² There was a tie between two solutions for the 10th spot on the list, so there are 11 solutions total.

stigma reduction and referral procedures, and (3) launching a communications campaign to increase the public's awareness and utilization of the helpline.

7. Develop a training program to educate both new and veteran physicians and other front-line medical professionals on substance use disorders, their treatment options, and prescribing guidelines to reduce stigma against people dealing with addiction and the overutilization of addictive pain medications. Explore possibilities of requiring such training for city physicians and other practitioners as part of their continuing education and incorporating it into medical school curricula.
8. City leadership should coordinate and launch an appeal to Congress and the Centers for Medicaid and Medicare Services to bring coverage for substance use disorders in Medicare into parity with other medical benefits, covering all levels of care and settings of care, including opioid treatment programs and all licensed practitioners. As part of this advocacy, explore partnering with the American Association of Retired Persons (AARP) and other advocacy groups for the elderly and persons with disabilities to coordinate advocacy on Medicare coverage for substance use disorder treatment and services.

Housing and Recovery Support Services

9. City leadership should coordinate and launch appeal to the State to strengthen standards and regulations regarding intensive outpatient programs (IOPs), inpatient/residential programs, and State certified recovery residences. A central piece of this advocacy should be involving consumer feedback into program evaluation.
10. Implement stronger enforcement of existing federal, state, and local laws and regulations that prohibit discrimination against individuals engaged in treatment or recovery support services—including individuals using prescribed medications to treat substance use disorders—in all areas, including housing, benefits, and other services. Where gaps in anti-discrimination laws exist, launch a coordinated advocacy campaign to create new city or state anti-discrimination protections.
11. Increase access to sustainable funding and providing technical assistance to help improve quality of services (including data collection and outcome tracking) and sustainability throughout the behavioral health continuum of care.

PRESSING ISSUES AND POTENTIAL SOLUTIONS GENERATED BY WORK GROUPS

What follows is a wider discussion of the themes generated by participants during the initial work group sessions in June 2016. As mentioned above, the issues fell into four categories and each category is described and discussed below.

[Provider Capacity and Consumer Access](#)

Background

Provider capacity and consumer access are two related issues that affect the ability of consumers to connect with and receive timely care for their health needs. Provider capacity includes not only the number of treatment slots a particular provider has available, but also the diversity of providers with various specialties available in different communities across a geographic area (in this case, Baltimore City). This capacity is dependent upon factors such as the availability of trained medical professionals to serve as staff, the billing structures that affect whether a given provider can be sustainable, and the regulations that govern where providers can operate and how they are licensed. Consumer access to behavioral health care depends partly upon the capacity of providers in the community, but also depends on factors specific to the consumer side of health care. These factors include the coverage and costs of consumers' health insurance plans, the ease of finding accurate information about providers, the availability of evening and weekend operating hours that work for consumers' schedules, and the accessibility of transportation to get to appointments.

Work group findings

With regard to provider capacity, concerns were raised across all work group sessions about the recruitment, retention, and burnout of staff. There was discussion about the shortage of talent in the pipeline; the lack of funding to recruit professionals to work in treatment programs; and the inability to provide staff with a livable wage. Additional concerns surfaced across all work group sessions about the lack of integration and parity between substance use disorder (SUD) providers and mental health providers. There were also a number of discussions regarding the general lack of awareness and training regarding SUDs and mental illness at the primary care level. Providers specifically referenced the capacity "bottleneck" created by:

- Restrictions on who is allowed to prescribe Medication Assisted Treatment (MAT), and
- The significant waiting periods in place to secure provider and individual licenses.

With regard to consumer access, concern was raised across all work group sessions over both youth and those 65 and older on Medicare. Regarding young people affected by SUDs, there was discussion that youth are not viewed as a distinct segment of the consumer population with specific needs, and yet they ought to be. For those on Medicare, there was a great deal of discussion regarding the lack of coverage for SUD treatment compared to Medicaid coverage for other adults and how this leaves many people without access to care. Additional concerns were raised across all sessions about the general affordability of various treatment options for working poor individuals with high deductible private insurance. Advocates and consumers raised great concern regarding the limitations of the current fee structure, which does not take a comprehensive view of all that consumers may need to access across a continuum of care (see section below for further discussion of care coordination and integration).

Participants generated a number of ideas to address the provider capacity and consumer access issue area. The following ideas surfaced multiple times across the sessions:

- Strengthen and enhance the Crisis Information and Referral hotline to ensure it is centralized, accessible, and current
- Require more extensive training and education of physicians as it relates to the epidemic (e.g., what substance use disorders are, options to treat them, and how dispensing pain medication is contributing to the epidemic)
- Advocate to regulatory agencies to allow nurse practitioners to prescribe buprenorphine
- Advocate to Congressional representatives to address the lack of SUD coverage in Medicare

Billing/ Funding

Background

The billing and funding processes for behavioral health directly affect providers' capacity to provide services and consumers' access to care. If a provider is not billable through a consumer's health insurance plan, that consumer is less likely to engage with that provider, and may not engage with any provider if no covered provider is available nearby. If certain needed services such as case management or care coordination are not billable to insurance plans, then providers have to absorb the costs if they choose to provide these services. Most providers cannot provide substantial services like care coordination without reimbursement, so the lack of a funding stream results in reduced quality of care. Billing and funding issues are particularly important for providers seeking to serve the uninsured population; without a funding mechanism to provide care for low-income, uninsured individuals unable to pay out-of-pocket, this most vulnerable group will be left unserved.

Work group findings

The limitations of the fee-for-service model as well as the "silo-ed" nature of the current model were expressed as concerns across the sessions when discussing Billing/Funding. Details of this discussion included:

- High no-show rates and their direct financial impact on providers,
- Red tape in getting services provided reimbursed by private insurance and Medicare,
- Care coordination not being billable,
- The roll-up of control over block grant funding from local (county) health authorities to the state's administrative services organization (ASO), Beacon Health Options, and fears about losing the safety net provided by these funds,
- Providers not able to plan or project appropriately to address needs of patients and the provider organization, etc.

There was extensive discussion in favor of a more comprehensive funding system. Providers specifically raised the challenges of billing with Medicaid through Beacon Health Options.

A number of ideas emerged across the sessions to address the Billing/Funding issue area. Specifically:

- Evaluate the addiction epidemic more strategically in order to get the full picture of what it costs to address the opioid and other drug addiction in Baltimore
- Conduct a study of the cost to provide the full spectrum of needed behavioral health services, including case management and care coordination, and use that research to set service rates accordingly
- Focus on finding ways for more broad and less specific line items through BHSB grants
- Think outside of pre-conceived payment notions (Medicaid, Medicare, etc.)
- Evaluate Chesapeake Regional Information System for our Patients (CRISP) and Beacon Health Options to understand if there is duplication which impacts billing. Quality of data is important in knowing who to treat and how to avoid "double treatment" and non-reimbursable encounters. Establish a notification system for providers to know when patients are enrolled in another program with a separate provider or facility
- With the goal that access to treatment be available regardless of income level, BHSB should take a systemic look at all potential billing and funding options and create a financing and advocacy plan to ensure that needed services are funded and available to all in need of care

Care Coordination and Integration

Background

Care coordination is the intentional organization of health care activities across multiple providers for the purpose of facilitating the appropriate delivery of services. Because no provider can provide every possible health care service, consumers commonly use multiple providers at the same time. For example, a given consumer may have a primary care physician, one or more medical specialists, a therapist she sees for mental health support, a separate psychiatrist who manages her psychiatric medications, a substance use disorder treatment provider she goes to for weekly groups, and a separate methadone treatment provider. Because one provider's treatment can affect the others, it is imperative that providers coordinate their care with one another, such as through the use of case managers or care coordinators. In the behavioral health realm, the frequent separation of mental health and substance use disorder services creates barriers to addressing these interrelated issues holistically, making care coordination even more important. Relatedly, care coordination is needed when consumers transition from one level of care to another, such as when being discharged from a hospital to an outpatient provider.

Work group findings

This was a key issue that emerged from the advocate and consumer work group sessions that was not represented in the issues identified during the initial March 2016 convening. The discussion focused on how consumers and families have a very difficult time navigating the highly fragmented and complex system of resources in Baltimore. There was strong consensus that the system was not designed to be consumer-centric and that coordination of care, recovery support services, and case management are not currently prioritized or adequately funded. This fragmentation and lack of coordination results in significant issues for consumers in their efforts to receive care.

Providers expressed a concern during their work group sessions about the state's Behavioral Health Administration not yet integrating mental health and SUD services under the umbrella of behavioral health or communicating effectively. This lack of integration and communication impacts providers' ability to function effectively. The provider groups also noted that the lack of integration and coordination poses especially increased risks for those with co-occurring mental illness and SUD, a particularly vulnerable group.

Ideas that surfaced to address this issue area include:

- Build patient advocacy programs at all treatment providers and BHSB, so consumers can feel heard and supported and at the center of the system – possibly using peers to help facilitate the patient advocacy programs
- Publish a thorough inventory of providers and services as a resource to help consumers navigate the complex behavioral health treatment system
- Undertake an analysis of all current services and service gaps, including analysis of provider capacity
- Secure financing through different mechanisms available such as Medicare Access and CHIP Reauthorization (MACRA) grants, and savings in intensive levels of services
- Strengthen team training on SBIRT to build coordinated, cross-disciplinary care teams, including in:
 - Primary care physicians' offices

- Schools
- Criminal and juvenile justice systems
- Build stronger collaboration between case managers and peer recovery advocates to help consumers locate useful community resources that are person-centered and provide wraparound services, including community integration. Improve follow-up documentation and data reporting to yield useful information to improve collaboration and care coordination

Stigma Reduction

Background

Stigma unfortunately permeates the behavioral health field, existing across multiple levels and groups. Individuals dealing with a mental illness or addiction are subject to social stigma that negatively labels and judges them, often driving them to hide or deny their symptoms or avoid seeking treatment for fear of social reprisal. This stigma can exist even within the health care field, such as when primary care doctors avoid asking about or addressing patients' behavioral health needs or when behavioral health providers condition their treatment and services on an abstinence-only model and marginalize those who are still in active use. Social stigma also creates community pushback against behavioral health providers being situated in neighborhoods where people live, with residents fearing that such providers will bring more harm than good to their communities. Stigma can go beyond individual or community bias to become manifested in social policy, such as with policies that criminalize behavior that is related to addiction or require drug testing to access public benefits such as housing.

Work group findings

A number of concerns were expressed across all work group sessions about the very low social acceptance of SUDs as diseases. There was a comparison made to the HIV/AIDS epidemic in the 1980s. Stigma is not isolated; it exists across many layers: physician/provider, patients, families, communities, policy makers, and within systems and institutions. Specific to the state of Maryland, there was concern raised about the lack of content expertise in the highest levels of decision-making at the state's Department of Health and Mental Hygiene as well as perceived negativity about SUD and MAT coming from the Governor's office. There was also concern raised about the confusion that exists across providers, advocates, and consumers about the new Crisis Information and Referral Line (the "hotline") and where to direct consumers.

For providers, stigma surfaced in their attempts to access medical office space for their programs. They raised the issue that MAT programs are often unwelcome in traditional medical office space and throughout communities and neighborhoods. There was discussion that behavioral health providers were being subjected to different rules than other businesses due to stigma.

There were several ideas generated across the work group sessions to address the issues of stigma, including:

- Enhance and raise awareness of the Crisis Information and Referral hotline to make it a centralized and well-known resource for the people of Baltimore
 - Enhance the quality of representatives answering the calls to ensure consumers get respect, dignity, and a proper referral when they call
 - Consider the role of peers in hotline staffing

- Create a media marketing/ public service campaign to normalize SUD – there is a real need to change perceptions, eliminate stigma, educate the society at large about recovery, promote positive images and success, and showcase “the face” of living well with substance use disorders
 - Additional thoughts on this idea:
 - Teach consumers how to tell their story and interact with the public in order to create a corps of people in recovery who could be called out to neighborhood association meetings, events, and schools to share their experience and how treatment helped them – a way to normalize people with addiction and encourage others to seek treatment
 - Include family members who are willing to speak about their experiences with a loved one suffering from a SUD
 - Create opportunities for medical providers to build empathy and understanding toward patients with behavioral health issues
 - Acknowledge and articulate why those with a SUD need a continuum of care
- Train primary care providers to use SBIRT for adolescents, adults, and families

Additional Issues and Potential Solutions Generated by Work Groups

Due to the limited time available for the work group sessions, the following issues were not discussed in as much detail as the preceding issues. However, these issue areas generated discussion among the small groups, including some generation of ideas to address these issues.

Advocacy

Background

Due to the stigma surrounding behavioral health, coordinated advocacy is needed to drive reform efforts that will bring about change with many of the issues identified above. There are many stakeholders who have important voices when advocating for improvements to the behavioral health system, including consumers in treatment, people struggling with addiction but not yet engaged in treatment, the family members and other loved ones of people experiencing addiction, medical professionals and treatment providers, academic researchers, and policy experts, among others. Bringing these groups together to discuss common needs and potential improvements to the behavioral health system is the first step in coordinating such advocacy. While some groups presently exist to coordinate advocacy on mental health issues, there are fewer such groups working to coordinate advocacy on substance use disorder related issues.

Work group findings

Providers raised concern about the perceived absence of an advocacy/education/support organization (like National Alliance on Mental Illness) specific to SUDs. Consumers and advocates discussed the fact that advocacy is more of a “tactic” than an issue of its own; it was identified as a tool that can be used in any number of solutions within each of the other issue areas discussed.

Specific ideas that surfaced to boost advocacy include:

- Work with the American Association of Retired Persons (AARP) to advocate for Medicare to cover SUD treatment services

- Support efforts by the American Association for the Treatment of Opioid Dependence in discussions with the US Department of Health and Human Services
- Use influence to push regulators to allow Nurse Practitioners to prescribe Suboxone/buprenorphine and to allow non-physician providers to prescribe medications use to treat SUDs

Housing and Recovery Support Services

Background

Traditional behavioral health treatment services address people’s mental illnesses and substance use disorders, but do not always focus on the wider social needs of their consumers. Having a mental health or substance use disorder can affect one’s ability to maintain housing or employment, access educational or legal services, or maintain social connections, so there is a need to ensure that resources exist to help meet these social needs. Community organizations that provide these resources should ensure that they are welcoming and accessible to people with behavioral health needs, and that they do not stigmatize or discriminate against this group. One common area where people with substance use disorders face such barriers is in accessing supportive housing services, many of which prohibit individuals who use prescribed medications to treat opioid use disorders from accessing their services.

Work group findings

Advocates and consumers expressed concerns about how the social components of recovery were not being addressed sufficiently, including housing, jobs, life skills, etc. Discussion focused on how important these components are to the continuum of care. Specific to housing, advocates and consumers highlighted the problem of Medication Assisted Treatment (MAT) consumers lacking access to supportive housing because there are restrictions regarding their placement in such housing while utilizing MAT. One idea that surfaced across multiple sessions included a need to create many pathways to recovery that are person-centered and offer multiple options for housing and other recovery support, including for MAT patients. A second idea that surfaced included a strengthening of standards and regulations from the state for intensive outpatient programs (IOPs) and involving the consumer voice in the evaluation of IOPs and other treatment programs.

Data

Background

In the process of providing services, health care providers collect and track a significant amount of data about their patients, but in the behavioral health arena there is little coordination of what data should be tracked and assessed across providers. Many smaller community-based behavioral health providers lack the scale or funding to implement robust electronic health record systems, which creates difficulties in tracking patient needs and outcomes or coordinating care across providers. Improved data standards and a shared platform for collecting data are two potential solutions to address this need.

Work group findings

Providers discussed the uncertainty about whether they were collecting the right data to advocate for what consumers need. There was concern that there is no effective data collection database or central system that is relational, where provider-level electronic health record data could be uploaded in order to track all consumers and the effectiveness of treatment. An idea that surfaced involved the need for Beacon Health Options to play a more prominent role in coordinating quality data collection across providers.

Other

There were a few additional concerns raised by advocates and consumers that surfaced outside of the issues already identified above. Some specific needs identified included visionary city and state level leadership related to this epidemic, broad public education, and a focus on prevention. Ideas to address these concerns included:

- Strengthen BHSB's role in creating training programs and education to:
 - Providers of SUDs on how to address bias and educate decision-makers about the needs and problems of those in treatment or in need of treatment
 - Offer incentives and certifications to providers to increase the pipeline and retention of providers in the field of behavioral health
- Embed prevention in Baltimore's behavioral health model, including education about the epidemic in school systems and other non-traditional venues, and raising awareness within medical institutions of the role of prescription pain killers, etc.

APPENDIX A – ISSUE AREAS IDENTIFIED DURING INITIAL MARCH CONVENING

During a meeting of 16 behavioral health providers convened by OSI-Baltimore in March 2016, the following issue areas were identified as pressing. These issues formed the basis for further discussion that took place during subsequent behavioral health work group sessions in June 2016.

Data

- Determining appropriate metrics and data standards by which to assess program effectiveness
- Behavioral Health System Baltimore’s (BHSB) role in collecting and sharing data
- The need for a comprehensive behavioral health needs assessment across the city/state

Billing

- Funding and sustainability issues, including the rollup of block grant dollars from BHSB to Beacon
- How the behavioral health merger of mental health and substance use disorders affects billing for services

Provider capacity and consumer access

- The need for a Medicaid Institutions for Mental Diseases (IMD) waiver to increase residential treatment capacity
- Inadequate insurance provider networks (lack of in-network Substance Use Disorder (SUD) treatment providers)
- Lack of service coverage under Medicare
- Consumers on exchange plans not being able to afford copays/deductibles
- Technical assistance needs of providers, including marketing, public relations, and legal support

Stigma

- Physician stigma regarding treating patients with SUDs (e.g., prescribing buprenorphine)
- Social stigma and its effects on access to treatment

Advocacy

- What role BHSB and others should play in policy advocacy
- Developing a set of recommended avenues/issues for advocacy

Housing

- Lack of availability and funding of supportive housing

APPENDIX B – WORK GROUP SESSION METHODOLOGY

In June 2016, four work group sessions were conducted, each lasting two hours. Two sessions were held with providers and two were held with advocates and consumers. A total of 14 provider representatives and 22 advocate and consumer representatives participated across the four work group sessions. The objective of the work group sessions was to collect more detailed information on the issues facing behavioral health providers, advocates, and consumers in Baltimore, and gather ideas about steps that could be taken to address those issues.

The format of the work group sessions was interactive. The sessions began with brief introductions and then a review of the six key issue areas listed above, which surfaced during the initial convening of behavioral health providers in March. Flip charts were posted around the room with each issue – these issues were also distributed to participants in advance of the session. The facilitators worked with each group to identify major pressing issues or concerns that were missing from the initial list of six posted – these issues comprise the “other” category. After that discussion, each participant was given three sticker dots to use as a means of voting, from their perspective, on the most critical issues facing Baltimore’s behavioral health landscape. Each group then discussed root causes and thoughts related to the top issues that emerged from the voting exercise.

The issues that were considered most pressing across the work group sessions, according to the voting exercises, included:

- Provider capacity and consumer access
- Billing/ funding
- Coordination, integration and continuum of care
- Stigma
- Advocacy
- Housing and recovery support services
- Data
- Other (beyond those issues mentioned above, there were some additional issues raised as missing from the initial list)

After the voting exercise and discussion of root causes of the identified issues, the facilitators split participants into small groups to generate ideas to address the most pressing issues identified by each group.