Howard County Behavioral Health
TASK FORCE

FINAL REPORT

Howard County Behavioral Health Task Force

EXECUTIVE SUMMARY

Mental health is an integral part of overall health and wellbeing. The World Health Organization defines health as "a complete state of physical, mental, and social well-being and not merely the absence of disease or infirmity." But often, Howard County residents face pronounced challenges in achieving a full state of wellness because of gaps in our community's behavioral health system of care. People living with addiction and mental illness in our county often struggle to understand their diagnosis, find treatment, navigate through care, and access supportive services -- like housing and employment – that can help the road to recovery.

With the goal to better understand these gaps in the full continuum of behavioral health care, identify public and private opportunities to expand care, and develop immediate, actionable recommendations for Howard County government, the former County Executive created the Behavioral Health Task Force in 2014. After only six months of intensive work, the Behavioral Health Task Force formally submits its recommendations to our current County Executive, Allan Kittleman, with the hope of building a robust behavioral health system that values prevention, early identification and intervention for those at risk, and integrated care and treatment for people living with behavioral health conditions.

Our county, state, and nation have seen major advancements over the past few decades, including a better understanding of mental illness and addictions, new treatment and medications that have become available, and increased funding for behavior health, especially for publicly-funded residents. Although the Task Force could not complete a comprehensive, behavioral health needs assessment in the given timeframe, available data and community experiences show deep assets in our county. Our publicly-funded behavior health system is sound. The county has increased support for behavioral health crisis services, such as the mobile crisis team at Grassroots and mental health staffing within the Police Department. We are fortunate to have inpatient psychiatric services for adults at Howard County General Hospital and emergency psychiatric services for adults, adolescents, and children. The Howard County Public School System has a robust psychological services program and the county seems to have a sufficient supply of mental health professionals in the community.

However, challenges abound. Many of our community mental health providers either do not take or have difficulty taking private insurance coverage. Consumers face unfair hurdles by insurance companies. Urgent access (i.e. care within 24-48 hours) to such outpatient care is nearly impossible; leading to crowding of the emergency department at Howard County General Hospital. Primary care is often a gateway for people needing behavioral health services, but primary care providers often feel ill-equipped to respond. Publicly-funded substance abuse services are at risk as grant funding is replaced by a fee for service reimbursement model. Services and funding are siloed and we have no alcohol or drug detox treatment center in the county. Not surprisingly then, coordination across and among county agencies, providers, the school system, and community organizations is challenging. And the challenge of identifying one's illness or a family member's illness, seeking care, and getting on the path to recovery is made so much harder.

Our recommendations support an ambitious goal to build a full continuum of behavioral health services so that our residents can fully realize wellness and recovery. We recommend concrete, short-term action steps that will further distinguish our county's ability to identify, address, and improve the overall quality of life for all residents. We have not solved every problem; but believe we have provided a set of actionable, meaningful, and prioritized recommendations. Thank you for the opportunity to serve and to reconvene later this year to assess our county's progress.

Co-Chairs

Donna Wells
Executive Director
Howard County Mental Health Authority

Nikki Highsmith Vernick
President and CEO
The Horizon Foundation

Howard County Behavioral Health Task Force

TASK FORCE MEMBERS

Andrew Angelino, MD
Director, Inpatient Psychiatry
Howard County General Hospital

Connie Anguili
Regional Director, Trauma and Family Services
Family and Children's Services

Rebecca (Becky) Bell
Howard County Resident

Leah Blain
Behavioral Health Director
Chase Brexton Health Services, Columbia Center

Mary Murphy
State's Attorney's Office, Howard County

Karen Booth
Vice President, Residential and Rehabilitation Services
Humanim

Karen Butler
Director
Howard County Department of Social Services

Lisa Cooper-Lucas
Manager, Medical Services and Compliance Branch
Washington Metropolitan Area Transportation Authority

Mark Donovan
Director and CEO
Congruent Counseling Services

Beverly Francis Gibson
Executive Director NAMI
Howard County

Chief Gary Gardner
Chief of Police
Howard County Police Department

Nikki Highsmith Vernick
President and CEO
The Horizon Foundation
Task Force Co-chair

Andrea Ingram
Executive Director
Grassroots Crisis Intervention Center

Bonnie Katz
Vice President
Business Development and Support Operations
Sheppard Pratt Health System

David Leichtling, MD
Columbia Medical Practice

Helen Lui
Howard County Resident

Lisa Lomas, PhD
Member
African American Community Roundtable

Tina Maddox
Principal
The Homewood Center

Danilsa Marciniak
Member
Ethnic Community Roundtable

Vickie Miles
Home/Hospital Program
Howard County Public School System

Lois Mikkila
Director
Howard County Department of Citizen Services

Jennifer Pollitt-Hill
Executive Director
HopeWorks

The Honorable Mary Reese
Associate Judge
District Court of Maryland, District 10, Howard County

Scott Rose
President and CEO
Way Station, Ine.

Maura Rossman, MD
Howard County Health Officer

John Butler
Howard County Department of Fire and Rescue Services

Patricia (Trish) Schupple
Deputy Director
Howard County Detention Center

Steve Snelgrove
President
Howard County General Hospital

Brendan Solaner, PhD
Assistant Professor, Mental Health
Johns Hopkins Bloomberg School of Public Health

Sue Song,
PhD Member
Ethnic Community Roundtable

Tammy Spengler

Focused Solutions, LLC

Joy Stephens, PhD
Assistant Director, Mental Health Counseling
Howard Community College

Joan Webb Scornaienchi
Executive Director
HC DrugFree

Councilmember Jen Terrasa
Howard County Council, District 3

Donna Wells
Executive Director
Howard County Mental Health Authority
Task Force Co-Chair

Anne Towne
Facilitator
Towne Group

Howard County Behavioral Health Task Force

TABLE OF CONTENTS

Overarching Issues

In addition to the specific, actionable recommendations listed in this report, the Task Force also raised several overarching issues that drove its recommendations. These issues are fundamental to improving our behavioral health continuum of care and to ensuring access for consumers and family members.

1. So that consumers in need can receive the services they need when they need it, identify and remove barriers so that behavioral health care providers can expand to meet the need. Consumers need to be able to receive the services they need when they need it. Howard County should identify and remove barriers to care for providers, so they can meet current and future needs, and for consumers and their families.
2. Advocate for parity in behavioral health insurance coverage and payment.
3. Support all Howard County residents by promoting and expanding community based resources - especially for early identification and intervention of suspected behavioral health issues. Support groups for individuals, friends, and family; as well as Mental Health First Aid training for the community and for professionals should be widely available.
4. Promote the sustainability of mental health and substance use providers by advocating for improved insurance coverage, reimbursement, credentialing and paneling so that providers can decrease waiting time for appointments, eliminate waiting lists, and affordably offer a wider array of services.

The Task Force quickly found that while the community needs to know more about the services in the County and how to access them, the providers are not always in a position to admit new patients. This forces those in extreme need to enter the behavioral health system at certain "crisis" points of entry such as the emergency department of Howard County General Hospital, the Grassroots Crisis Walk-in program, or through the criminal justice system. Many of our recommendations, therefore, focus on expanding access to outpatient community providers. This expansion of supply must occur before expanding education and awareness about behavioral health conditions (i.e. mental health first aide) or implementing universal behavioral health screening. Otherwise, our county may not have the capacity to meet a surge in demand.

The Task Force wants to keep the collaboration and synergy created in this workgroup. To that end, the Task Force requests further dialog with the County Executive once the recommendations have been considered and the county has a plan and a budget for moving forward. Later in the year, the Task Force would like to convene again to update its membership on progress made toward, not only these recommendations, but the recommendations that were made in the Work Groups as well.

The issues of access by people who need services and the ability of providers to respond effectively are critical. The community needs intense focus on how to make the "system" into a true and effective "safety net" for some of our most vulnerable residents.

Recommendations and Strategies

RECOMMENDATION:
Strengthen the delivery of urgently needed behavioral health services.

STRATEGIES:

1. Expand rapid access to urgent behavioral health services by piloting a program that would assure prompt (24-48 hours) access for adults, and possibly children, to short-term, outpatient psychiatric crisis stabilization services.
   Cost: $50,000 to $100,000
2. Add a Behavioral Health Specialist to the Community Care Teams (CCTs) who are staffed by the Health Department and work closely with Howard County General Hospital to serve residents who are frequently hospitalized. The CCTs support residents' transitions from the hospital back to their home and facilitates linkages to community providers.
   Cost: $100,000
3. Develop a mechanism so that a multidisciplinary team, with representation from organizations (public and private) who serve residents who frequently use emergency services, meet to review and coordinate care issues (i.e. Howard County General Hospital, Chase Brexton, Health Department, Howard County Mental Health Authority, Department of Citizen Services, Grassroots, among others.). The Howard County Provider Information Network might be a helpful tool.

RECOMMENDATION:
Develop a coordinated effort to assist providers of behavioral health services in resolving private insurance problems and help consumers navigate private insurance barriers.

STRATEGIES:

1. Identify and address the causes of barriers for those who have private health insurance coverage to assure timely access to affordable services. Hire a behavioral health ombudsman within the Howard County Mental Health Authority to assist consumers with such barriers. Provide education to consumers about their insurance coverage, including what "out-of-network" costs include, how to access services along the continuum of services, etc.
   Cost: $75,000
2. Advocate for appropriate behavioral health insurance reimbursement codes and rates, making sure specialists and specialized treatments are covered and accessible and that in-patient hospitalization and crisis services as recommended by the individual's treating physician is considered as part of the covered plan of care.
3. Work with insurance companies, advocacy organizations, and the Maryland Insurance Administration, that regulates the insurance industry, to address and resolve the issue of adequate providers on insurance panels for behavioral health treatment to assure that individuals can be seen within a reasonable timeframe.

4. Encourage all providers of behavioral health services (including nonprofits) to bill and collect from insurance companies in order to expand the local network of available resources.

   A full-time person working at the Howard County Mental Health Authority is needed to facilitate collaboration among Howard County providers for Strategies 2-4 and to advocate as described to improve access, coverage, and reimbursement.

   Cost: $100,000

5. Ask Howard County Government to examine its own insurance programs and ensure behavioral health parity.

RECOMMENDATION:

Better screen for behavioral health conditions in the County by supporting the development and use of universal screening tools.

STRATEGIES:

1. Support the Howard County Public School System's (HCPSS) Mental Health Advisory Committee in the adoption and implementation of universal screening tools and support mechanisms to connect students and their families to the needed community resources.

2. Hire a HCPSS Project Manager to advance the planning and preparation for universal screening, and to create an effective system to connect those screening positive for behavioral health indicators with community resources.
   See Appendix C

   Cost: Program Manager $100,000; costs of screening tools – to be determined

3. Conduct a Continuing Medical Education (CME) all-day event or a Friday evening dinner with local pediatricians and pediatric psychiatrists for education and discussion of screening for youth behavioral and emotional problems (see American Academy of Pediatrics clinical report January 2015) and Behavioral Health Integration in Pediatric Primary Care (BHIPP - a free consultation resource for pediatric primary care providers). The Maryland Academy of Pediatrics (MDAAP) could coordinate this event or series of events, as they have done in the past. A portion of this training would be to talk about how to make more effective referrals to the community so that individuals can be more effectively linked to the help they need.

   Costs: $10,000 for promotion, event, and follow-up.

4. Conduct a CME all-day event or a Friday evening dinner with primary care providers and psychiatrists who serve adults for education and discussion of using the PHQ9 and other tools for adult (and older adult) behavioral health screening – PHQ9 was also used in Howard County's biannual health survey. A portion of this training would be to talk about how to make more effective referrals to the community so that individuals can be more effectively linked to the help they need.

Costs: $10,000 for promotion, event, and follow-up.

5. Gather information on information kiosks (i.e. from The Scattergood Foundation) to place in our community that could screen for behavioral health conditions and provide linkages to community services. The kiosks could be used perhaps in conjunction with our food and housing initiatives. People accessing such services could be far more likely to have undiagnosed behavioral health conditions; helping them understanding why they may be overwhelmed /sad/depressed might lead residents to seek support of some kind.

RECOMMENDATION:

Educate the community about how to identify signs of behavioral health issues, how to connect with community resources, and how to act in a more informed manner.

STRATEGY:

Market, deliver, and expand Mental Health First Aid (MHFA) training broadly throughout the County, particularly to community and faith-based organizations. Evaluate and improve trainings over time.

Mental Health First Aid (MHFA) Training is an evidence-based program developed in Australia in 2001 and brought to the US in 2008 through a partnership between the Maryland Department of Health and Mental Hygiene and the Missouri Department of Health. Howard County has supported the Howard County Mental Health Authority in funding certification of trainers and the initial delivery of trainings in FY15.

Each class is $1900 ($1500 for trainer and materials and $400 for food/space/incidentals/marketing).

Cost: $30,000

RECOMMENDATION:

Help residents access services by widely distributing current information on behavioral health providers in Howard County on an ongoing basis.

STRATEGIES:

1. Expand the work started under the Task Force work of providing information on behavioral health providers in the Howard County through the Howard County Mental Health Authority's directory.
2. Improve the Howard County Mental Health Authority's on-line directory to provide search options that will quickly link to listed providers based on the specific requests such as insurance coverage, language/cultural issues, or expertise with certain populations and to be accessible by mobile devices.
3. Use the Howard County Mental Health Authority's website to provide current information about community resources such as support groups, training programs, advocacy opportunities, and Mental Health First Aid Training (MHFA) along with opportunity to schedule and purchase MHFA training on-line.

   Cost: $30,000 for the technical upgrades; $ 50,000 for person to assist in the content development, collaboration with the providers and the community, and marketing the new site.

RECOMMENDATION:

Help individuals involved with the criminal justice system find community resources by funding a position to coordinate across agencies

STRATEGIES:

1. Provide funding for a full-time mental health case worker who would work with the Court system to assist individuals who are identified with a mental or cognitive health issue.
2. Continue to gather data needed to explore the development of a Treatment Court (formerly referred to as a Mental Health Court) in Howard County.
   Cost: $75,000

RECOMMENDATION:

Support the Local Health Improvement Coalition (LHIC) and its members as it advances its strategic plan 2015-2017.

Many Howard County agencies meet in various committees and workgroups on a regular basis. Some of these groups have a focus on behavioral health, such as the Criminal Justice Partnership Committee, but others have a broader focus, such as the Local Children's Board. In most cases, Howard County Mental Health Authority staff are represented and promote behavioral health issues and concerns. However, Task Force members felt that there was a need to better coordinate and assess the effectiveness of service coordination for individuals with behavioral health issues across these numerous groups. Howard County Mental Health Authority staff will work with community agencies to develop a comprehensive list of committees and workgroups currently underway and post this list on its website. Howard County Mental Health Authority staff will report on this issue as part of the LHIC committee on Behavioral Health. Should the requested staff positions for LHIC be funded by the county, staff would then be able to follow-up on the various Task Force recommendations such as data sharing across agencies and the effectiveness of service coordination across agencies to better address the needs of the local community.

STRATEGY:

1. Task Force members will be invited to participate as members of the LHIC committee on Behavioral Health which will continue to address identified behavioral health issues in the community.
   See Appendix D
2. Hire staff to support the Behavioral Health Committee of the LHIC.
   Cost: $100,000

Costs Associated with these Recommendations

Howard County's Behavioral Health Task Force recommends the following expenditures be budgeted to advance the recommendations made in this report. Not all expenditures are on-going but are considered to keep the work flowing and/or to enhance operations to improve service delivery and access to services by Howard County residents.

The Task Force also knows that public/private partnerships are mutually beneficial to our community, and to stakeholders such as Howard County government, Howard County General Hospital, the Howard County Public School System and others. Once the County Executive paves the way for implementing this plan, partnerships will follow.

Mental Health Authority:	
Criminal Justice Support Person	$75,000
Insurance/Advocacy Person	$100,000
Ombudsman	$75,000
Person to work with the IT person to expand the HCMHA website to include on-line MHFA training registration, community events (support groups/training), mobile device accessibility	$50,000
IT	$30,000
MHFA training costs – scholarships	$30,000
TOTAL	**$360,000**

Health Department:	
LHIC Coordinator	$100,000
CME Events (2):	$20,000
Behavioral Specialist for the CCT	$100,000
TOTAL	**$220,000**

Howard County Public Schools System:	
Program Manager	$100,000
Screening tools	TBD
TOTAL	**$100,000 *plus tools (TBD)***

Information/screening kiosks (Scattergood)	TBD
Rapid Access Program:	$50,000 – $100,000
TOTAL	**$730,000-$780,000 *plus screening tools plus kiosks***

Overview of the Work of the Task Force Meetings

The following is a brief summary of the work done in the full Task Force. Notes from the meetings, along with handouts/reference materials were posted on the Howard County Mental Health Authority's website for Task Force members and the public to view.

October 2014

On behalf of County Executive Ken Ulman, Elizabeth Kromm welcomed task force members and provided an overview of how this task force has come to be. She then introduced co-chairs Nikki Highsmith Vernick (the Horizon Foundation) and Donna Wells (Howard County Mental Health Authority) and thanked all task force members for their willingness to serve.

Nikki and Donna acknowledged that activities of the County Executive and his staff in bringing together a wide variety of people to fulfill the following mission:

1. To understand the roles played by all community partners in providing ongoing support for individuals with mental illness as well as in reducing the frequency and intensity of mental health crises;
2. To identify gaps in the continuum of care. These services may include but are not limited to consistent access to outpatient treatment and psychiatric services, as well as critical supportive services such as wrap-around stabilizing services, peer support services, community re-entry support post discharge from detention center, housing, employment, and case management;
3. To identify synergies and strategies to maximize return on existing investments in this area as well as to understand where additional funding or support (public and private) should be directed in the future; and
4. To develop an action plan with policy, program, and funding recommendation to enable the implementation of a preventive and recovery-oriented continuum of care for both Howard County adults and children.

The task force is charged with coming up with recommendations not later than March/April 2015 so Nikki highlighted the focus of identifying what we can change locally – what we can control and fund. While the task force may hear from state-level speakers, the task force's responsibility is on advancing this work in Howard County.

Donna talked about the role the Howard County Mental Health Authority plays in the county and the relationships it has with providers and government. She offered her website as the location for information on meetings, reports, and other relevant materials (www.hcmha.org).

Donna introduced Howard County's Health Officer Maura Rossman. Maura and her staff, building on Horizon Foundation materials and those developed by the Local Health Improvement Coalitions (LHICs), pulled together Howard County Behavioral Health Data and presented it to the task force. APPENDIX A (?)

Nikki then talked about organizing the work of accomplishing the mission by identifying work groups. She asked for ideas on this and the following is a list of initial thoughts:

Define demand more clearly through a demographic demand analysis

Complete the work begun by the Health Department to identify who the providers are – what services they offer, who they serve, when and where.

Explore the connectivity of the providers and of the providers to the community.

Identify what regulatory barriers there might be for improving the continuum.

See where the greatest gaps in the continuum are and what might be done to close them.

Discover potential new models for financing. This includes taking a closer look at what insurance covers (public and private) and what that means for the continuum of providers.

Explore how to improve prevention services that promote healthy behavior so people do not enter the continuum.

Examine how transition from services to the community can become more effective.

Task force members were also asked about who was missing from the membership and several ideas were offered given the potential direction of the work. Future task force meeting dates were set for:

November 2014

Developing the Data and Defining the Potential Areas of Work

There was quite a spirited discussion about the data that was presented at the Kick Off meeting and what it might inspire in terms of priority issues to work on. The top recommendations, along with the agreement to break into work groups, included Urgent Care Services and Payment, Criminal Justice System, Trauma Informed Care, Mental Health Care in Primary Care, and "Super" Users.

It was also agreed that a glossary of terms would be created as well as a guidance to work groups.

December 2014

Because of the interest expressed both in universal screening and in the Howard County Public School System's (HCPSS) Behavioral Health Advisory Committee, a special presentation was planned to learn more.

"HCPSS Continuum of Supports for Behavioral/Mental Health"

Cynthia A. Schulmeyer, Ph.D., NCSP, Coordinator, School Psychology, Instructional Intervention and Home & Hospital and co-chair of the Mental Health Task Force, Howard County Public School System

APPENDIX B (?)

Initiating Work Groups

Task Force members selected the Work Groups they wished to participate in and all Work Groups held their initial meetings and created meeting schedules for the future. Work Groups were encouraged to invite non-Task Force members to the Work Groups if they could be helpful in advancing the work.

January 15, 2015

Remarks from County Executive Allan Kittleman

Updates from Work Groups:

Screening and Prevention for Persons Most at Risk and In Need of Behavioral Health Services

Primary Care (including Urgent Care) and Behavioral Health Services

"Super Users" of Behavioral Health Services

Impact on Howard County's Behavioral Health System through the Criminal Justice System

February 12, 2015

Behavioral Health and the Public Policy Agenda

Adrienne Ellis
The Parity Project Director, Mental Health Association of Maryland
and Co-chair of the Maryland Health Benefit Exchange's Board

The Maryland Parity Project is an initiative of the Mental Health Association of Maryland that works to educate insured Marylanders of their rights in accessing mental health and substance abuse disorder treatment under the federal Mental Health Parity and Addiction Equity Act
of 2008.

Sheena Siddiqui
Analyst, Policy & Data Analytics
Maryland Hospital Association

The Maryland Hospital Association advocates on behalf of Maryland's 65 hospitals and health systems; membership is composed of community, teaching, specialty, long-term care, and veteran's hospitals.

Work Group Summaries

Prevention and Screening Work Group

General points of discussion:

SCREENING

- Group focused on a universal screening as opposed to screening for those "most at risk and in need of behavioral health services"
- Universal screening is a great opportunity to implement a trauma informed system
- http://thriveinitiative.org/ is a great resource regarding trauma informed system response
- Adverse Childhood Experiences (ACE) screening tool for adults might be a good screening tool to investigate – promoted by the CDC - http://www.cdc.gov/violenceprevention/acestudy/
- HCPSS Mental Health Taskforce has looked at a variety of tools and is struggling with the costs of implementing a tool for universal screening. Screening is now done by parental consent for students in middle and high schools
- National Center for Trauma-informed Care might be another resource to investigate for possible screening tools - http://www.nasmhpd.org/TA/NCTIC.aspx
- American Academy of Pediatrics new screening guidelines can be promoted.

The overarching concern with screening is the ability to connect a person identified to be at risk to the right resources in real time. Until a more accessible system is created, screening may remain limited to those who request help or are identified by others as exhibiting risky behavior. Those who could benefit from early intervention would remain

PREVENTION

- Public education about the screening efforts and the elements that are identified could serve as a form of prevention
- Only some aspects of behavioral health are considered in this category – so letting the community know more about the resources available to them (non-medical) would be a big service.
- Prevention can also be considered along the continuum – as the prevention of falling into a higher risk category. Perhaps more can be done in this regard.

The Work Group explored a wide array of providers and their screening and prevention activities. Presentations (or information was provided) were made by representatives from Grassroots, Office on Aging, Office on Children's Services, Columbia Addictions Center along with the knowledge of the members of the Work Group. As a result, the Work Group makes the following recommendations.

Continuing Future Work:

Strengthen (create) the ability to connect a person with a trained, behavioral health worker when screening identifies help is needed and provide case management/navigator/ombudsman support to help the individual set up a plan to achieve improved health.

Primary Care Work Group

General points of discussion:

The Work Group explored issues related to the consumers' ability to find behavioral health providers and related to behavioral health providers being able to find community support – and insurance reimbursement.

Existing websites, databases, HC PIN (Howard County Provider Information Network) were all reviewed and the concern remains: content of information – is it current; level of detail of information (such as insurance, languages spoken);

Issues related to the financial incentive of providers to provide behavioral health services was also discuss in detail. Insurance companies limit insurance reimbursement, who and how many they allow on panels, generally do not work well to update their provider information. This leads to frustration on the consumers' part as well. Behavioral health benefits are not always clear, and can be difficult to navigate.

The insurance company's process for registering therapists (who have state licenses) with the company (can take up to four months) (or a month or 120 days even to change therapists place of employment if they have already been on the insurance company's panel)

Credentialing of addictions counselling clinics, centers is also presenting itself to be a costly activity with little hope of recouping the costs. Will this lead to closings or a decline in services?

There is an industry push to integrate mental health and primary care. Chase Brexton (because FQHCs were encouraged to do this first) has an integrated model that they shared with the Work Group. Advocacy was discussed related to influencing health and behavioral codes for billing insurance in Maryland.

(Source: http://www.integration.samhsa.gov/financing/billing-tools).

The Work Group would like to explore further what the evolution of the new model – Health Care Home – would offer in terms of access and improved services for people with behavioral health symptoms.

Continuing Future Work:

Recruit and train a navigator who would help clients with a more accessible website and serve as an Ombudsman/advocate to help improve clients connect with providers.

Hire a Navigator to collaborate with practice managers/practitioners regarding best practices in screening for behavioral health issues, billing, and referral (website, education events) to community organizations.

Train primary care providers and point of entry professionals regarding resources (specialized providers) for trauma-informed care, screening, and treatment.

Advocate on behalf of providers regarding insurance issues and payment rates.

Super Users Work Group

General discussion points:

Who is a "super user" and why? The Work Group talked about the difference in the person who uses a fair number of resources so that they can stay as health and stable as possible and the person who may not be "on board" or "able" to follow a plan of care that would lead to greater health and stability. For children, the Work Group liked the Red Zone defined in the HCPSS model.

Discussions revolved around points of entry for services by these two populations and particularly via the hospital emergency room or through fire and rescue or police involvement. The Work Group then began identifying points of entry (stakeholders) for various populations – Youth (children and adolescents), Adults, Geriatrics.

It became clear to the Group that the protocols used to work with "super users" at the various points was not well known. Neither was how that point of entry identified a "super user" - three visits in three months, lack of compliance, or what?

A member shared that most professionals know what is required (additional services, transportation supports, specialized treatment etc.) but the financial infrastructure is not in place to support all the services a "super user" might need. This is true even if some services are offered – are they enough to achieve stability for this population.

Continuing Future Work:

Conduct Points of Entry research to learn more about what synergies/efficiencies could be accomplished in the care of "super users". Convene various groups to discuss findings and determine next steps.

Consider ways (like HC PIN or using CRISP differently if possible) that individuals and providers can collaborate on the care and support of the "super user" beyond what is happening today.

Consider if a case management/assessment process that helps sort out why super users are super using and if there are alternatives to assist the super user get the resources. Multidisciplinary team from organization among those who most frequently serve super users to review and problem solve care issues.

Criminal Justice System Work Group

To ensure that the membership reflected consideration of behavior health strategies incorporating Age Continuum, Diversity, and Trauma-informed care, ---and we added those who are undocumented---the group brainstormed a number of folks to invite (included are those already at the table) including folks from DHMH-Forensics, DDA, Dept. of Juvenile Services, Div. of Parole and Probation, SAO, OPD, Courts, HCHD-Addictions, Humanism, Waystation, Corrections, HCMHA, JH School of Public Health, HCPD, NAMI, Mediation and Conflict Resolution Center. *Later, after the meeting upon review of the list, it was determined that the representation above was in large part the County's Criminal Justice Partnership Committee, begun a few years ago through the efforts of MHA and Corrections, which meets quarterly. Therefore, the CJPC meeting was merged with this group meeting. January 9, 2015 8 am, District Court Judges Conference Room.*

General Discussion Points

Treatment and Service Options for Court-Involved Individuals

In FY13, the County (HCMHA) received a Transition from Jail to Community grant from the Department of Justice. The grant focuses on building better community partnerships and linkages to community services for those who are released from incarceration in the hopes of addressing recidivism for this population.

Alliance, Inc. is the state-approved mental health case management program for Howard County. Alliance serves both adults and children.

Diversion Programs by CSA:

Howard County has a Mobile Crisis Team (MCT) that works closely with the local Police Department that is then able to divert individuals from the Criminal Justice system to treatment options in the community. MCT is considered an "unofficial" diversion program. In FY15, additional county and state funds will be available to expand to two (2) MCT teams during the daytime hours.

In FY14, Howard County received funding for a Mental Health Liaison position within the local Police Department to help identify individuals/families where patrol makes repeated visits to the home/family but the needs are not public safety but linkage to various community resources. The goal is to allow early intervention and prevention of more costly services such as out of home placements for youth and inpatient/Emergency Department use. This staff position will also function as the CIT Coordinator for the Howard County Police Department.

In FY13, Howard County received a Transition from Jail to Community (TJC) grant from the Department of Justice. This grant focuses on building better community partnerships and linkages to community services for those who are released from incarceration in the hopes of addressing recidivism.

In FY15, Howard County has funded a full-time position to do an Emergency Department Follow-up Program with Howard County General Hospital, based on the SAMHSA model. Individuals who have emergency petitions (EPs) but who are not hospitalized for whatever reason, will be encouraged to consent to participate in this program, which will link them to needed community services and follow-up.

RECOMMENDATION:

The Work Group agreed to request funding for a staff position to coordinate across agencies and help individuals navigate community resources. (Note any/all individuals?) Currently there is a full-time mental health position in the Detention Center and one within the Howard County Police Department. Both work closely with the Courts, and the missing piece is a position that can follow up with individuals once they have been to Court to help them follow through on the Court's recommendations. It was also felt that individuals could be offered access to community services such as housing, finding a job, as part of this work.

Continuing Future Work:

Involve CJ-BH partners in developing inclusive strategies to:

- Divert individuals with SMI, and prevent or reduce re-offending
- Provide incentives or requirements for CJ-BH to maintain treatment
- Provide a continuum of service and intervention, understanding privacy issues.

Address any gaps in services especially if due to insurance issues.

Provide performance measures and follow-up to identify improved outcomes.

Discussion included possibility of a pilot program or initiative.

Scott Rose offered to develop a draft concept paper prior to the meeting to focus and generate discussion of the topic.

Reviewed:

Current Programs/Committee:

a. Case Conferences on individuals are arranged as needed across agencies.

b. Re-entry Coordinating Council (RCC) initiated by the Detention Center as part of the Transition from Jail to Community (TJC) national grant. This group meets every other month and is well attended by community agencies who are working with the Detention Center to assist with re-entry issues for inmates.

c. COMET – meets to discuss issues related to sex offenders in the system.

Confidentiality:

Concerns were raised about how to share information across agencies.

a. CFAP – Community Forensic Aftercare Program. Individuals are required to waive confidentiality to participate in this program.

b. Probation orders may be able to "waive confidentiality" under certain circumstances.

c. Mental Health Authority uses a consent form for residential services that allows information to be shared to all members of the committee that reviews applications.

Draft proposal on "Structured Supervision/Rehabilitative Sentencing" was presented by Scott Rose and discussed by committee. Issues discussed included:

a. Creative disposition sentencing.

b. Post court monitoring that could include a position staffed within the court system.

c. Sanctions vs. violation of probation.

Juvenile Issues:

a. It was agreed that K. Turner from the HCPD's Juvenile Diversion Program be asked to join this sub-committee.

b. T. Madden, DJS, raised issue of transition from juvenile services at 18.

Howard County Behavioral Health Task Force

WORK GROUPS

Criminal Justice

Meetings were attended by thirteen members of the existing Criminal Justice Partnership Committee of which six are also members of the Behavioral Health Task Force. Two additional members of the Task Force - Scott Rose and Brendan Saloner - also attended.

Donna Wells
Tim Madden
Lori Manning
Andrew Eckstein
Mary Murphy
Paula Langmead
Patricia Schupple
Brendan Solaner
Julie Cleveland
Roe Rodgers Bonacorsy
Robert Ehrhardt
Kathy Rockefeller
Gary Gardner
NAMI representative

Primary Care

Lisa Lomas
Joy Stephens
Becky Bell
David Leichtling
Mark Donovan
Beverley Francis-Gibson
Sheena Siddiqui
Judy Grusso
Jordan Kurtzman
Steve Snelgrove/Jordan Kurtzman/ Elizabeth Kromm
Vickie Miles
Leah Blaine
Danilsa Marcinak
Tammy Spengler
Connie Angiuli
Maura Rossman
James Brothers

Speakers: Vidia Dhanraj, DCS – HC PIN

Screening and Prevention

Tammy Spengler
Starr Sowers
Jenn Pollitt-Hill
James Brothersr
Ofelia Ross Ott
Maura Rossman
Joan Webb Scornaienchi
Judith Jakubowski
Helen Liu
Marcy
Lois Mikkila
Cynthia Schulmeyer
Kaya Swann
Adenike Ojo
Tina Maddox

Speakers: Cynthia Schulmeyer, HCPSS; Kaya Swann, DCS Children's Services; Nicole DeChirico, Grassroots; Judy, Columbia Addictions Center

Super Users

Andy Angelino
Karen Booth
Tammy Spengler
Becky Bell
Connie Angiuli
Matt Levy
Maura Rossman
Jesse Guercio
Sue Song
Helen Lann
Ayesha Holmes
Andrea Ingram
Jordan Kurtzman

Task Force Meetings

October 8, 2014 8:30 am – 10:00 am
George Howard Building, Ellicott City, MD

November 17, 2014 5:00 pm – 6:30 pm
December 9, 2014 8:00 am – 9:30 am
January 15, 2015 5:00 pm – 6:30 pm
February 12, 2015 8:00 am – 9:30 am
The meetings listed above were held at the *Roger Carter Community Center,*
3000 Milltowne Road, Ellicott City, MD

March 11, 2015 5:00 pm – 6:30 pm
Room 401, 6751 Columbia Gateway Drive, Columbia, MD

Steering Committee Meetings

September 30, 2014 3:00 pm – 4:30 pm
George Howard Building

October 20, 2014 2:45 pm – 4:30 pm
Barton Room, Health Department

November 10, 2014 Noon – 1:30 pm
Columbia Room, Health Department

December 3, 2014 3:00 pm – 4:30 pm
Howard County General Hospital Administration – Board Room
Meeting with Chair of the Transition Team for Health, Mental Health, and Social Services

February 4, 2015 10:00 am – 11:30 am
Howard County Mental Health Authority Offices

February 19, 2015 9:00 am – 10:30 am
Horizon Foundation Offices

Work Group Meetings

Criminal Justice System

Wednesday, January 28, 2015 8:00 am – 10:30 am
George Howard Building – Columbia/Ellicott City Room (first floor), Ellicott City, MD

Friday, January 9, 2015 8:00 am
Conference Room at the District Court,
3451 Court House Drive, Ellicott City, MD 21043

Tuesday, December 9, 2014 8:00 am – 9:30 am
Roger Carter Community Center, Ellicott City, MD

Primary Care

Tuesday, February 3, 2015 8:30 am – 10:00 am
Congruent Counselling, 10630 Little Patuxent Parkway, Suite 209, Columbia, MD 21044
Speaker from Department of Citizen Services re: HC PIN (provider information network)

Wednesday, January 14, 2015 8:00 am – 9:30 am
Chase Brexton, 5500 Knoll North Drive, Suite 370, Columbia, MD 21045

Tuesday, January 6, 2015 9:00 am – 10:30 am
Chase Brexton, 5500 Knoll North Drive, Suite 370, Columbia, MD 21045

Thursday, December 18, 2014 8:00 am – 10:00 am
Congruent Counseling, 10630 Little Patuxent Parkway, Suite 209, Columbia, MD 21044

Tuesday, December 9, 2014 8:00 am – 9:30 am
Roger Carter Community Center, Ellicott City, MD

Super Users

Wednesday, February 4, 2015 8:00 am – 9:30 am
Wednesday, January 14, 2015 10:00 am – 11:30 am
Wednesday, January 7, 2015 8:00 am – 9:30 am
Friday, December 19, 2014 8:00 am – 9:30 am
After the kick-off meeting, all meetings of this work group were held in the same location and offered telephone conferencing: *Howard County General's Executive Conference Room,*
5755 Cedar Lane, Columbia, MD 21044
Dial in information is: 1-800-925-9789, ACCESS CODE 5548347

Tuesday, December 9, 2014 8:30 am – 10:00 am
Roger Carter Community Center, Ellicott City, MD

Prevention and Screening

Wednesday, February 4, 2015 2:30 pm
6751 Columbia Gateway Drive, Suite 401, Columbia, MD
Speaker from Grassroots

Wednesday, January 21, 2015 2:30 pm
Focused Solutions, 5570 Sterrett Place, Suite 206, Columbia, Columbia, MD
Speakers from the Department of Citizen Service's Office of Children's Services

Tuesday, January 6, 2015 8:00 am – 9:30 am
Focused Solutions, 5570 Sterrett Place, Suite 206, Columbia, MD

Agendas and notes from the Task Force and Work Group meetings were posted on the Task Force section of www.hcmha.org along with Task Force membership, purpose, and materials of interest.

Howard County Behavioral Health Task Force

APPENDIX A

Glossary of Terms

Many thanks to the Healthy Montgomery Behavioral Work Group and the Howard County Mental Health Authority for contributions to this glossary. As the Howard County Behavioral Task Force advances its work, additions are always welcome.

Access to Care: The ability to obtain wanted or needed services in a timely manner. An individual's ability to access care is influences by:

- The availability of services (providers, facilities, etc.)
- The availability of appointments
- the cultural competency of providers, including language capabilities and cultural understanding
- The ability to pay for services, either through health insurance or out-of-pocket; and
- The individual's understanding of how to access care.

ACT

Action Step: The specific action(s) that will be taken to achieve each stated objective and strategy.

Age-adjustment: Age-adjustment is a method of adjustment applied to data estimates to control for differences due only to differences in age composition; usually done when comparing two or more populations (such as race/ethnic groups) at one point in time or one population at two or more points in time.

Behavioral Health: For the purposes of the Howard County task force, behavioral health refers to mental health, abuse of legal and illegal substances, and tobacco use.

Benchmark: Originally, benchmark meant the real best performance level, somewhat like "best of breed" in dog shows. Usage has evolved to mean a standard of reference to which an outcome is compared. Examples include Health People goals, the state of Maryland, or peer counties.

CIT

Community: For the purposes of this process, community is defined as not only the collective community of county residents, but also to the various constituent communities defined by geography, language, race, ethnicity, genders, age, sexual orientation, health status, disability status, or a combination of these attributes.

Contributing Factor: A scientifically established factor that directly affects the level of a risk factor.

Determinants of Health: Factors that contribute to a person's current state of health. These factors may be biological, socioeconomic, psychosocial, behavioral, or social in nature (DCD and Health People):

- Biology and genetics (i.e. sex and age)
- Individual behavior (i.e. alcohol use, injection drug use (needles), unprotected sex, and smoking)
- Social environment (i.e. discrimination, income, and gender)
- Physical environment (i.e. where a person lives and crowding conditions)
- Health services (i.e. access to quality health care and having or not having health insurance)

Dimensions: Divisions of the data into sub-groups. For example, age, race/ethnicity, or geographic area.

Environmental Scan: Review of data sources and past needs assessments in Howard County.

Health: a state of complete physical, mental, and social well-being and not merely the absence of disease of infirmity (WHO).

Health Equity: absence of systematic disparities in health (or in the major social determinance of health) between groups with different social advantages/disadvantages (i.e. wealth, power, prestige).

Health inequities: Differences in the health status, morbidity, and mortality rates that are systematic, avoidable, unfair, and unjust whereby certain segments of the population fare better or worse than others. These differences do not occur randomly as they are caused by systems of power and privilege, policies and the implementation of those policies.

Indicator: A measurement that reflects the status of a social, economic, or environmental system. An indicator must be valid, reliable, relevant, specific, and se3nsitive. IT must also have a reference group, such as the Maryland State average or the performance of all other Maryland counties.

Indirect Contributing Factor: Community-specific factor that directly affects the level of the direct contributing factors.

Mental Health: A state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community. (WHO)

Network of Care for Behavioral Health: an online information site for individuals, families, and agencies concerned with mental and emotional wellness. This online community provides information, communication, and advocacy tools with a single point of entry for the following:

+ Services Directory – provides information about local community-based organizations
+ Library – offers evidence-based information on more than 4,000 health topics
+ Legislative – offers bill tracking for state and federal legislation, email alerts, and direct email connection with legislators
+ Links
+ Insurance coverage
+ Support and Advocacy – for individuals and family members living with mental illness
+ My Folder – a private, secure place to keep important personal information about community support services and a wellness recovery action plan (WRAP).

Objective: A specific, measurable change in health status or behavior; objectives add specificity to goals by stating "who, what, when, and where" and by stipulating "hoe many, by how much, and how often." They typically begin with active verbs such as "increase, decrease, create, reduce, establish".

+ Impact Objective: a goal for the level to which a direct determinant or risk factor I expected to be reduced. An impact objective is intermediate (one to five years) in length of time and measurable. These are statements about how much and when the program should affect the determinant.
+ Outcome Objective: a goal for the level to which a health problem should be reduced within a specific time period. It is long-term (within five years) and measurable. These are statements about how much and when the program should affect the health problem.

+ SMART Objective Characteristics:

  Specific – what will change and for who?

  Measurable – is it quantifiable and can we measure it?

  Attainable – can we accomplish this in the time-frame with the resources we have?

  Relevant – is it directly related to the underlying causes or problem we are trying to change?

  Time-specific – have we defined when this will be accomplished?

PARITY

Risk Factors: Direct causes and determinants which, based on scientific evidence or theory, are thought to relate directly to the level of a specific health problems. A health problem may have any number of risk factors associated with it (CDC)

Social Determinants of Health: complex social and economic circumstances, in which people are born, grow up, live, and work. These circumstances are shaped by a wider set of forces including economics, social policies, and politics. Examples of social determinants of health include socioeconomic status, discrimination, housing, physical environment, food security, child development, culture, social support, healthcare services, transportation, working conditions, and democrative participation (CDC and others).

Strategy: The method, approach, or process that will achieve the stated goal(s) and objective(s). It describes how you will go about accomplishing your action plan and specifically answers the question "How can we get from where we currently are to where we want to be?"

Substance Abuse: According to Merriam-Webster: "excessive use of drug (as alcohol, narcotics, or cocaine); use of a drug without medical justification."

Tobacco Use: According to the National Institutes of Health: "any habitual use of the tobacco plant leaf and its products."

Unhealthy Behavior: a patterned behavior regarded as detrimental to one's physical or mental health.

Acronyms

Acquired Brain Injury ..... ABI
Administrative Services Organization..... ASO
Assertive Community Treatment ..... ACT
Association of Community Services ..... ACS
Behavioral Health Administration (MHA/ADAA)..... BHA
Center for Mental Health Services ..... CMHS
Clifton T. Perkins Hospital ..... CTPH
Community Action Council ..... CAC
Community Criminal Justice Treatment Project (Detention Center Grant) .... CCJTP
Community Emergency Response Network..... CERN
Consumer Quality Team..... CQT
Core Service Agency..... CSA
Crisis Intervention Team ..... CIT
Department of Health & Mental Hygiene .....DHMH
Department of Juvenile Services .....DJS
Depression & Related Affective Disorders Association ..... DRADA
Dept. of Social Services ..... DSS
Developmental Disabilities Administration .....DDA
Division of Rehabilitation Services.....DORS
Domestic Violence Center..... DVC
Evidence-Based Practice .....EBP
Federal Emergency Management Agency .....FEMA
Foreign-Born Information & Referral Network..... F.I.R.N.
Health Care Policy & Planning Committee .....HCP&P
Housing and Urban Development.....HUD
Howard Community College ..... HCC
Howard County General Hospital..... HCGH
Howard County Mental Health Authority .....HCMHA
Howard County Public School System .....HCPSS
J.P. Hoyer Early Child Care & Education Center .....Judy Center
Local Children's Board (aka Local Management Board, LMB).....LCB
Local Coordinating Council LCC
Maryland Association of Core Service Agencies ..... MACSA
Maryland Emergency Management Agency .....MEMA
MD Coalition of Families .....MCF
MD Disabilities Law Center.....MDLC
Medical Assistance..... MA
Medicare ..... MC
Mental Health Association of MD..... MHAMD
Mental Health Disaster Team ..... MHDT
Mobile Crisis Team.....MCT
Mobile Treatment Services ..... MTS
National Alliance on Mental Illness .....NAMI

Network of Care . . . . . NOC
On Our Own of Howard County . . . . . OOOHC
On Our Own of MD . . . . . OOOMD
Outpatient Mental Health Clinic . . . . . OMHC
Primary Adult Care . . . . . PAC
Psychiatric Rehabilitation Program . . . . . PRP
Request for Expression of Interest . . . . . REI
Request for Proposals . . . . . RFP
Residential Rehabilitation Program . . . . . RRP
Resource Coordinator . . . . . RC
Shelter Plus Care . . . . . SPC
Social Security Administration . . . . . SSA
Social Security Disability Insurance . . . . . SSDI
Spring Grove Hospital Center . . . . . SGHC
Springfield Hospital Center . . . . . SHC
Substance Abuse & Mental Health Services Administration . . . . . SAMHSA
Supplemental Security Insurance . . . . . SSI
Supported Employment . . . . . SE
Transformation Workgroup . . . . . TWG
Transition-Age Youth . . . . . TAY
Traumatic Brain Injury . . . . . TBI
Value Options . . . . . VO/ASO
Wellness Recovery Action Plan . . . . . WRAP

Howard County Behavioral Health Task Force

APPENDIX B

Howard County Behavioral Health Data

Howard County
Local Health Improvement Coalition (LHIC)
Behavioral Health Work Group
Presentation to the
Howard County Mental Health Task Force

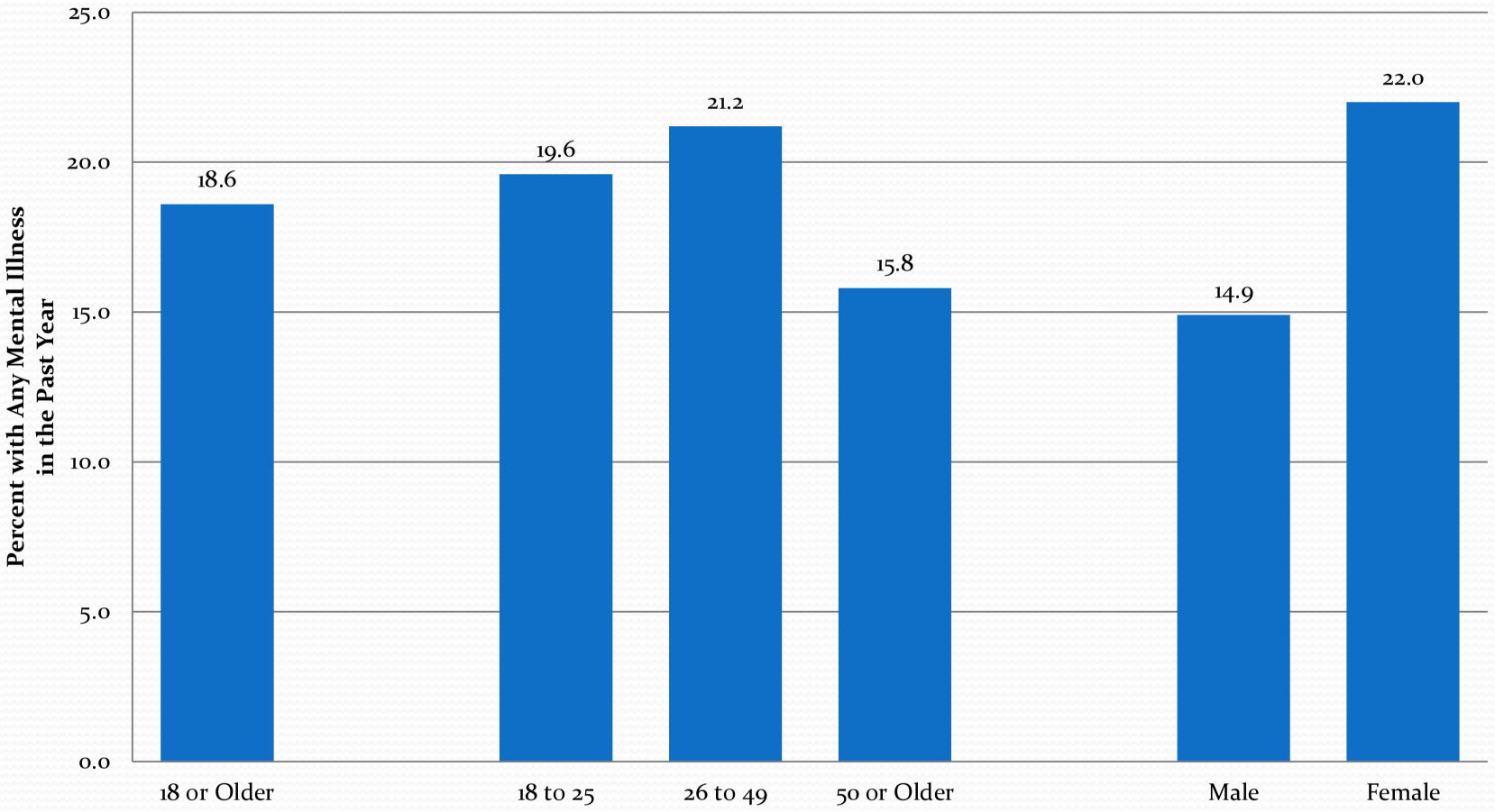
Dr. Maura Rossman
Howard County Health Officer
October 8, 2014

Outline

- Prevalence of Behavioral Health Disorders - National and Local Data
- Inpatient and Emergency Department Data
- Gap Analysis
- Stories

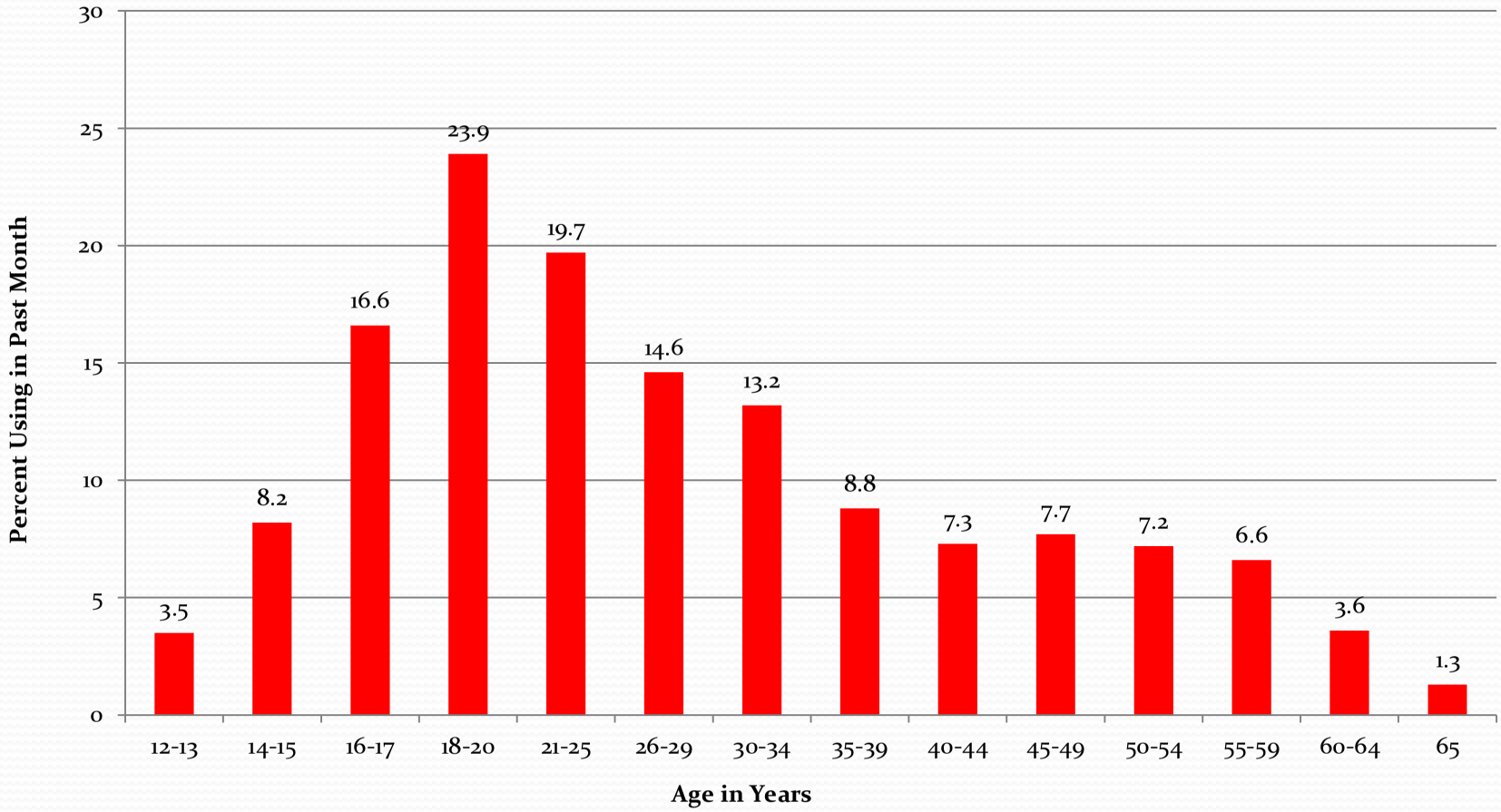
Prevalence of Behavioral Health Disorders – National Data

Mental Illness in the Past Year among Adults: 2012



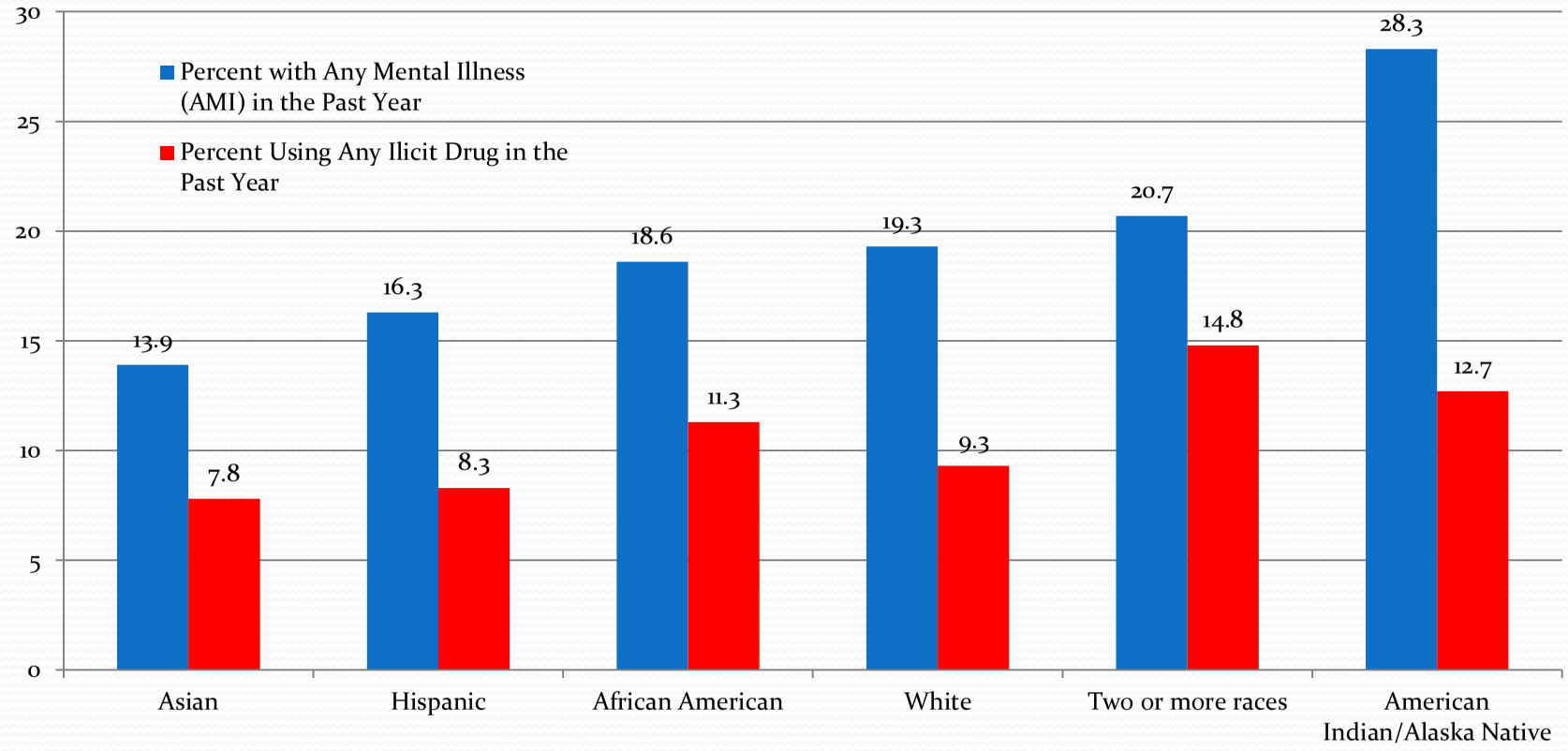
Substance Abuse and Mental Health Services Administration, *Results from the 2012 National Survey on Drug Use and Health: Mental Health Findings*, NSDUH Series H-47, HHS Publication No. (SMA) 13-4805. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2013.

Past Month Illicit Drug Use among Persons Aged 12 or Older, By Age: 2012



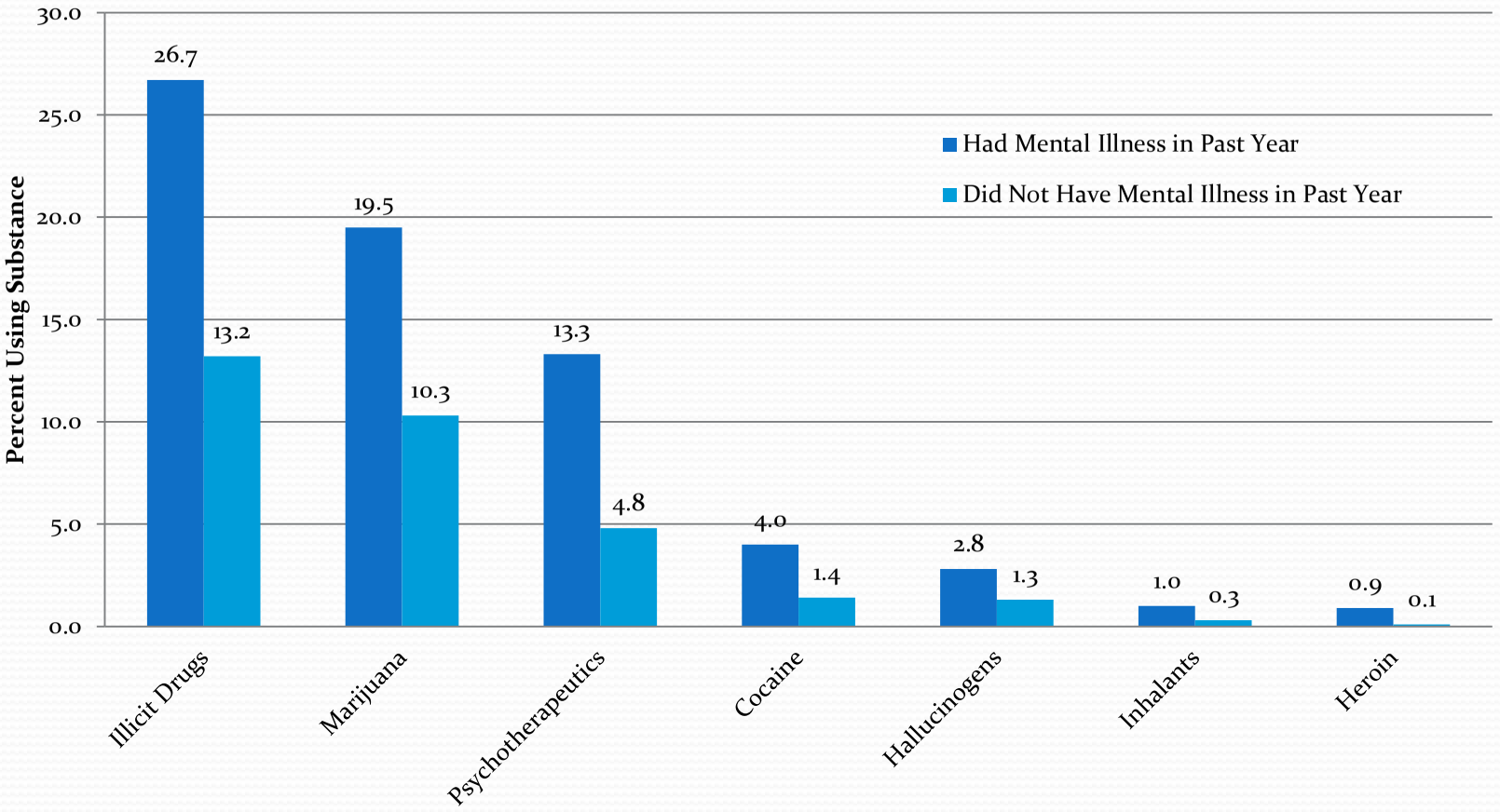
Substance Abuse and Mental Health Services Administration, *Results from the 2012 National Survey on Drug Use and Health: Mental Health Findings*, NSDUH Series H-47, HHS Publication No. (SMA) 13-4805. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2013.

Mental Illness and Illicit Substance Use in the Past Year among Adults by Race: 2012



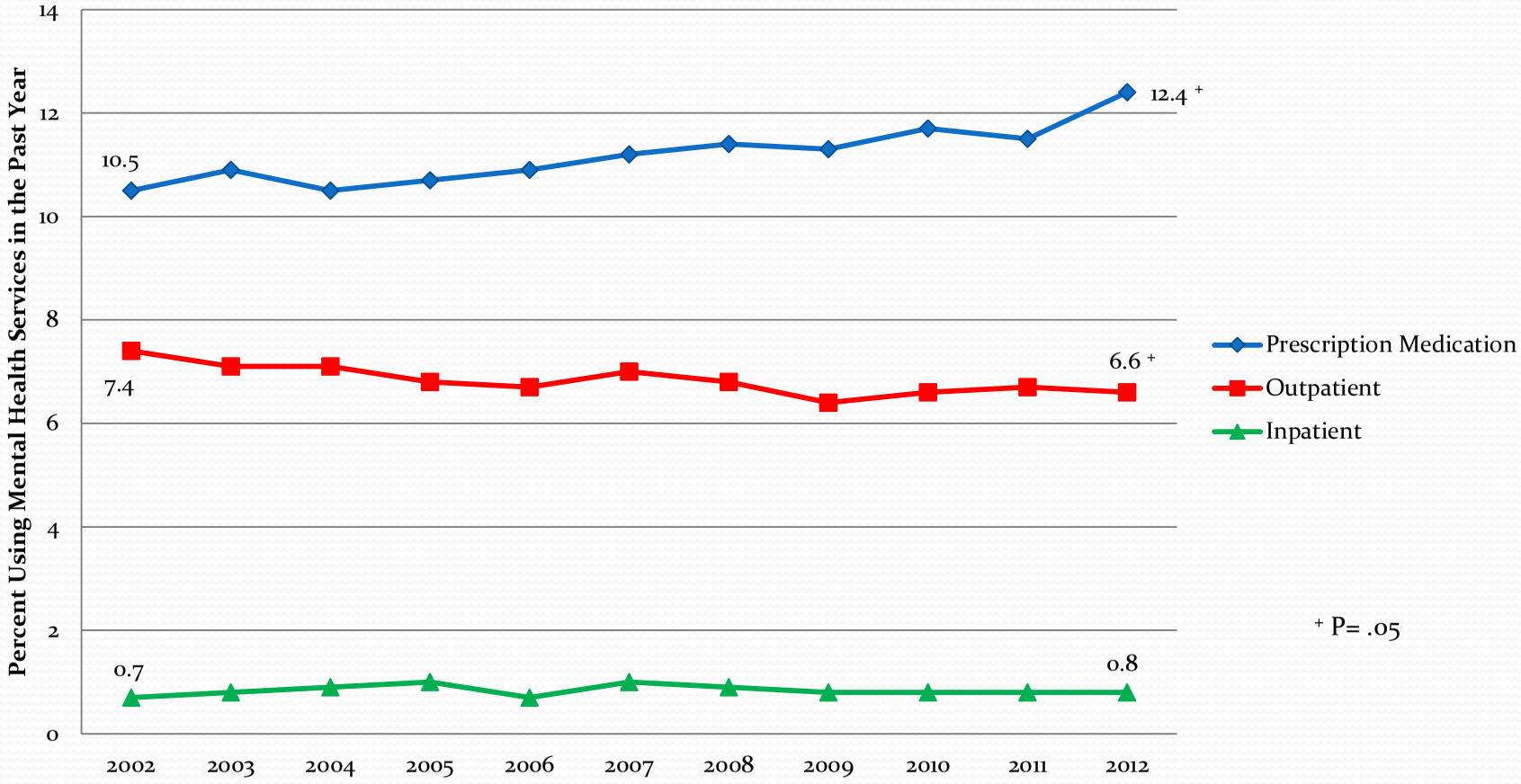
Substance Abuse and Mental Health Services Administration, *Results from the 2012 National Survey on Drug Use and Health: Mental Health Findings*, NSDUH Series H-47, HHS Publication No. (SMA) 13-4805. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2013.

Past Year Substance Use among Adults by Any Mental Illness: 2012



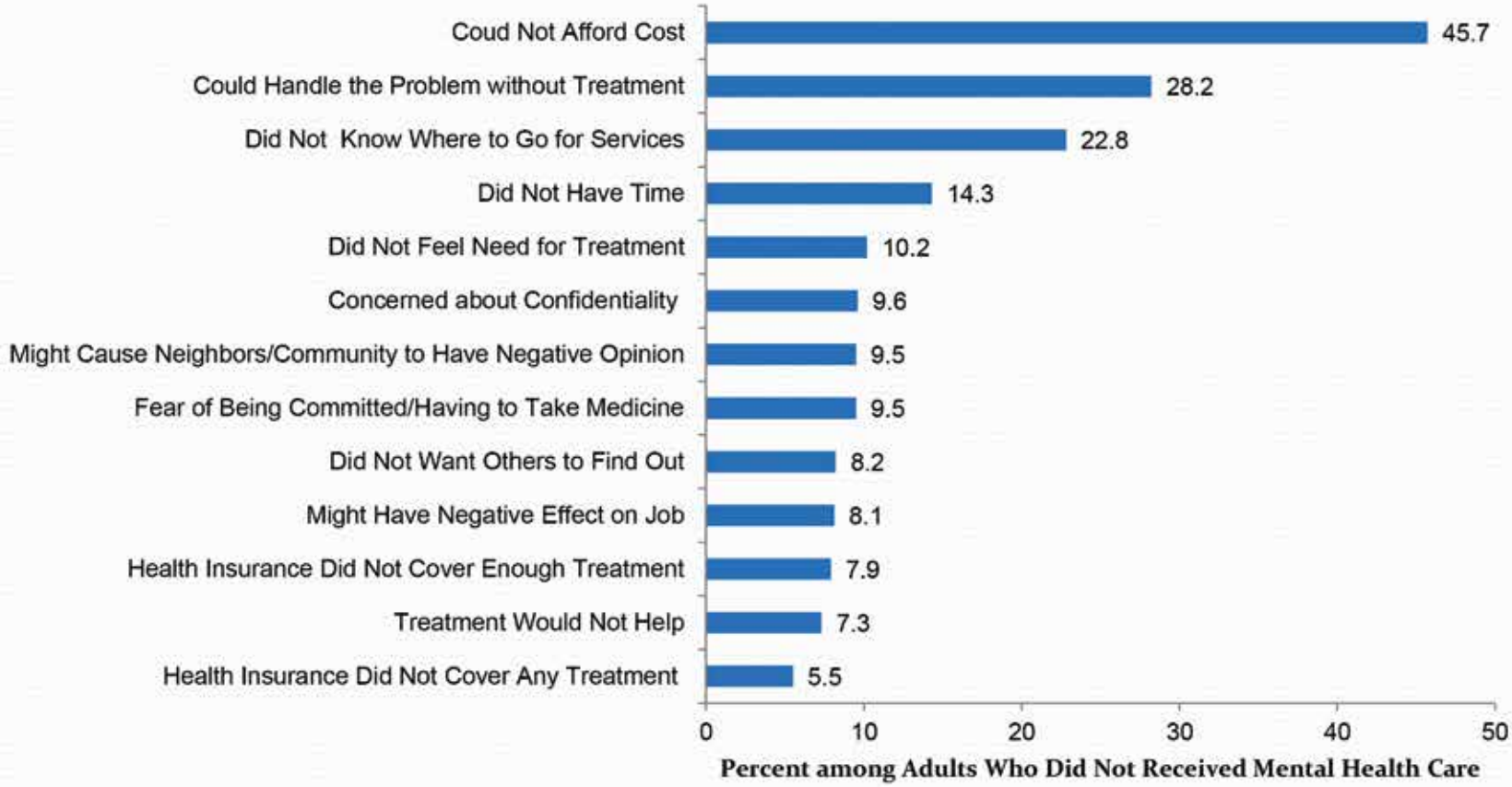
Substance Abuse and Mental Health Services Administration, *Results from the 2012 National Survey on Drug Use and Health: Mental Health Findings*, NSDUH Series H-47, HHS Publication No. (SMA) 13-4805. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2013.

Past Year Mental Health Service Use among Adults by Type of Care: 2002-2012



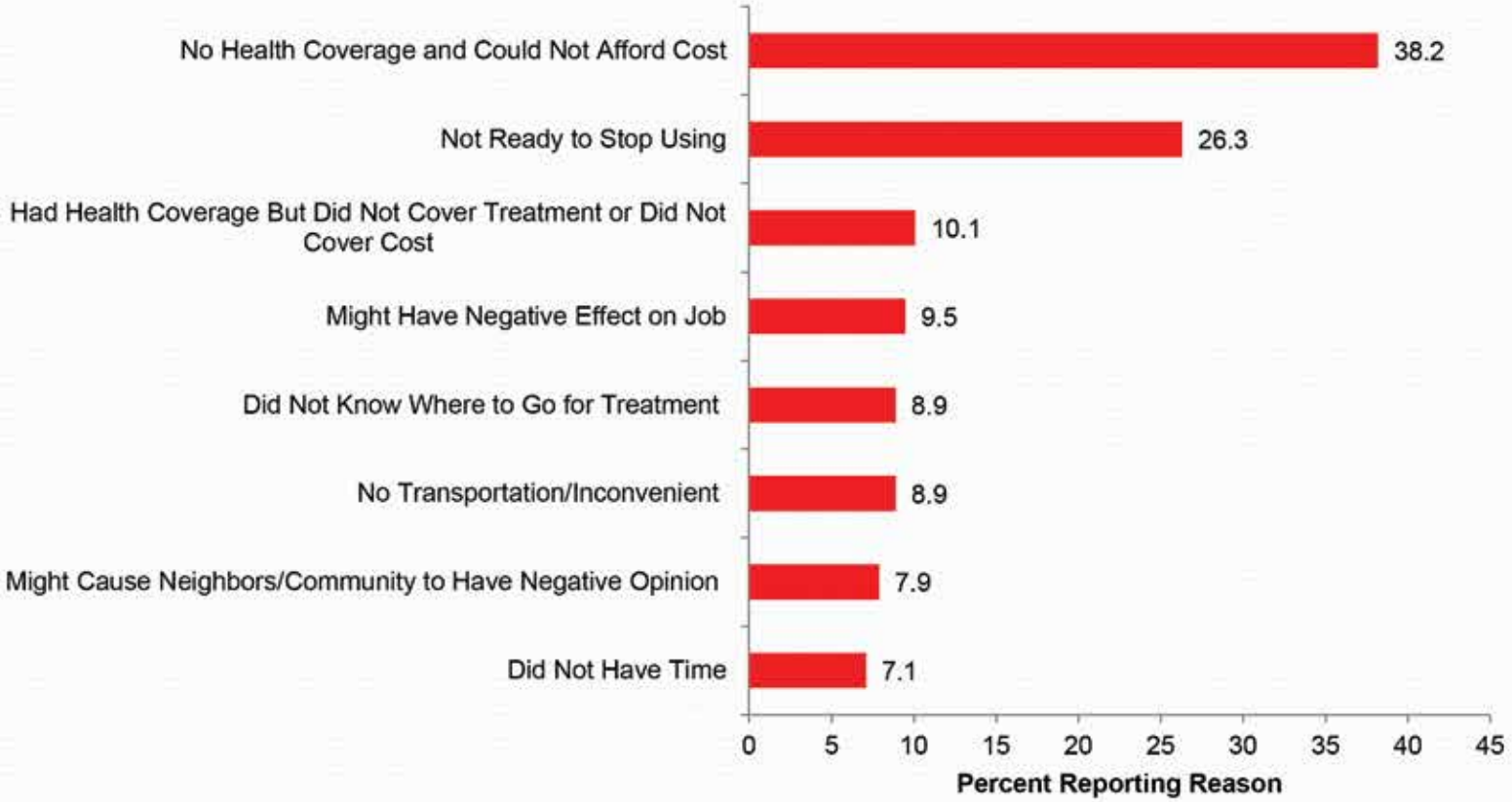
Substance Abuse and Mental Health Services Administration, *Results from the 2012 National Survey on Drug Use and Health: Mental Health Findings*, NSDUH Series H-47, HHS Publication No. (SMA) 13-4805. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2013.

Reasons for Not Receiving Mental Health Services in the Past Year among Adults: 2012



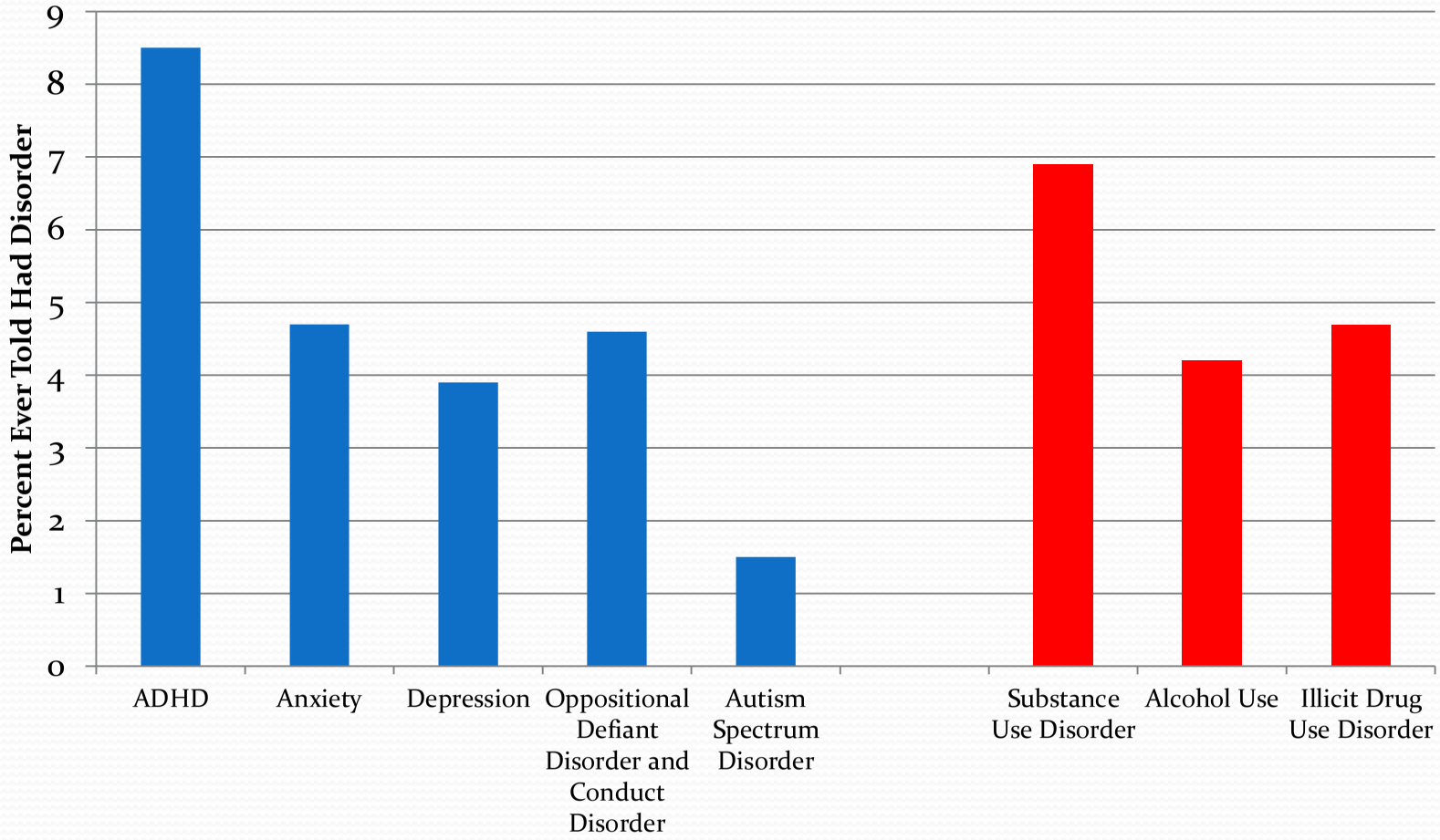
Substance Abuse and Mental Health Services Administration, *Results from the 2012 National Survey on Drug Use and Health: Mental Health Findings*, NSDUH Series H-47, HHS Publication No. (SMA) 13-4805. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2013.

Reasons for Not Receiving Substance Use Treatment among Persons Aged 12 or Older: 2009-2012 Combined



Substance Abuse and Mental Health Services Administration, *Results from the 2012 National Survey on Drug Use and Health: Mental Health Findings*, NSDUH Series H-47, HHS Publication No. (SMA) 13-4805. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2013.

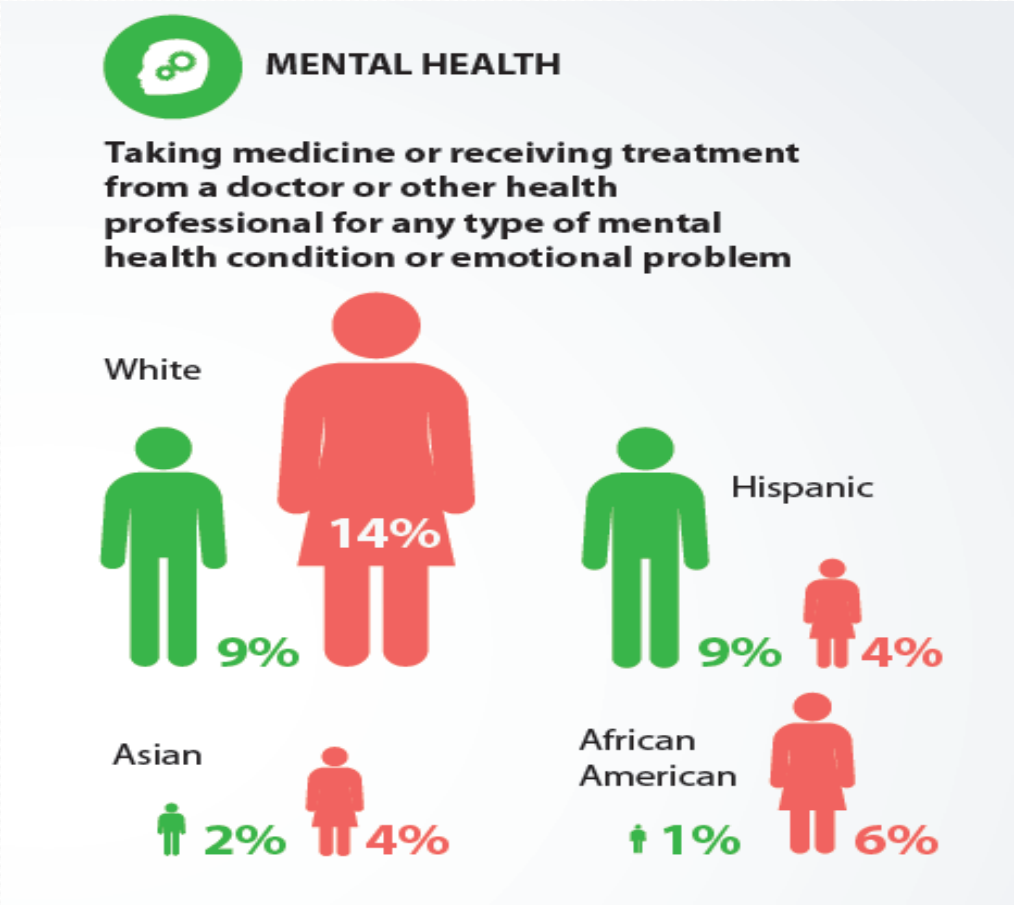
Mental Health/Substance Use Disorders Among Children and Adolescents



Morbidity and Mortality Weekly Report, Mental Health Surveillance Among Children — United States, 2005–2011

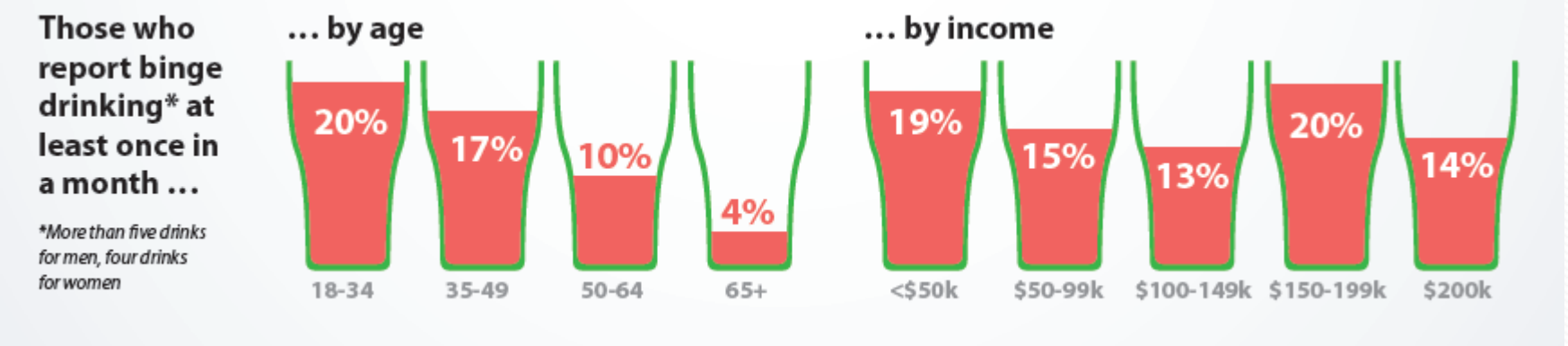
Prevalence of Behavioral Health Disorders – Local Data

Mental Health Medications or Treatment among Adults: Howard County, 2012



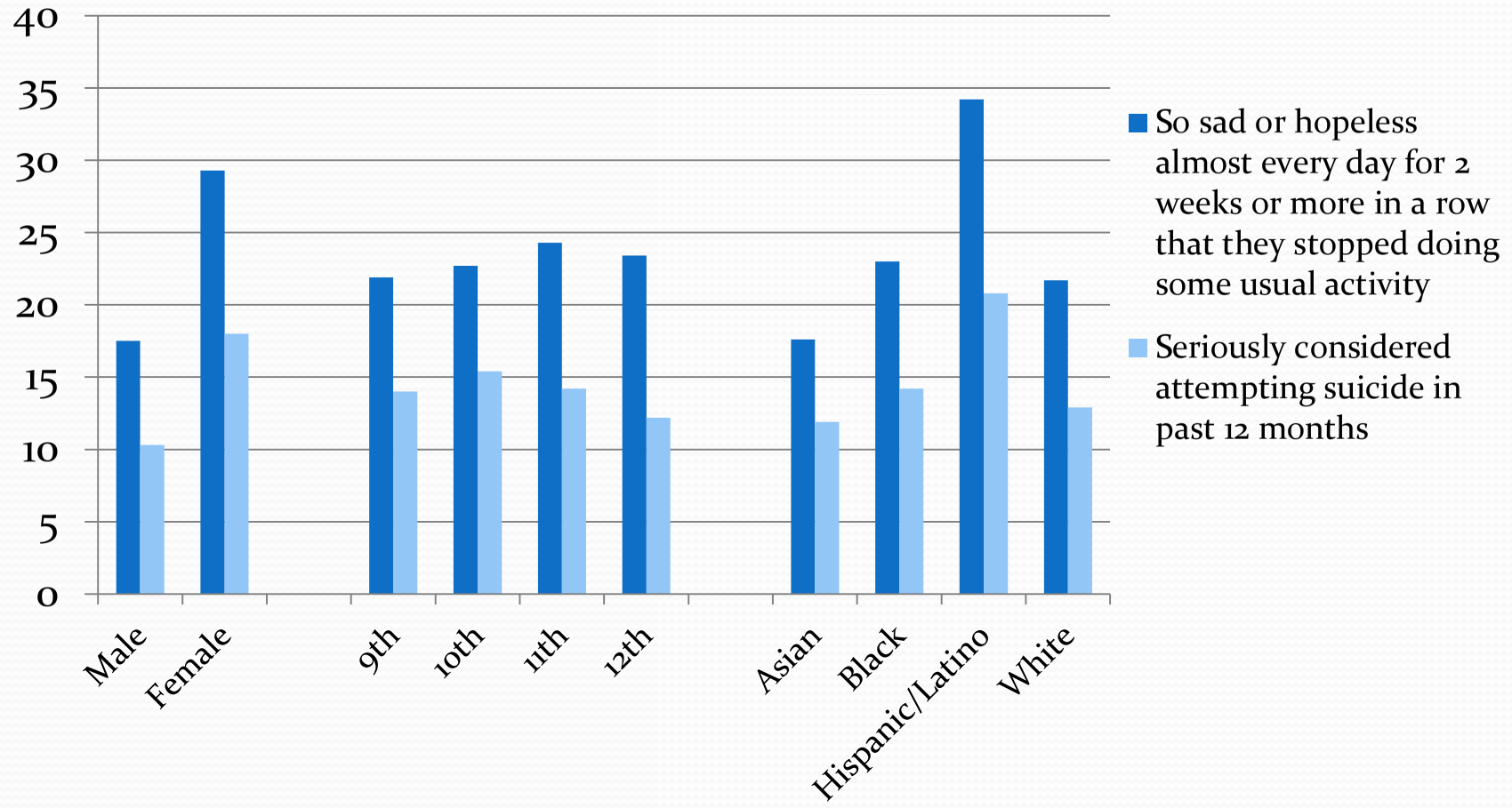
Howard County Health Assessment Survey, 2012.

Binge Drinking among Adults: Howard County, 2012



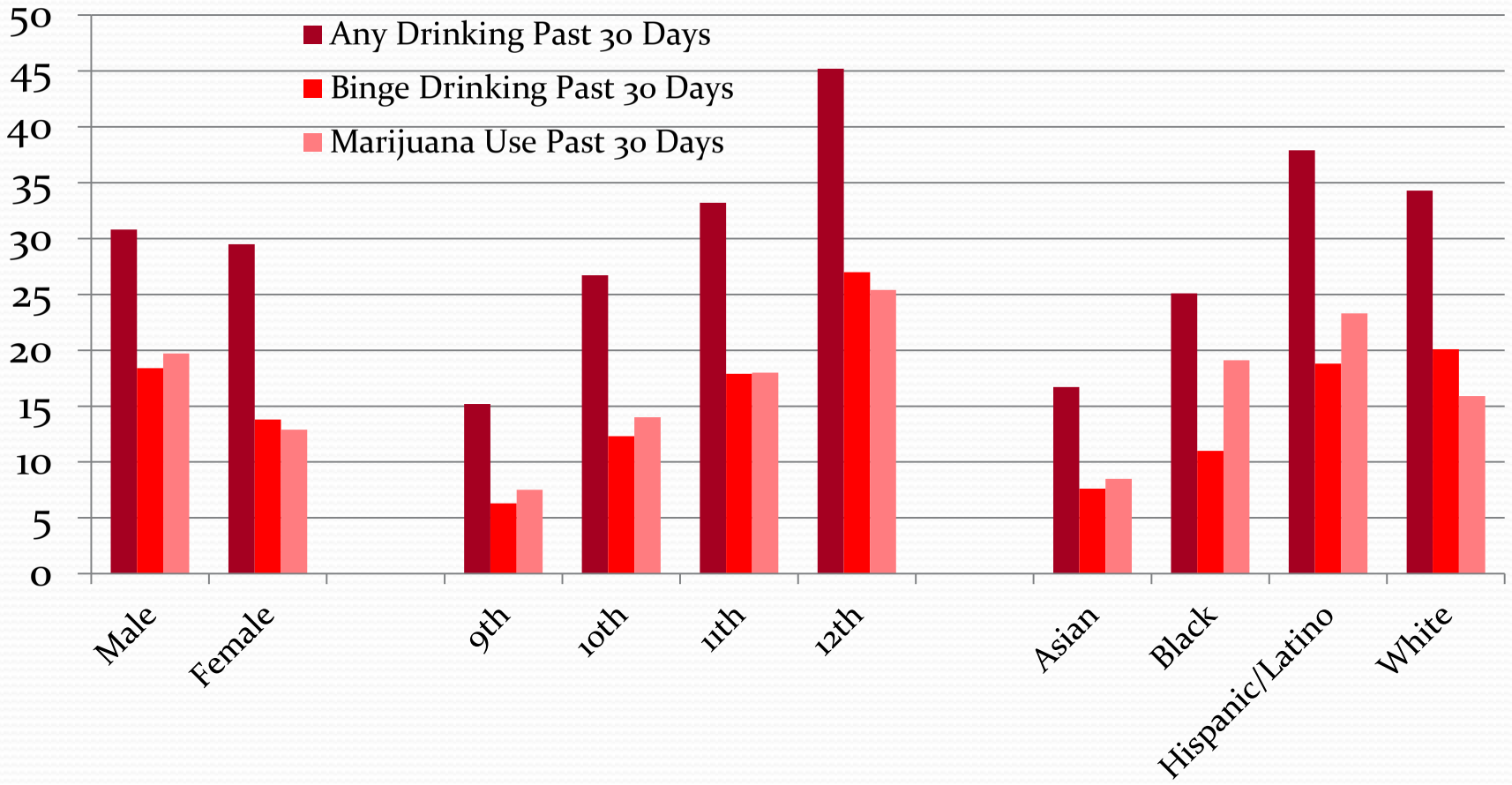
Howard County Health Assessment Survey, 2012.

Percentage of Howard County High School Students Experiencing Depression or Contemplating Suicide



Maryland Youth Risk Behavior Survey, 2013.

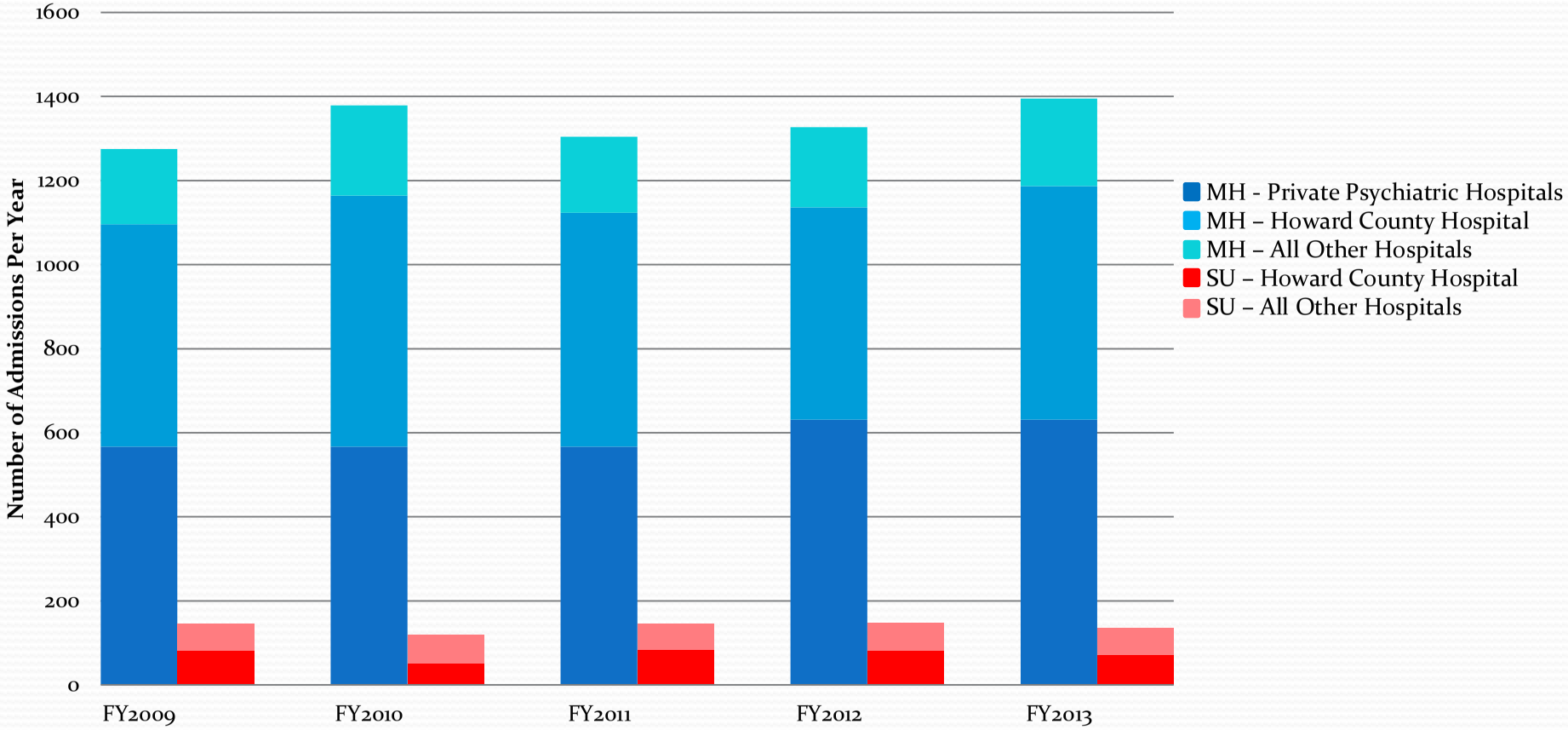
Percentage of Howard County High School Students Reporting Drinking or Marijuana Use



Maryland Youth Risk Behavior Survey, 2013.

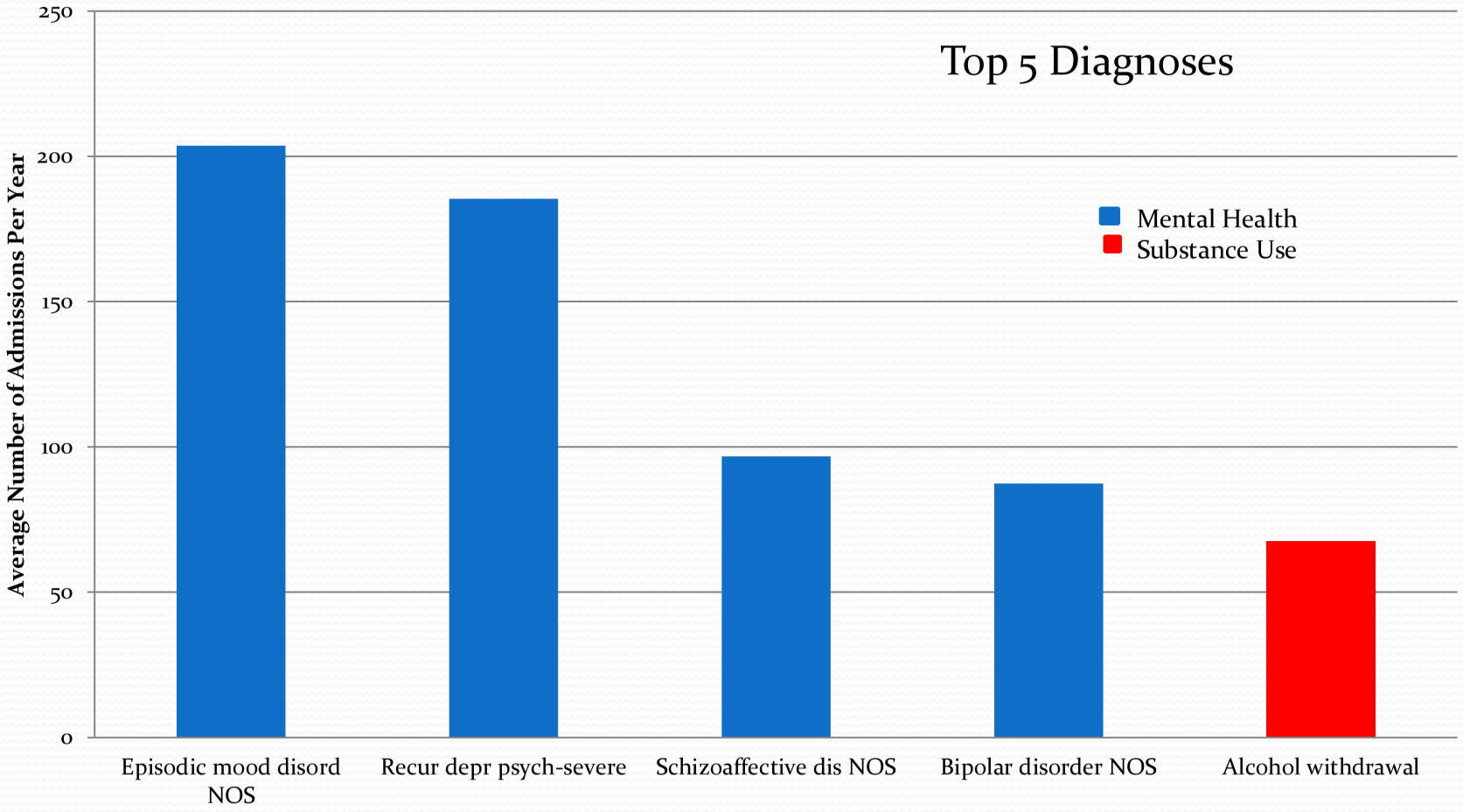
Maryland Hospital Inpatient Admissions for Behavioral Health Conditions by Howard County Residents

Mental Health/Substance Use Inpatient Admissions FY09-13



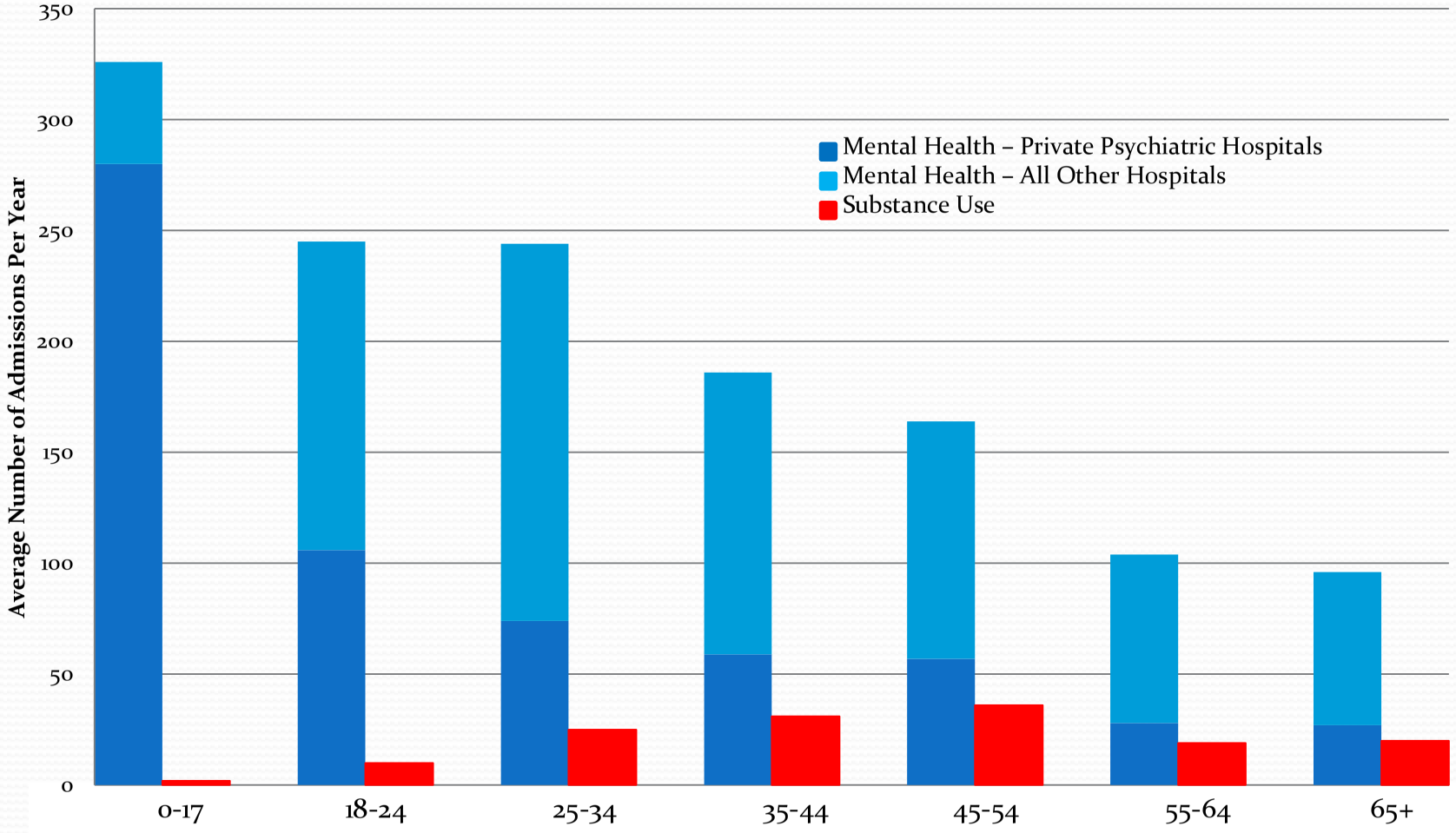
Maryland Health Services Cost Review Commission (HSCRC) Hospital Data

Mental Health/Substance Use Inpatient Admissions FY09-11 by Primary Diagnosis



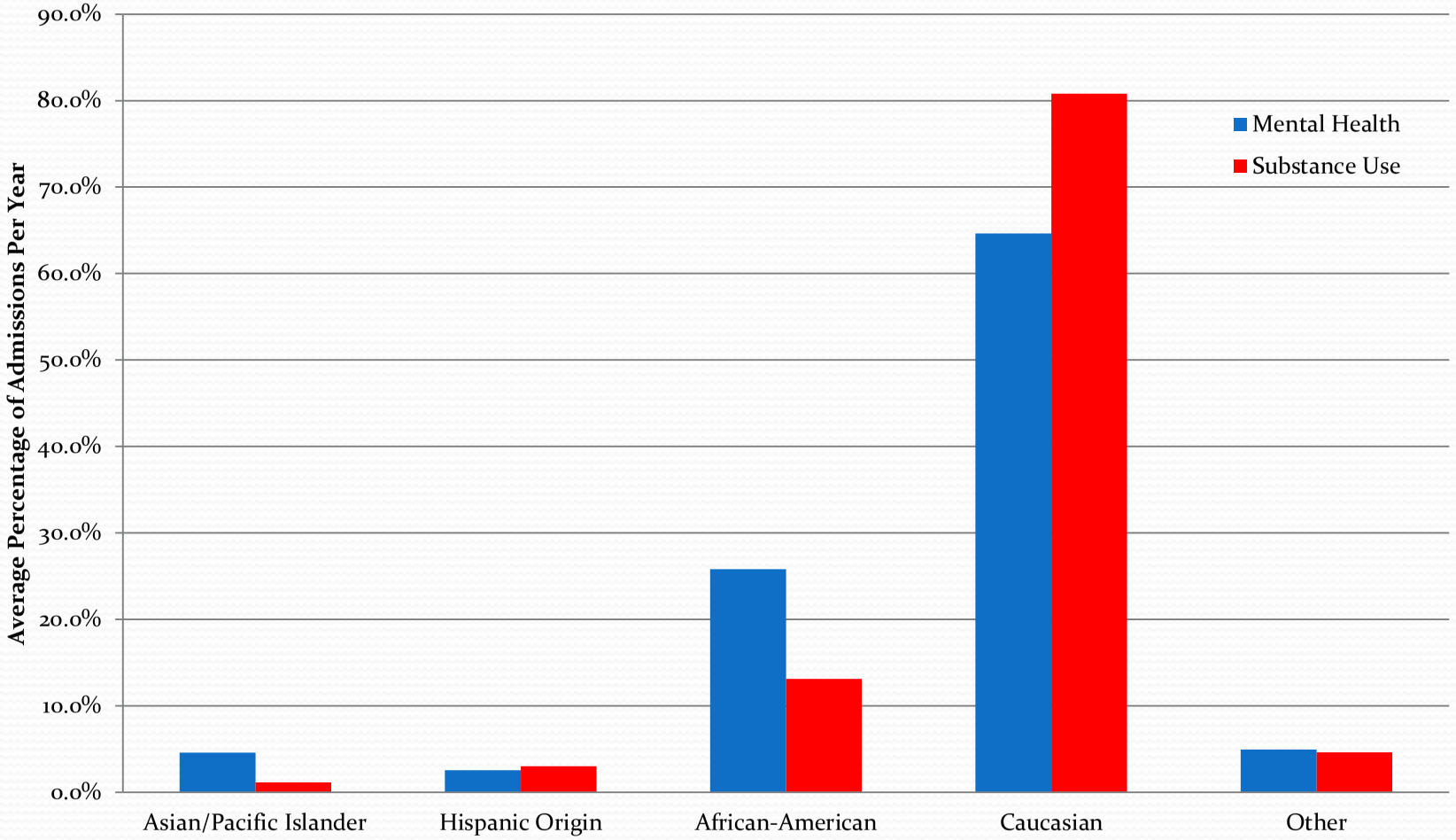
Maryland Health Services Cost Review Commission (HSCRC) Hospital Data

Mental Health/Substance Use Inpatient Admissions FY12-13 By Age



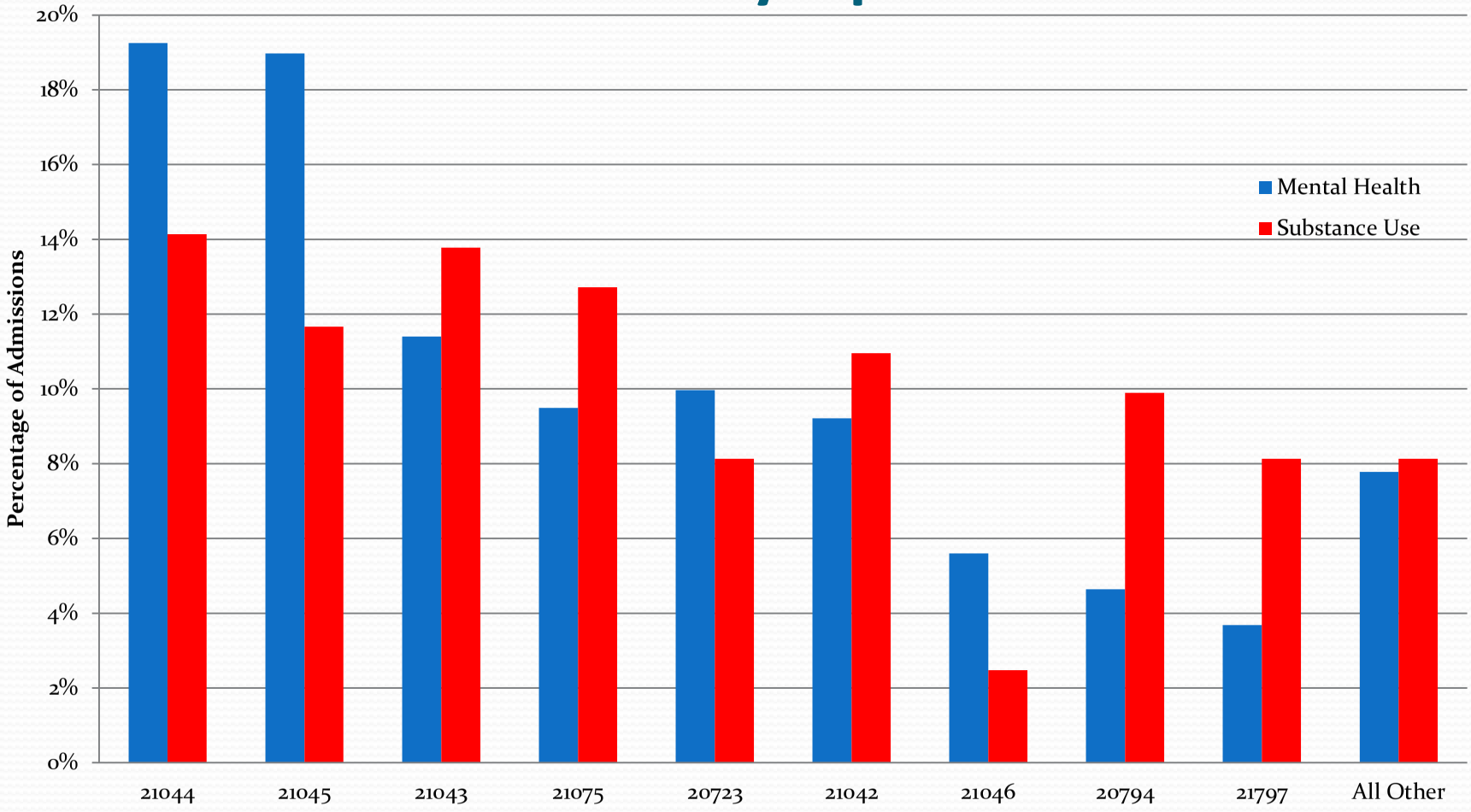
Maryland Health Services Cost Review Commission (HSCRC) Hospital Data

Mental Health/Substance Use Inpatient Admissions FY09-13 By Race and Ethnicity



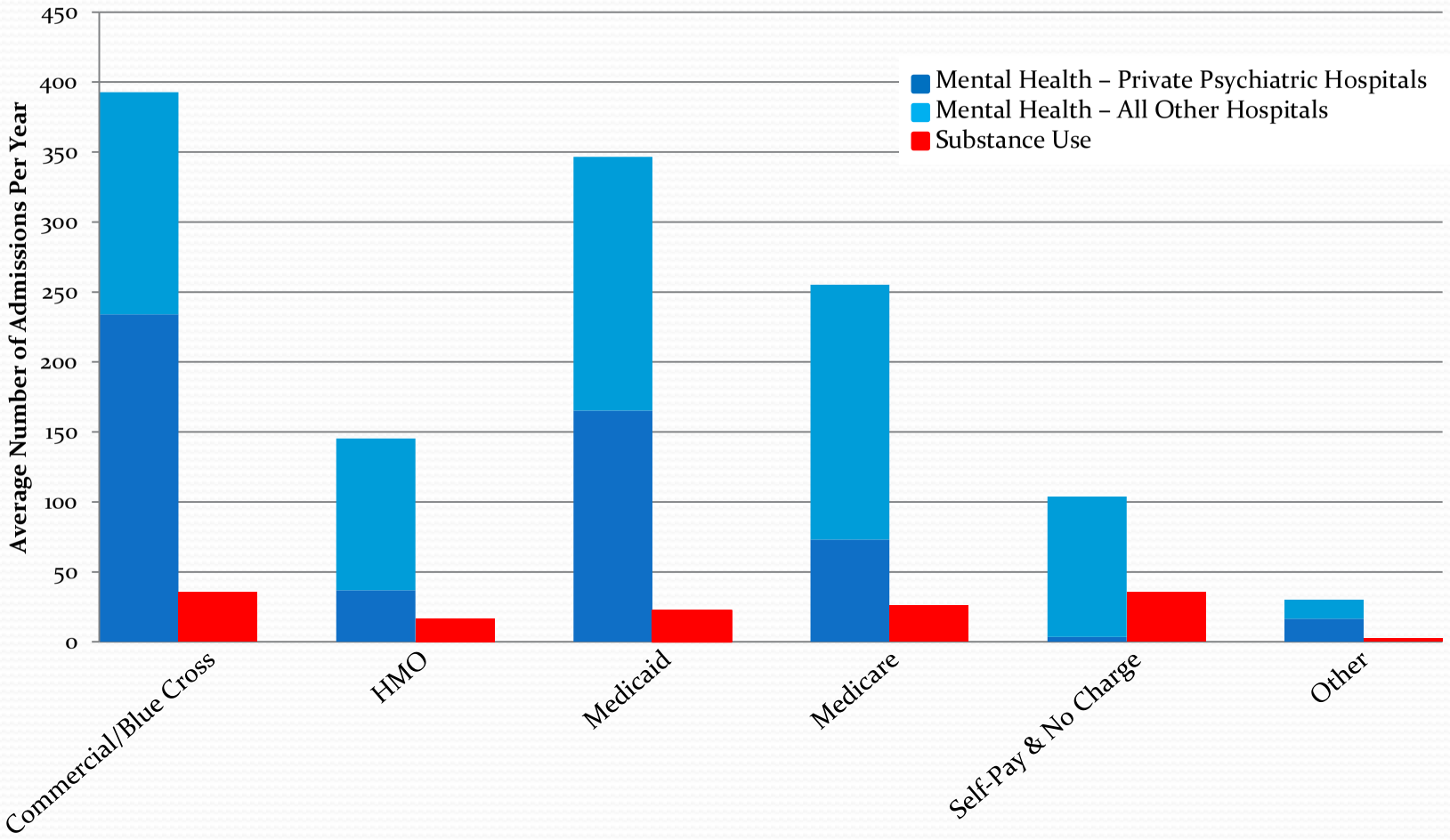
Maryland Health Services Cost Review Commission (HSCRC) Hospital Data

Mental Health/Substance Use Admissions FY12-13 By Zip Code



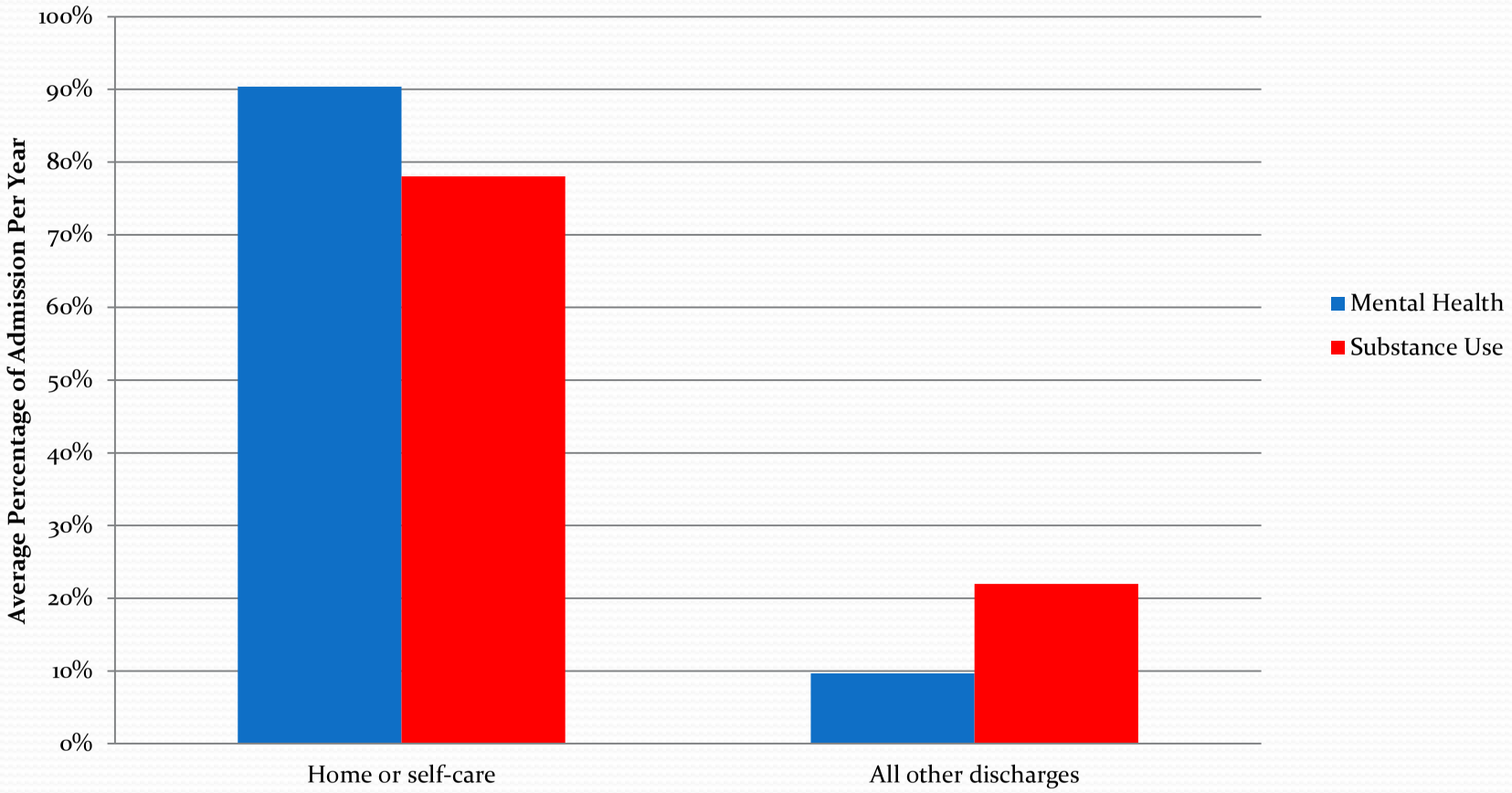
Maryland Health Services Cost Review Commission (HSCRC) Hospital Data

Mental Health/Substance Use Inpatient Admissions FY09-13 By Payer



Maryland Health Services Cost Review Commission (HSCRC) Hospital Data

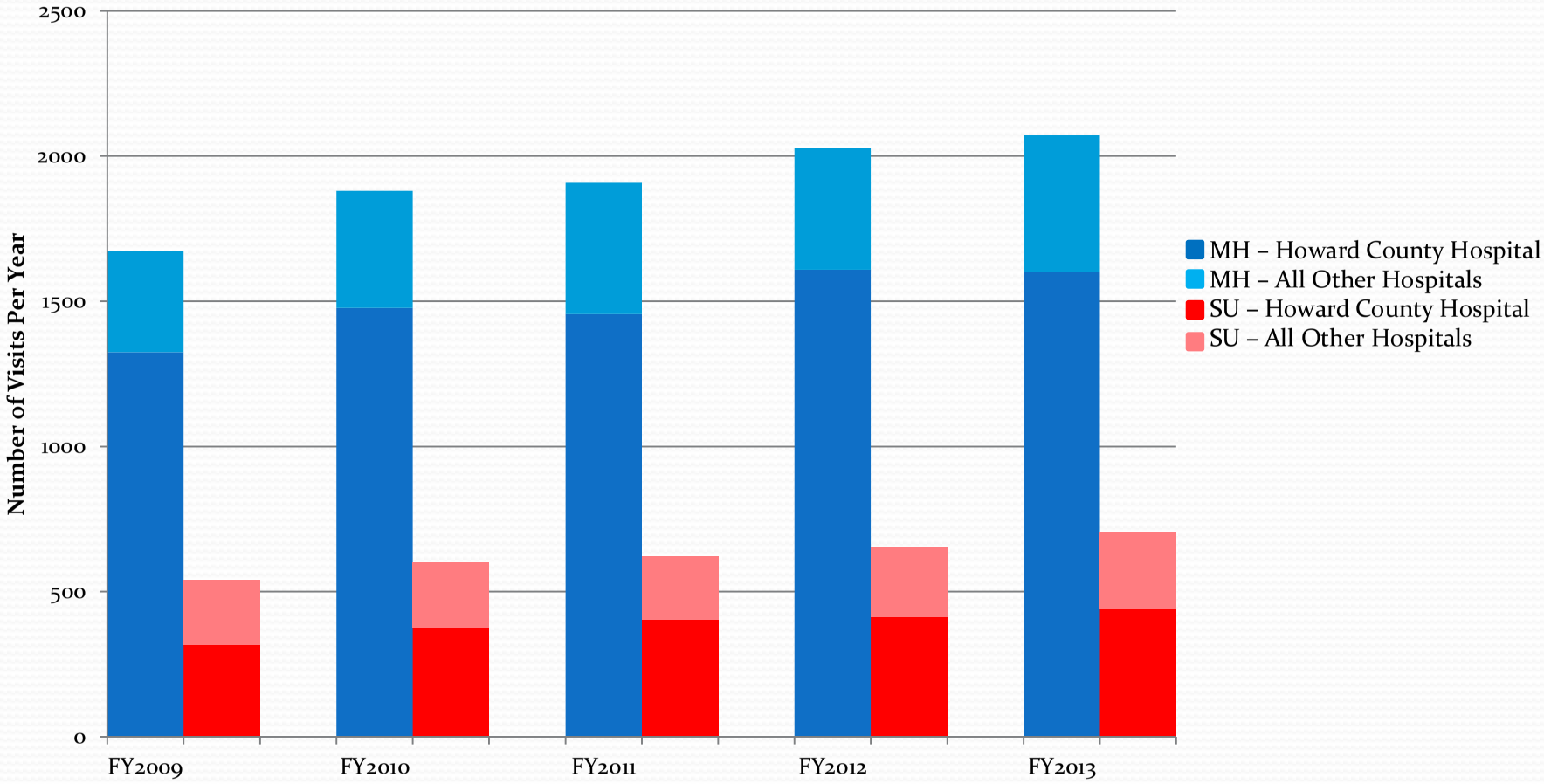
Mental Health/Substance Use Discharges FY12-13



Maryland Health Services Cost Review Commission (HSCRC) Hospital Data

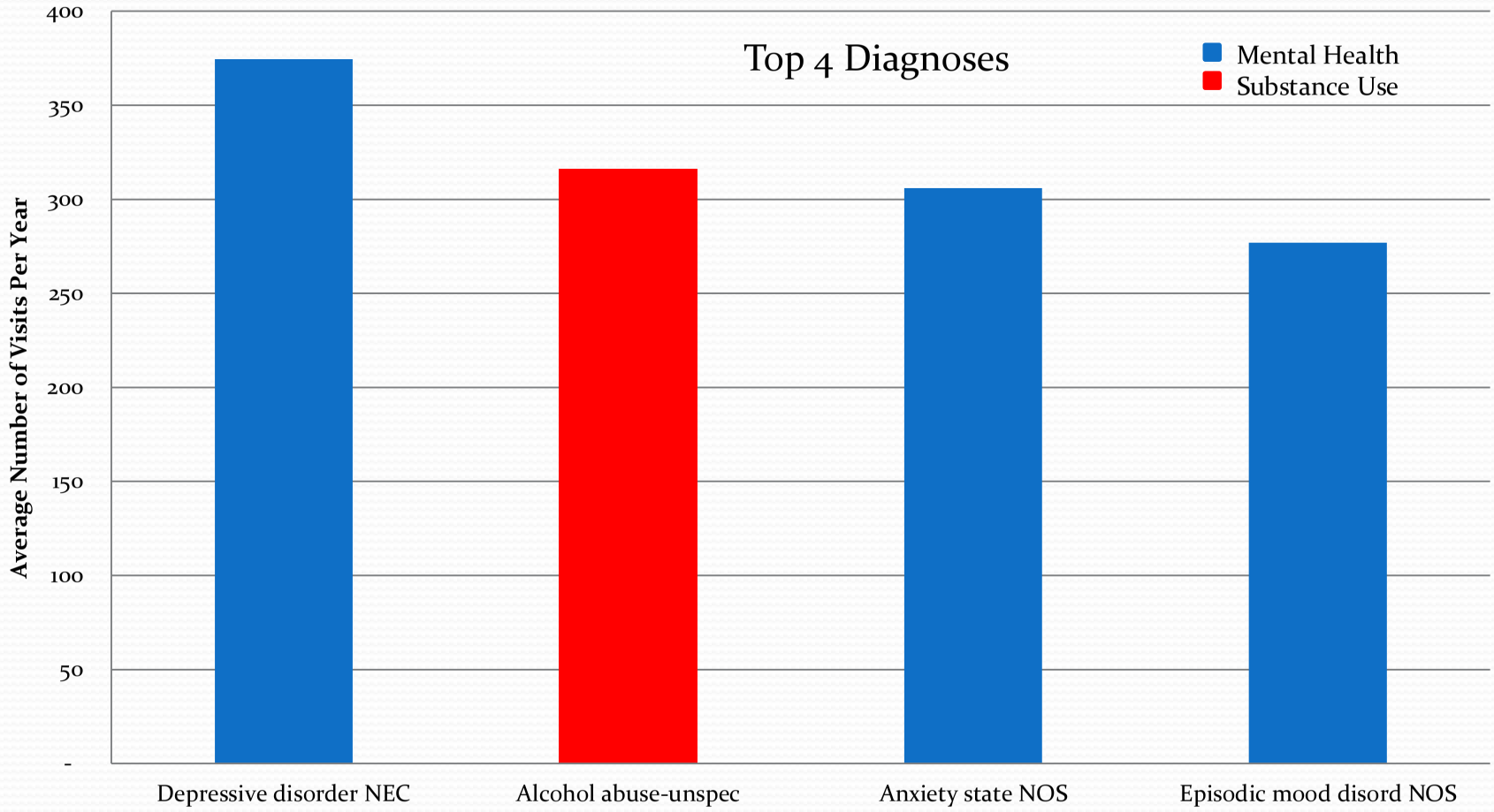
Maryland Hospital Emergency Department Visits for Behavioral Health Conditions by Howard County Residents

Mental Health/Substance Use ED Visits FY09-13



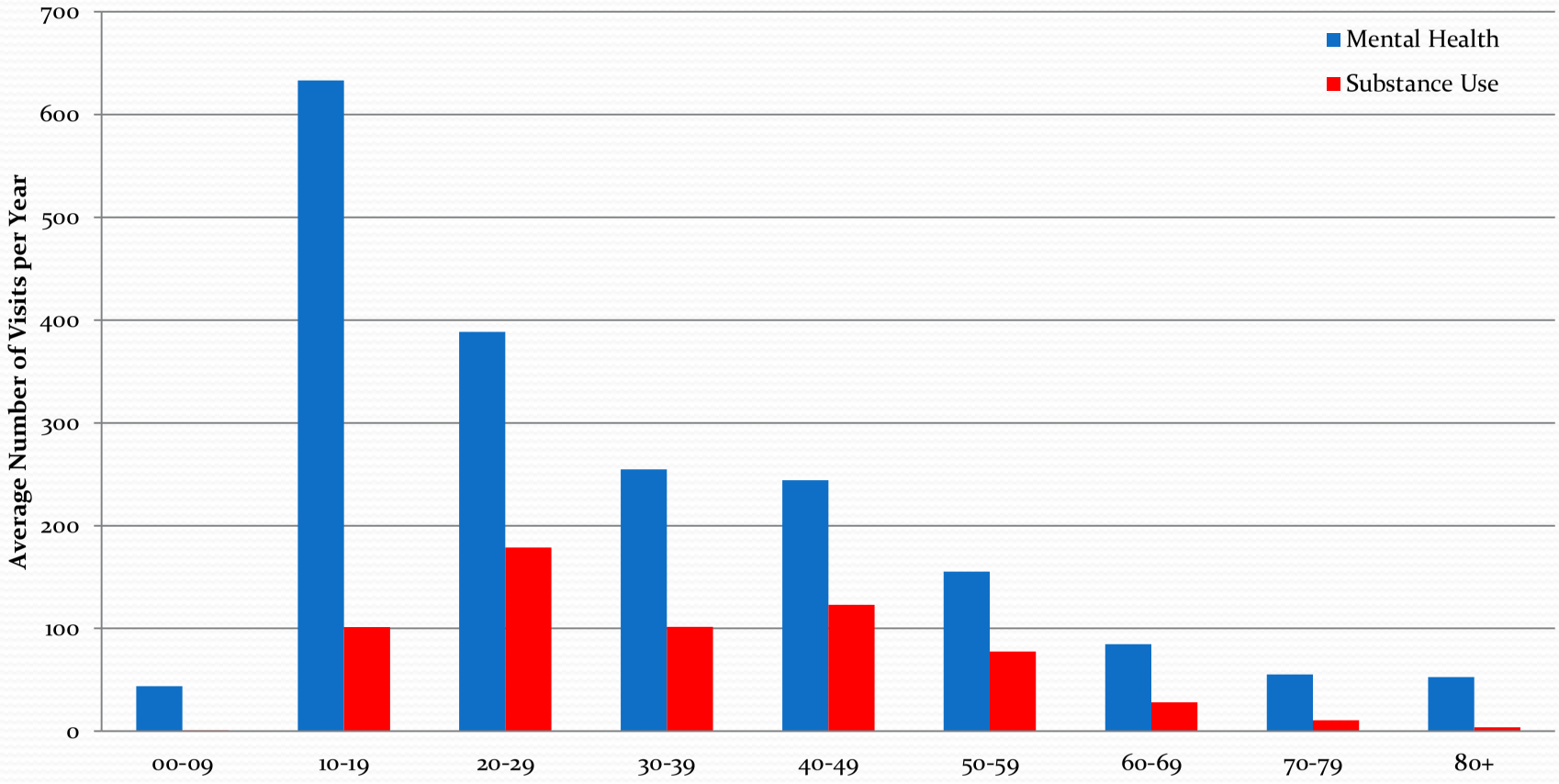
Maryland Health Services Cost Review Commission (HSCRC) Hospital Data

Mental Health/Substance Use ED Visits FY12-13 by Primary Diagnosis



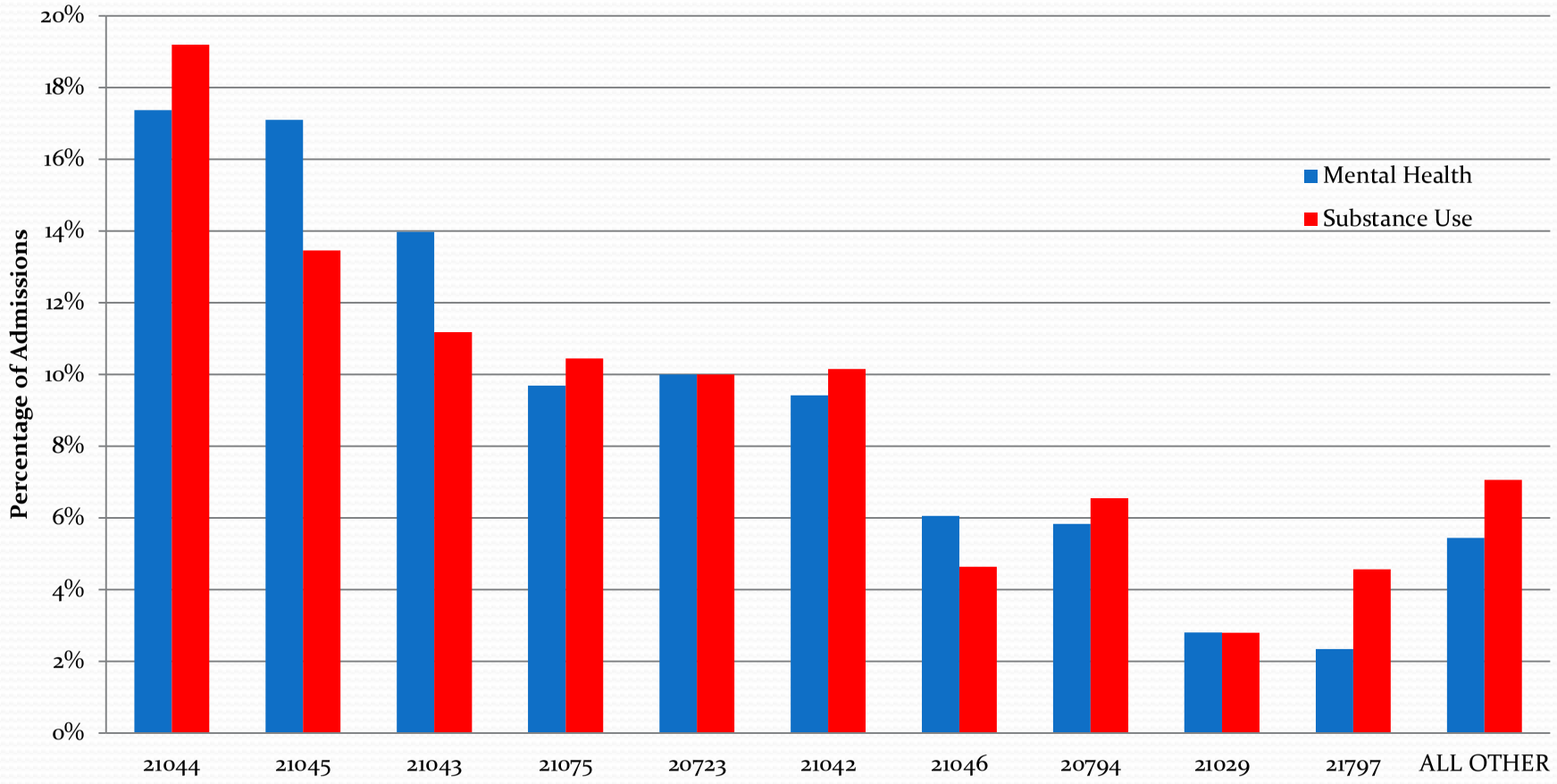
Maryland Health Services Cost Review Commission (HSCRC) Hospital Data

Mental Health/Substance Use ED Visits FY09-13 By Age



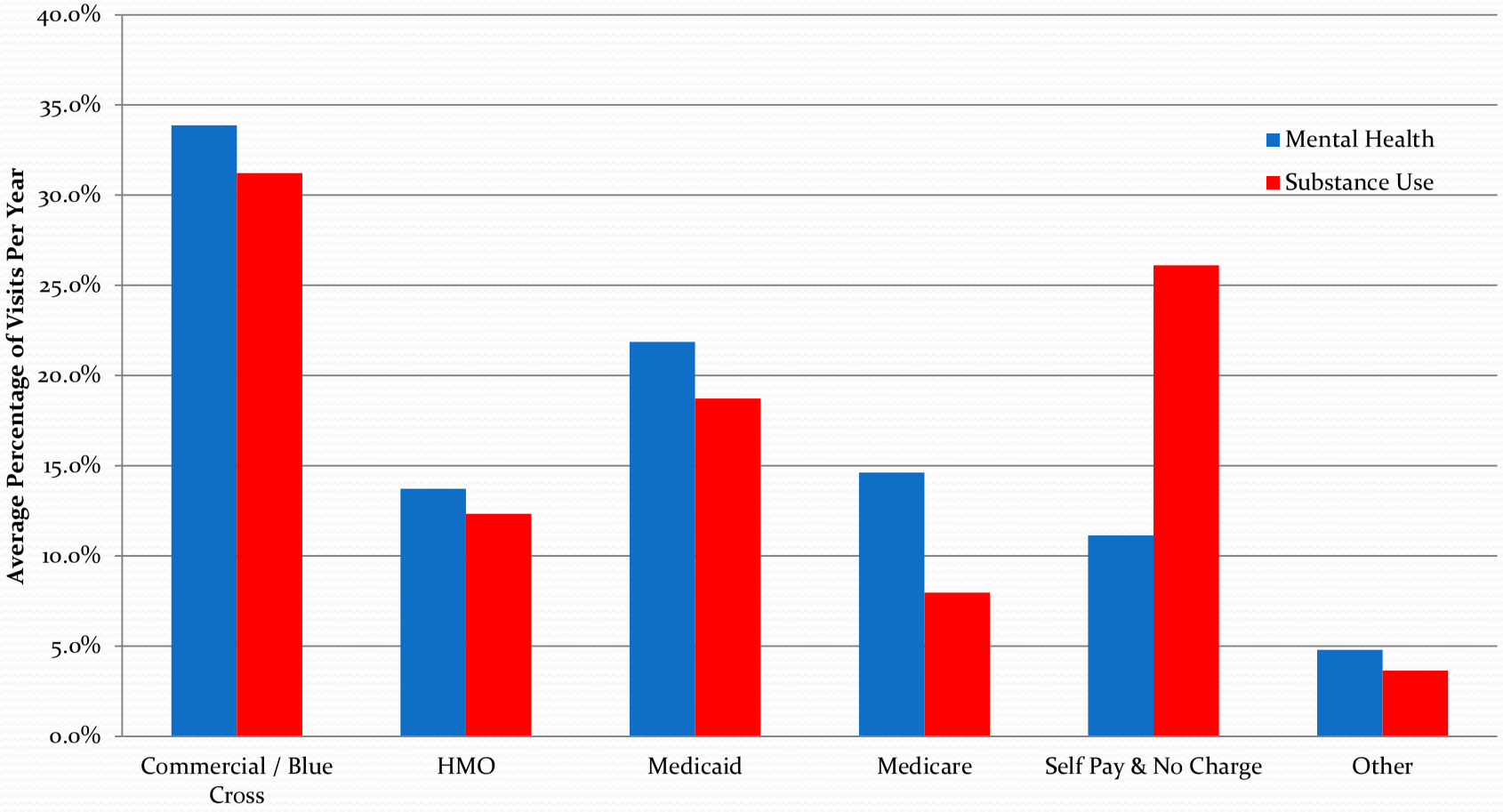
Maryland Health Services Cost Review Commission (HSCRC) Hospital Data

Mental Health/Substance Use ED Visits FY12-13 By Zip Code



Maryland Health Services Cost Review Commission (HSCRC) Hospital Data

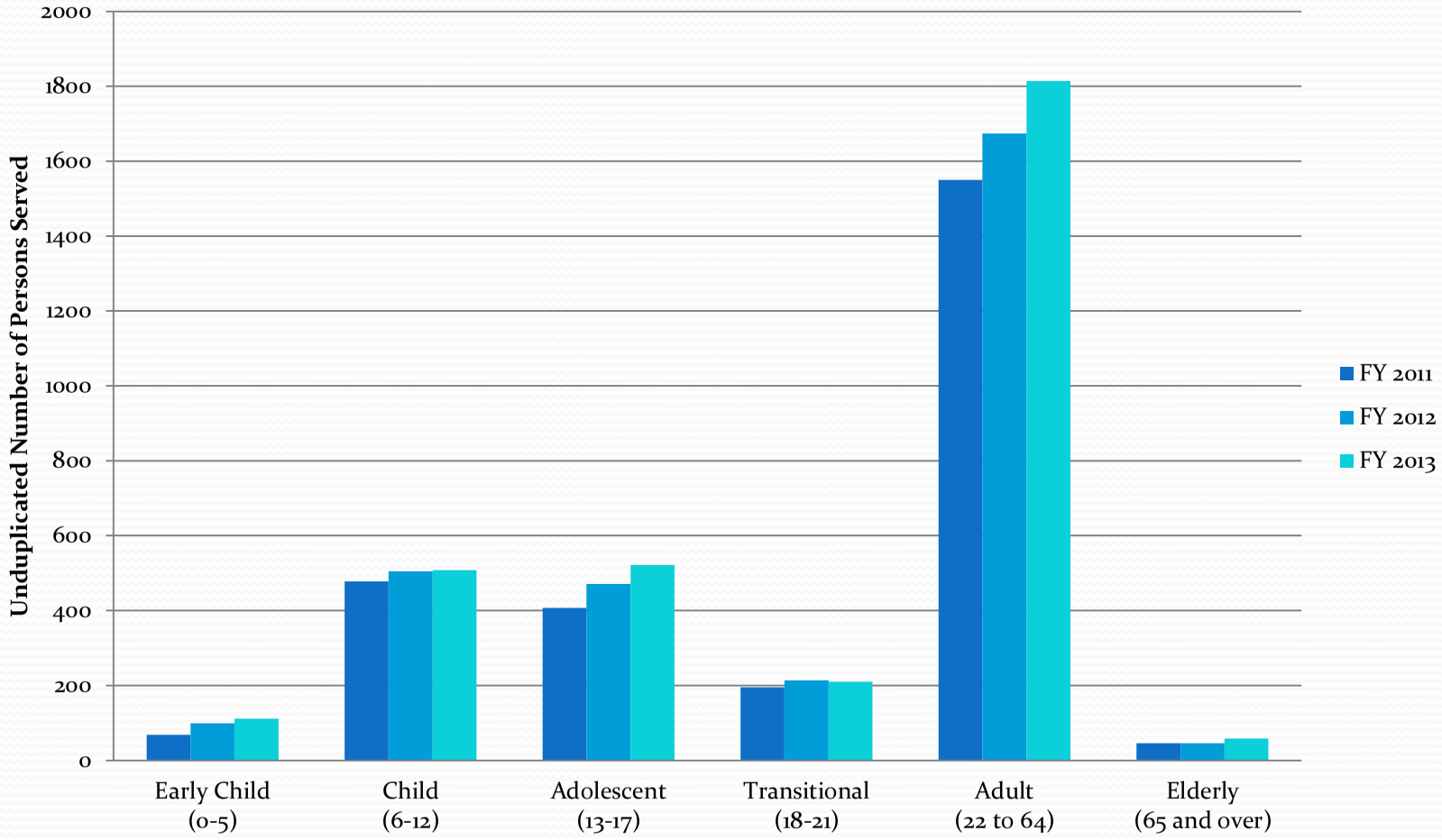
Mental Health/Substance Use ED Visits FY09-13 By Payer



Maryland Health Services Cost Review Commission (HSCRC) Hospital Data

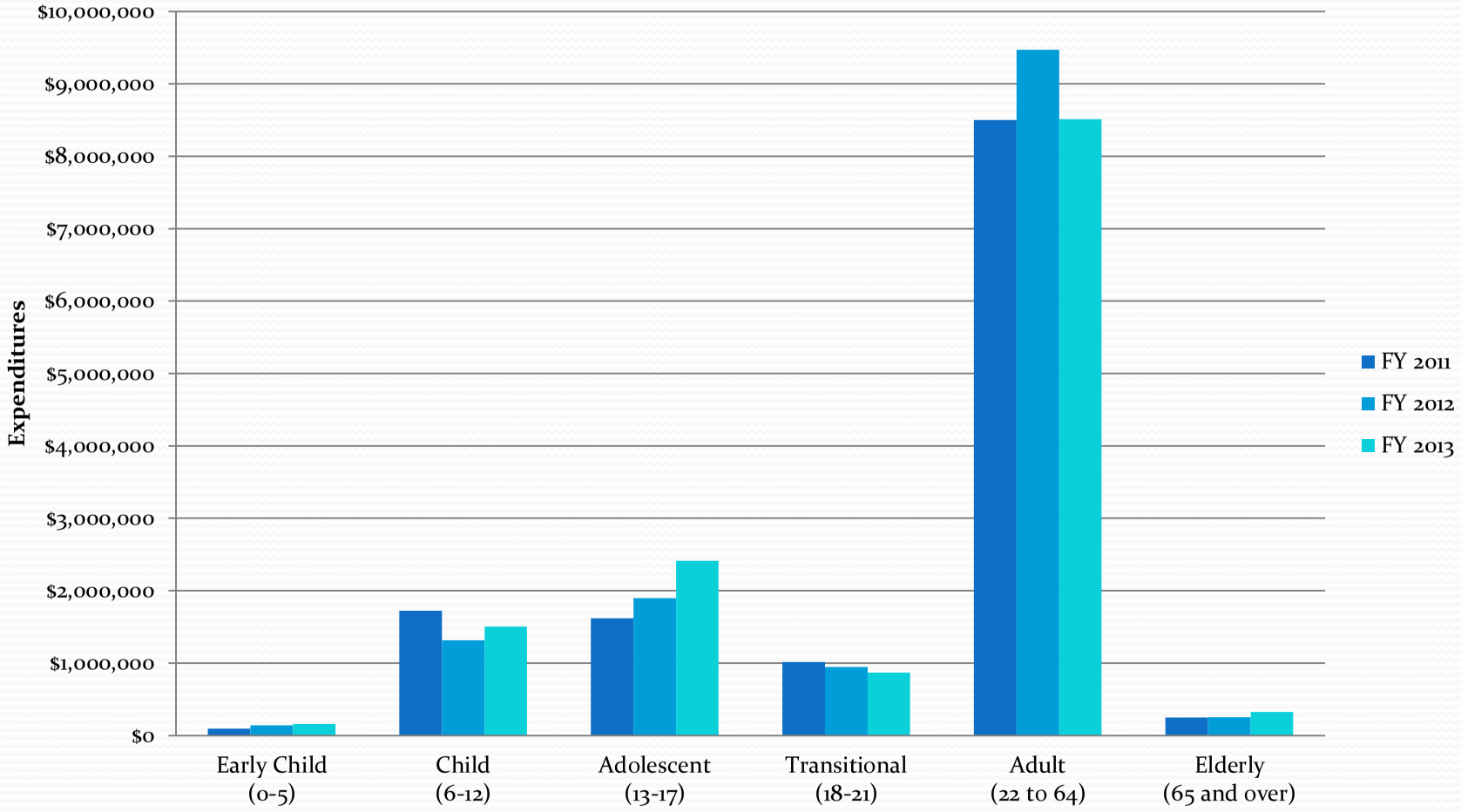
Howard County Mental Health Authority Claims Data

Publicly Funded Mental Health Services
FY11-13 Unduplicated Persons Served By Age



Source: Howard County Mental Health Authority

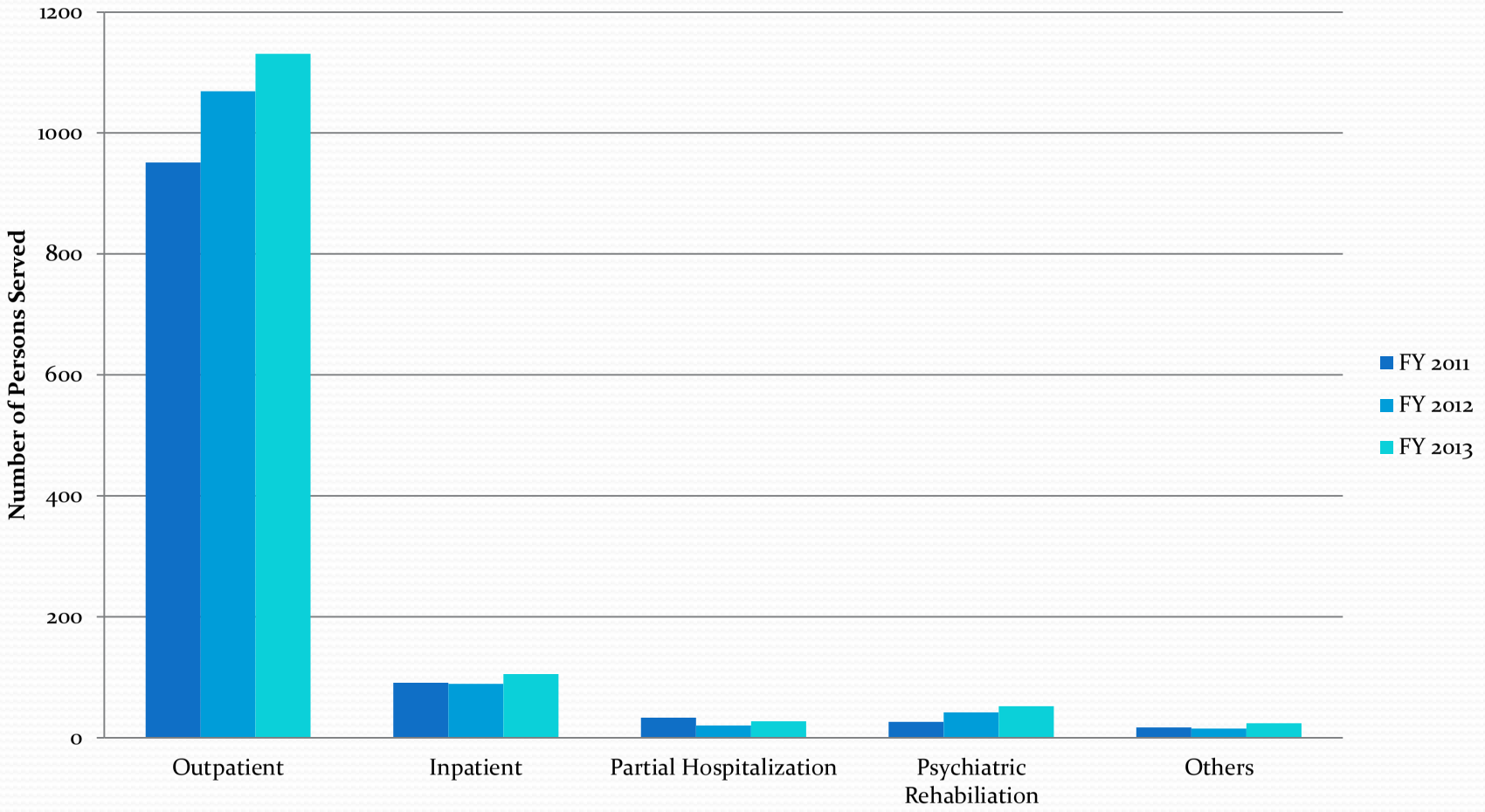
Publicly Funded Mental Health Services
FY11-13 Total Expenditures By Age



Source: Howard County Mental Health Authority

Publicly Funded Mental Health Services

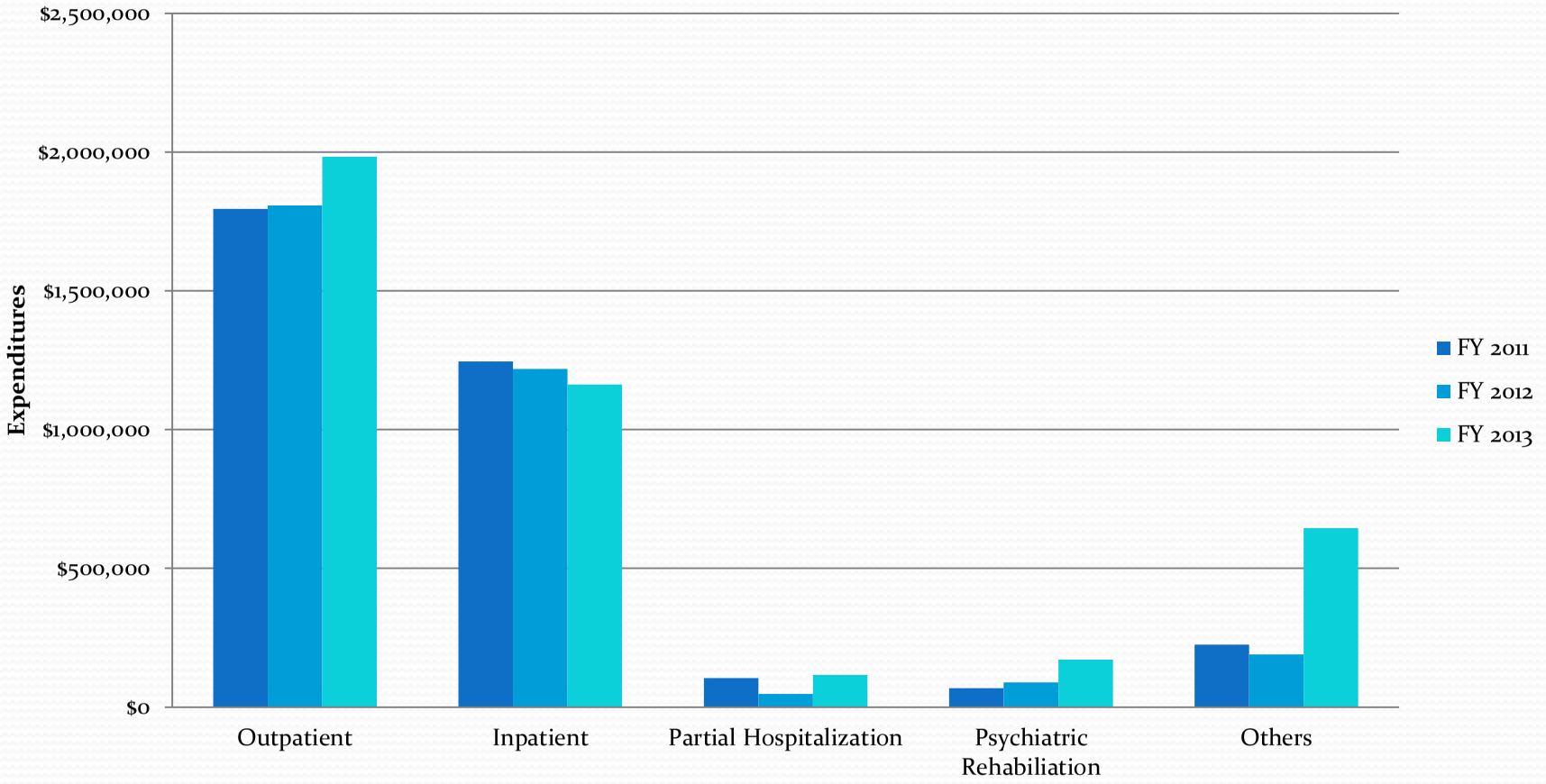
FY11-13 Persons Served by Type of Service: Children/Adolescents



Source: Howard County Mental Health Authority

Publicly Funded Mental Health Services

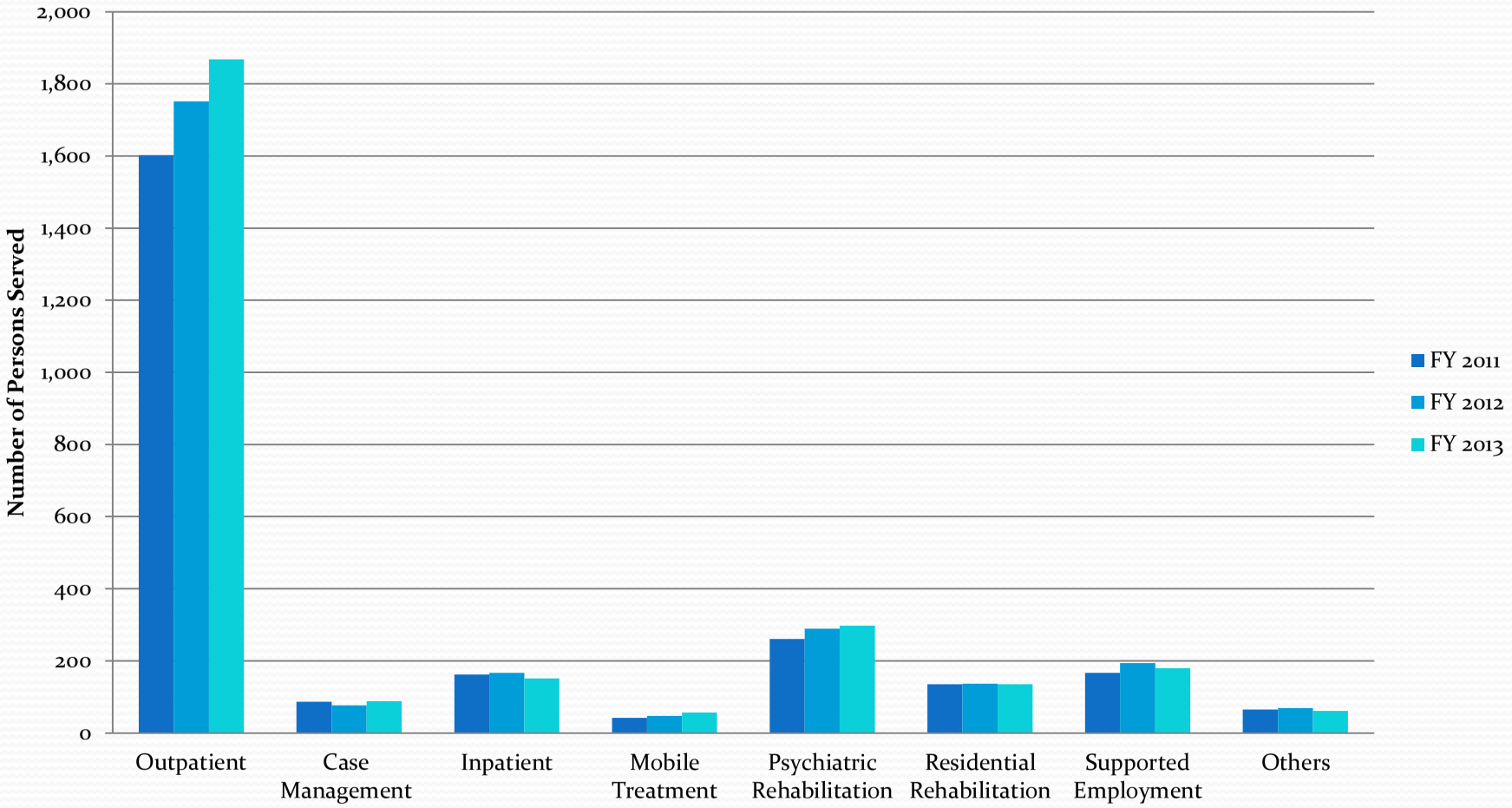
FY11-13 Expenditures by Type of Service: Children/Adolescents



Source: Howard County Mental Health Authority

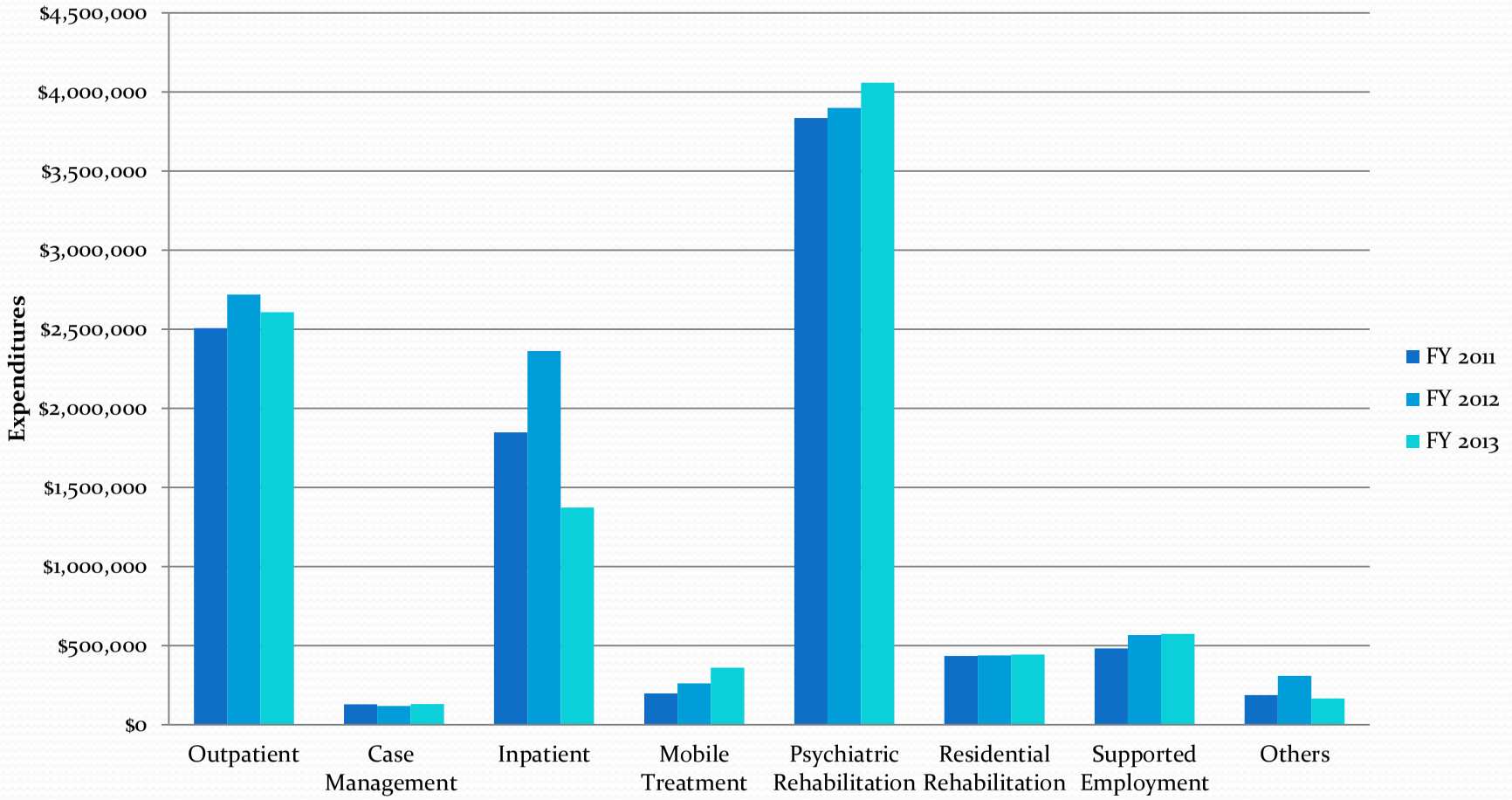
Publicly Funded Mental Health Services

FY11-13 Persons Served by Type of Service: Adults



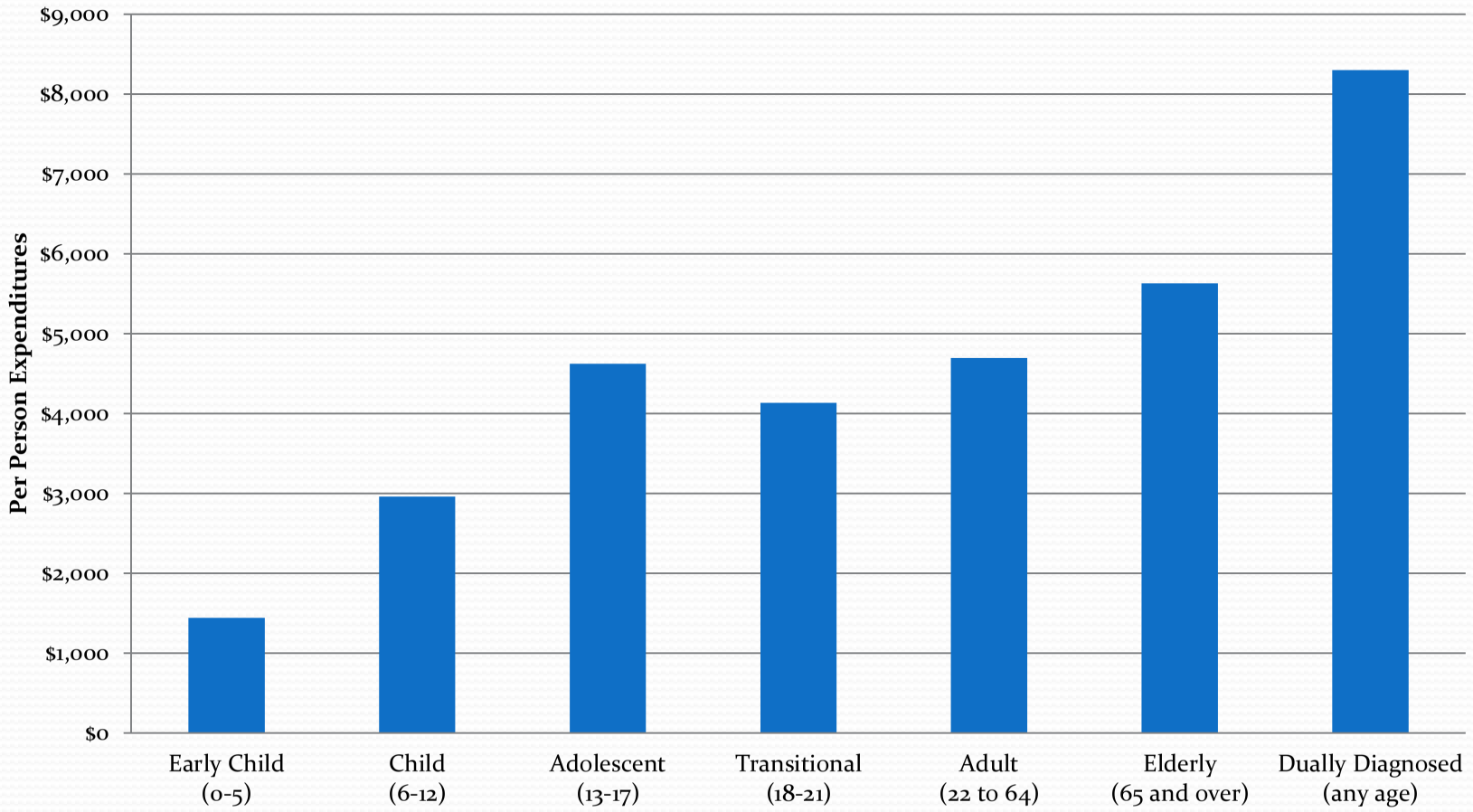
Source: Howard County Mental Health Authority

Publicly Funded Mental Health Services
FY11-13 Expenditures by Type of Service: Adults



Source: Howard County Mental Health Authority

Publicly Funded Mental Health Services
FY11-13 Per Person Expenditures By Age



Source: Howard County Mental Health Authority

Howard County Behavioral Health Resources

Gap Analysis

- Intermediate level of care between psychiatric inpatient care and community-based mental health providers
  - Residential crisis bed
  - Partial hospitalization program
  - Urgent care
- Providers who accept insurance/offer sliding scale fees
- Outreach to minority populations
  - Lack of awareness and stigma
  - Lack of bilingual providers
  - Cultural awareness/barriers

Gap Analysis Cont.

- Increased services for younger populations
- Integrating behavioral health with medical care
- Lack of detox centers in the County
- Treatment on demand
- Work force development
  - increasing primary care providers treatment of BH disorders
  - Urgent Care Centers
- Transportation – providers accessible by public transit
- Child care

Stories

Stories – Detox Workaround

- Patient in need of detox
- Present to ED intoxicated, danger to self/others
- Patient is admitted, stabilized, and transferred to psychiatric unit or
- Maybe transferred to Sheppard Pratt in Towson
- In a few more days, released
- Referrals to community recovery programs are limited

Stories – Private Insurance Gap

- Many providers are private pay only
- Individuals with private insurance contacting MHA
- Cannot find a provider who will accept their insurance
- Cannot afford co-pays
- Cannot get a timely appointment with a provider who accepts their insurance

Stories – No Place to Go

- Case: 70-year-old parents, 30-year-old son with personality associative disorder, anxiety, depression, schizophrenia
  - Cannot take care of him and have become "prisoners in their own home"
- 3 – 4 calls per week to NAMI Howard County from parents whose adult children or transition aged youth (18-26) can no longer be cared for at home or who present danger to parents
- Limited housing options:
  - long waiting lists
  - no open spaces at group homes in the county or lack of homes
  - lack of financial resources or insurance to pay

Stories – Overwhelmed ED

Night of 9/17 at HCGH

- 8 -9 psychiatric patients presented to ED
- Limited staff to evaluate and treat
- Discussed possible diversion
- Limited disposition options

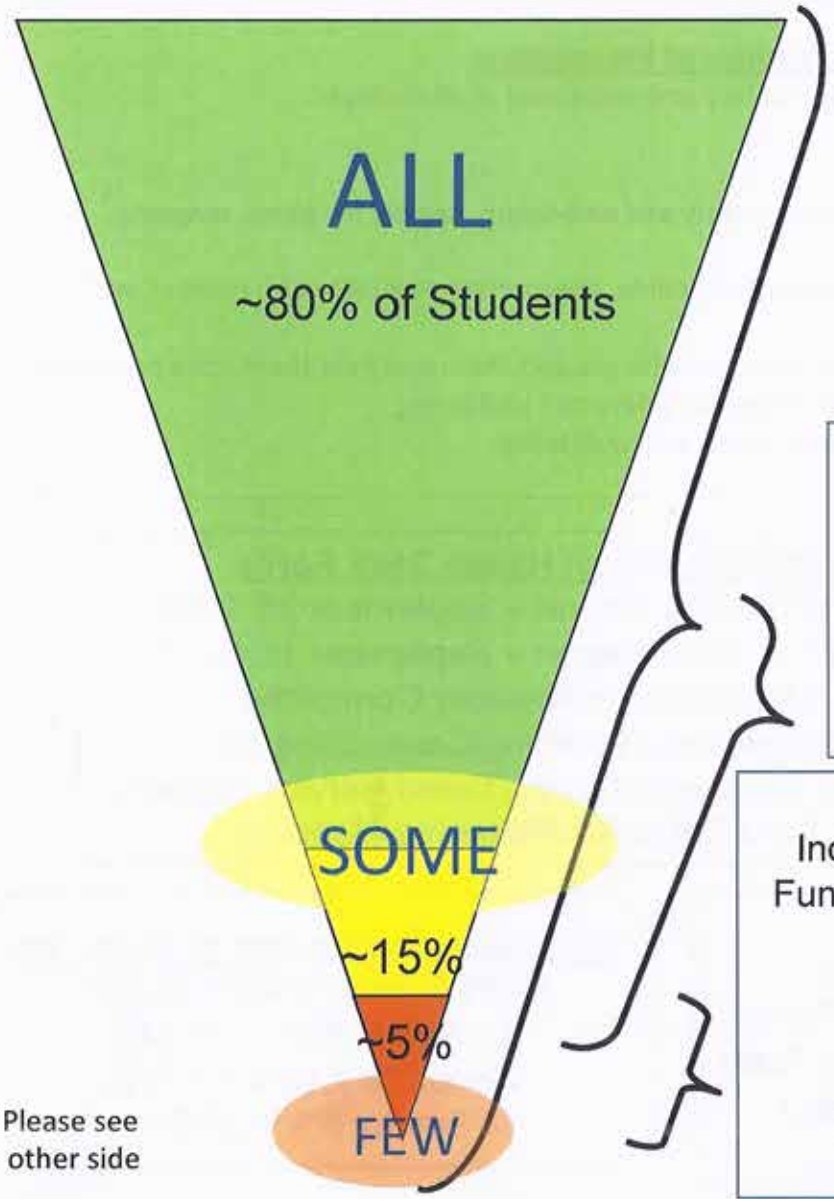
Howard County Behavioral Health Task Force

APPENDIX C

HCPSS Continuum of Supports for Behavioral/Mental Health

Presentation to Howard County Behavioral Health Task Force December 9, 2014

Cynthia A. Schulmeyer, Ph.D., Coordinator School Psychology, Co-Chair HCPSS MH Task Force



Please see other side

Universal/Primary Prevention and Intervention

Health Education Curriculum (K-9)
School Counseling Curriculum (K-12)
Positive Behavior Supports and/or PBIS MD (56)
Character Education and Developmental Assets
School-Based and Cluster Crisis Teams
Annual Suicide Prevention Overview for Staff
At-Risk Gatekeeper Training for Educators (2015-16)

Secondary Prevention and Intervention

Instructional Intervention Team/Student Support Team
In-School Alternative Education Programs (30)
Check In/Check Out (available at PBIS Schools)
Restorative Practices and Life Space Crisis Intervention
Small Group Counseling (School Counselor and/or School Psychologist) - Anger Management, Social Skills

Tertiary Prevention and Intervention

Individualized Counseling (School Psychologist/Counselor)
Functional Behavioral Assessment/Behavior Intervention Plan
Referral to Special Education, as appropriate
Connection Center (Pupil Support Services)
Suicide Intervention Procedures (SIP)
Threat Management Procedures
Homewood Center (Community Counseling Program)
Home and Hospital Teaching

HCPSS Continuum of Supports for Behavioral/Mental Health

Presentation to Howard County Behavioral Health Task Force December 9, 2014

Cynthia A. Schulmeyer, Ph.D., Coordinator School Psychology, Co-Chair HCPSS MH Task Force

HCPSS Vision 2018: Fulfilling the Promise of Preparation

Outcome 1.7 Schools support the social and emotional safety and well-being of all students.

1.7.1 Actively involve students in building positive school environments.
1.7.2 Model and reinforce civility and appropriate positive behavior.
1.7.3 Provide developmentally appropriate instruction on social and emotional safety and well-being, respect for peers, empathy, and personal strengths.
1.7.4 Collaborate with the community and county government to provide easily accessible, appropriate mental health services and supports for students in Pre-K through Grade 12.
1.7.5 Ensure students have access to culturally proficient professional staff members who support them and help them solve problems.
1.7.6 Strengthen professional learning in safeguarding students' social and emotional safety and well-being.
1.7.7 Strengthen staff collaboration to support students' social and emotional safety and well-being.

HCPSS Student Services

School Counselors
Health Services
Pupil Personnel Workers
School Psychologists

HCPSS Mental Health Task Force

Year One BOE Report – September 26, 2013
Year Two BOE Report – September 11, 2014
Mental Health Advisory Committee
Professional Learning/Communication
Student Curriculum/Three-Tiered Service Delivery
Data Collection/Resource Mapping

Team-Based Decision-Making

Instructional Intervention Team/Student Support Team
Section 504 &/or Individualized Education Program (IEP) Team
Central Admission Committee/Central Education Placement Team
Teams Consider: Risk Factors (academics, behavior, etc.)
DSM-5 Disorder vs. Educational Disability

Estimated Continuum of Supports

HCPSS Population = 51,681
Universal 80% = 41,345
Secondary 15% = 7,752
Tertiary 5% = 2,584

Screening Instruments for Youth and Adolescents
Prepared for the Howard County Behavioral Health Task Force Work Group on Prevention and Screening

Behavioral Assessment System for Children: Second Edition (BASC-2) (2004)

Publisher:	Pearson Assessments (www.pearsonclinical.com)
Ages:	2 - 21
Forms:	Self-Report, Teacher and Parent
Other Languages:	Spanish
Administration Time:	10-20 minutes (Teacher & Parent) 30 min (Self-Report)
Scoring:	QGlobal web-based scoring
Cost:	$1.58 per form plus $2.40 per score report = $3.96 each
Scoring Subscription:	$100 per user per year

NOTE: BASC-3 is due out in Fall 2015.

Behavioral Assessment System for Children: Second Edition, Behavioral and Emotional Screening System (BASC-2 BESS) (2006)

Publisher:	Pearson Assessments (www.pearsonclinical.com)
Ages:	Preschool – Grade 12
Forms:	Self-Report, Teacher and Parent
Other Languages:	Spanish
Administration Time:	5-10 minutes
Scoring:	Manual or ASSIST Software
Cost:	$1.15 per form
Software:	$667.95 per school

Children's Depression Inventory 2 (2010)

Publisher:	Multi-Health Systems, Inc. (www.mhs.com)
Ages:	7 – 17 years
Forms:	Self-Report, Teacher and Parent
Other Languages:	Spanish
Administration Time:	5-15 minutes
Paper and Pencil:	$2.20 per form; requires manual scoring
On-Line:	$3.00 per form; scored on-line (preferred)

Systemic Screening for Behavior Disorders: Second Edition (2014)

Publisher:	Pacific Northwest Publishing (pacifnwpublish.com)
Ages:	PreK – Grade 9
Forms:	Teacher
Administration Time:	5-15 minutes
Paper and Pencil:	$10.00 per classroom plus $225 Administrator's Guide
On-Line:	$30.00 per 100 students (preferred) plus $225 Administrator's Guide per school plus

Annual User fee (unable to determine cost)

Overall Estimated Costs Breakdown:

HCPSS Enrollment:
Total # HCPSS Students = approx 52,000 (approx 4,300 per grade)
Average High School Enrollment = 1,400 students (approx 350 per grade)
Average Middle School Enrollment = 650 students (approx 220 per grade)
One grade level across 12 high schools = 4,200 students
One grade level across 20 middle schools = 4,400 students

Costs For One-Time Administration at One Grade Level Across HCPSS:
BASC-2 = $17,028 plus scoring subscription ($100 per year) per school = $20,228
BASC-2 BESS = $4,945 forms plus one software ($668) per school = $26,319
CDI-2 = $12,900
SSBD = $1,290 plus Administrator's Guide ($225) and user fee per school = $8,490+

Costs for One-Time Administration for All Grades at one School:

	Middle School	High School	
BASC-2	$2,574	$5,544	plus subscription
BASC-2 BESS	$748	$1,610	plus software
CDI-2	$1,950	$4,200	
SSBD	$435+	$645+	user fee cost?

Additional Considerations:

- Parental written consent
- Self-Report versus Teacher Report
- Administration Plan
    - Paper versus on-line
    - Trained proctors
    - Staff to complete immediate scoring
- Plan for positive screen:
    - Contact parents
    - Immediate support available on-site the day of screening
    - Community resources
    - Community services pro-bono or at reduced cost
- Who has access to results?
- What is stored in student's record?
- Professional Development for HCPSS staff
    - Purpose of screening
    - Administration of instrument
    - Scoring and interpretation of screening results
    - School-based follow-up for positive screens
- Hire/identify a Project Manager

Howard County Behavioral Health Task Force

APPENDIX D

Howard County
Local Health Improvement Coalition
Behavioral Health Work Group 2015-2017 Action Plan

Goals: Expand access to behavioral health resources and reduce behavioral health emergencies.
Reduce number of drug-induced deaths in Howard County.
Reduce number of suicides in Howard County.

Note: This plan uses the SHIP measure of Emergency Department Visits Related to a Mental Health Condition under the assumption that an improved continuum of care for behavioral health conditions will result in fewer ED visits, per 100,000 population, for these conditions.

Emergency Department Visits Related to a Mental Health Condition, per 100,000 population	**All**	**African-American**	**Asian**	**Hispanic**	**Other**	**White**
2013 SHIP (2012 HSCRC)	2243.9	2919.0	519.1	914.9		2666.5
2014 SHIP (2013 HSCRC)	2209.9	2873.8	234.7	851.0		2590.4
2017 Goal	2099.4 (5% decrease)	2730.1	231.5	808.5		2460.9
Number of Drug-Induced Deaths in Howard County	**All**	**African-American**	**Asian**	**Hispanic**	**Other**	**White**
2017 Goal	(x% decrease)					
Number of Suicides in Howard County	**All**	**African-American**	**Asian**	**Hispanic**	**Other**	**White**
2017 Goal	(x% decrease)					

Strategies	Actions	Partners	Timeline	Outputs	Intermediate Measures
Create and maintain a listing of behavioral health providers in Howard County. (Need to think about the target audience for this list – providers who want to make referrals, patients themselves, policy makers, etc.)	Reach out to other organizations to discuss potential for partnering to create and maintain list.	- Network of Care - 211 Maryland - HCPIN – Dept of Citizen Services		- Established partnership - Number of providers included	Number of hits on website
	Need to identify other actions toward creation of list.				
Educate physicians, including pediatricians, primary care providers, geriatricians, and urgent care centers, to identify behavioral health issues and incorporate behavioral health screenings into services.	Organize a forum for providers to discuss behavioral health screenings.	HC DrugFree HCHD HC MHA Horizon PCMH Program Healthy Howard Evergreen Chase Brexton NAMI HC Faith Community		# of forums # of attendees	
	Develop educational tools for providers.			Toolkit developed # of providers reached	
	Research creating a program like BHIPP (Behavioral Health Integration in Pediatric Primary Care) for adult primary care providers.				
Educate the public, police officers, and fire and rescue personnel about behavioral health issues, how to identify when friends or family	CIT: Establish a group with each entity (fire department, EMS, etc.) to discuss how training would address the groups' needs.	- MHA - Grassroots - HCPSS - On Our Own HC - HC EMS - HC DrugFree	CIT: Twice/year MHFA: ????	MHFA: # trainers in Ho. Co. # trainings # individuals trained CIT: # trainings	Evaluation of trainings May also include: Number of injuries to officers (expect to decrease) Number of repeat calls

Strategies	Actions	Partners	Timeline	Outputs	Intermediate Measures
may be having issues, and where to go for help. (Mental Health First Aid and MHFA for Youth, Crisis Intervention Training)	Conduct trainings, including at least 2 per year for Crisis Intervention Training.			# officers trained # other first responders trained	(expect to decrease)
Support the recommendations of the County's Behavioral Health Task Force.	TBD	TBD		TBD	TBD
Increase suicide prevention activities.	Review and analyze data for at-risk populations, identify gaps in data collection, develop action plan.	- Suicide Prevention Association - MHA - Private providers - Grassroots - HCPD - HCGH		Completed action plan	YRBS – number of students contemplating or having plan for suicide HCPSS data HCPD data
	Educate providers and the public through an annual community forum.			# forum attendees # QPR trainings # trained in QPR	
	Investigate alternate ways to reach youth for suicide prevention messages.				
	Begin and monitor MHA/Grassroots ED Follow-Up Program for suicide prevention and BH ED visits to HCGH.		Begin – FY15 Q3 Monitor - ongoing	# individuals referred # linked to outpatient providers	ED visits for BH conditions
Support programs and activities working to reduce the number of drug-induced deaths.	Increase awareness of and participation in drug-prevention programs using social media, newsletters, forums, and community fairs.	-HC DrugFree -HCHD -HCGH -ADAAB -HCPD -Opioid Prevention Coalition -Community Providers	Ongoing	# of forums and community activities # of activities advertised in LHIC Digest	
	Continue overdose response program trainings for naloxone use for the public and for specific groups such		Ongoing	# trainings conducted # individuals trained # calls for refills of naloxone	

Strategies	Actions	Partners	Timeline	Outputs	Intermediate Measures
	as police officers.			# calls to Poison Control to report use of naloxone	
	Reduce overdose fatalities by identifying and targeting services to individuals who have survived previous overdoses.			# patients served	# drug-related ED visits
	Establish overdose fatality review team.		Sept 2015	# of meetings # of fatalities reviewed	
	Establish opioid prevention coalition.		January 2015	# of members # of meetings	
	Install at least 3 permanent medication collection boxes.		June 2015	# boxes installed # lbs. medicine collected	
	Continue to have bi-annual drug take-back days and review collection data to determine on-going need.		Ongoing, review by Dec 2015	# take-back days # lbs. medicine collected	