Alternative Approaches to Structuring Behavioral Health Integration Across Maryland Jurisdictions

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Contents

Executive Summary

In order to plan for potential integration of mental health (MH) and addictions (AD) services within Howard County as encouraged by the Maryland Behavioral Health Administration, the Howard County Health Department (HCHD) leadership sought to learn from the experiences of other jurisdictions. The Health Officer commissioned a study to review the status of behavioral health (BH) integration in jurisdictions around Maryland. In addition to understanding the existing structure, information was sought on the integration process as well as perspectives on the advantages and disadvantages of the two dominant integration models – 1) combining the Local Addictions Agency (LAA) and Core Service Agency (CSA) within the Local Health Department (LHD) and 2) integrating the LAA and CSA within a separate non-profit agency. The combined findings will be used to inform the health officer's proposals to re-organize Howard County behavioral health services to yield the most effective integrated system for the unique behavioral health issues facing Howard County.

Approximately half of the jurisdictions in Maryland have undertaken some form of behavioral health integration. Of those that have integrated all but one has integrated by moving the CSA into the health department. Only Baltimore City has integrated its behavioral health functions under a separate non-profit, Behavioral Health System Baltimore. Four of nine integrations occurred prior to 2010.

Most jurisdictions that integrated reported few challenges regarding personnel systems, as many of the transitions involved reorganizing legacy functions that had been previously organized under different departments within the health department and now were combined under a single authority, bureau or department. Garrett County leadership shared their experience moving staff from non-profit to governmental payroll. While personnel systems did not prove unusually burdensome, most respondents reported challenges managing change associated with such significant reorganization. Public health leaders generously shared their experiences, their challenges and their strategies for addressing human nature that is generally resistant to change. A number of themes emerged concerning successful approaches:

- Involve those who will be subject to change in the planning process
- Identify and empower change champions
- Communicate early and often regarding change
- Be clear about the rationale for change (i.e. improved service to those suffering behavioral health issues) and frequently remind all those involved of this rationale

The most frequently mentioned non-personnel challenge was interacting with a state behavioral health structure that is integrated in name, but not yet completely integrated in systems and budgets, which diminishes the economy of scale benefit that should accrue with integration. However, several jurisdictions report having been successful in appealing to the Maryland Behavioral Health administration to submit a single behavioral health plan (instead of preparing an annual mental health plan and a separate annual addiction plan). It appears that the state is prepared to work with those who are interested in innovating to create new value.

Behavioral health leaders and other stakeholders in Howard County were interviewed to gain their perspectives on the prospect of reorganizing around an integrated behavioral health model. There was general support for such reorganization, with nearly universal recognition of the value that integration offers to consumers requiring BH services from the county. There was further a recognition that a

blended BH service might offer more flexibility to move funds to areas of greatest need, a phenomenon noted by leaders in other jurisdictions. Also, stakeholders noted that the unique demographics in Howard County, with such a relatively large proportion of the population covered by private insurance, may offer opportunity to more rigorously address the challenges of planning for access to care for the broader county population seeking BH services, rather than just those served by the public health system.

This study concludes with the author's recommendations regarding structure and approach to integration given the learning from this survey.

Methodology

After clarifying the objectives of the study, a discussion guide (*Appendix 1*) was developed and approved by the project sponsor. An introductory email from project sponsor Maura Rossman, MD, Howard County Health Officer was sent to Local Health Officers (LHO), Core Service Agency (CSA) executive directors and Local Addiction Authority (LAA) officials (*Appendix 2*). Calls were made to each jurisdiction seeking a phone appointment with the official "best able to address the questions surrounding behavioral health integration outlined in Dr. Rossman's introduction email". Phone appointments were scheduled with at least one of the above named individuals from every jurisdiction. Appendix 3 is a list of those interviewed. Several jurisdictions (Allegany County, Baltimore City, Cecil County, Charles County) requested a group telephone interview, citing that multiple perspectives would be important to provide a full picture of the integration process in that county.

In two cases, one organization served as the CSA in multiple counties, and the leadership of that organization was interviewed to obtain perspective from those communities. The Mid-Shore Mental Health System (MSMHS) serves as the CSA for Caroline, Dorchester, Kent, Queen Anne's and Talbot Counties. While several of these jurisdictions have their own mental health services, the MSMHS executive director was able to address integration efforts in these communities. In Wicomico and Somerset Counties the behavioral health program director for the Wicomico County Health Department serves as the CSA director for both Wicomico and Somerset Counties.

Officials from every jurisdiction were generous with their time and thoughtful consideration of the questions posed in this study. Interviews ranged in length from 10 minutes up to 90 minutes. Most lasted about half an hour. Interviewees were candid in sharing not only their successes at integration, but the challenges faced and observations on what they would do differently if given the opportunity to repeat the integration process.

Several interviewees cited publicly available documents as providing valuable insight to behavioral health integration. These were reviewed and relevant findings are summarized in the Literature Review section below.

In addition to officials in Maryland jurisdictions outside of Howard County, five interviews were conducted with Howard County officials and related interested parties. Interviewed were Donna Wells, executive director of the Howard County Mental Health Authority (HCMHA) and co-chair of Howard County's 2014 Mental Health Task Force; Roe Rogers-Bonaccorsy, director of the Howard County Bureau of Behavioral Health; Stephen Liggett-Creel, HCMHA Board Chair; Elizabeth Edsall-Kromm, senior vice

president of population health and community relations at Howard County General Hospital; and Nikki Highsmith-Vernick, president of the Horizon Foundation and co-chair of Howard County's 2014 Mental Health Task Force. The discussion with Howard County stakeholders was focused on prospective opportunities and challenges presented by behavioral health integration within the county, rather than on historical integration efforts. Aggregated findings from these discussions are reported separately in the Interview Findings section below.

Literature Review

Several interviewees cited publicly available documents as providing valuable insight to behavioral health integration. Scott Greene, Director of Behavioral Health Planning and Management for Montgomery County referred us to Behavioral Health in Montgomery County, a 2015 study prepared by the Maryland Office of Legislative Oversight for Montgomery County Government (Report Number 2015-13, July 28, 2015). The report offers a comprehensive view of behavioral health services in the county and an assessment of gaps in services which are not dissimilar to challenges facing Howard County. These gaps include:

- Access to services for individuals not eligible for Medicaid
- Services designed to support individuals with serious mental illness living in the community
- Crisis facility capacity and coordination
- Facilities for individuals with multiple needs

The similarities between Howard and Montgomery counties suggest opportunities for sharing best practices.

Sue Doyle, Director, Bureau of Prevention, Wellness, and Recovery (formerly the Bureau of Behavioral Health) in Carroll County, referred us to Integration, a 2016 Beacon Health Options whitepaper. Although the focus is on systems of organizing treatment, prevention and support services rather than organization of services within a public health agency, it provides valuable context for more far-reaching integration questions. At its core the paper notes,

> "the best-in-class approach for integration is the "collaborative care model". This model, originally developed to support the delivery of behavioral health in primary care settings, has been expanded across different settings and for different population segments. While there may be variation among collaborative care models, all of them require organization around the following five distinct components that, when applied collectively, improve health outcomes:
>
> 1. Patient-centered team care
> 2. Population-based care
> 3. Measurement-based care
> 4. Evidence-based care
> 5. Accountable care"[1]

Both documents are included in *Appendix 11*, References.

[1] Integration, Emma Stanton, MD, Beacon Health Options Whitepaper, 2016.

Interview Findings

Maryland Jurisdictions Outside of Howard County

This section will summarize the findings of 18 interviews held with behavioral health officials in 23 jurisdictions outside of Howard County. For presentation purposes the interview notes were summarized under broad themes (e.g. Existing Structure, Integration Logistics, Integration Hurdles, etc.) and reported by jurisdiction in tabular format (*Appendices 3-9*). Given the two situations cited above where one CSA has responsibility for multiple jurisdictions, the discussion below will report quantitative findings relative to a total of 18 respondents outside of Howard County.

Are Your Mental Health and Addictions Services Integrated? Describe Structure.

Nine of the eighteen respondents (50%) reported that Mental Health (MH) and Addictions (AD) services were integrated in their jurisdictions. Several integrated jurisdictions reported a "work in progress". Two communities that have not integrated referred to efforts in years past to integrate which did not materialize because of internal opposition to such integration.

Of the 9 communities that have moved to integrated behavioral health structures, eight (88.9%) have consolidated services within the local health department. Only Baltimore City has its behavioral health structure housed in an independent non-profit, Behavioral Health Systems of Baltimore, which is the result of combining two legacy non-profit organizations.

The Core Service Agency (CSA) was found to be located in several locations as set forth below:

CSA Location	# Jurisdictions
Within Health Department	9
Independent Non-Profit	7
• Quasi-Government Non Profit	2
• Non-Profit serving multiple communities	2
• Single jurisdiction private non-profit	3

Details by jurisdiction are set forth in *Appendix 5*, Structure/Location of CSA.

Integration Issues

Interviewees were asked a number of questions concerning their integration activities. Detailed responses are set forth in *Appendix 6*. The earliest integration occurred in Montgomery County (1996), followed by Worcester County (2008), Garrett County (2008) and Baltimore County (2009). All other integrations have occurred since 2012.

When asked about how long integration took nearly all respondents indicated the process took longer than originally expected. Anne Arundel County, which has not completed its integration, indicated it has been working on iterative steps towards integration, such as Joint Co-Occurring Task Force and its

Health and Human Services Core Group, for several years. Similarly, Worcester County cited many small steps towards full integration. Four respondents indicated time frames for integration ranging from 11 to 18 months. Carroll County, which took 18 months, set out with a concrete integration plan that was informed by research done with the NIATX learning collaborative out of the University of Wisconsin.

Respondents were asked about human resources challenges faced during integration. Specifically, "Were there challenges moving employees from state of Maryland HR systems to county HR systems, or vice versa?" Of the jurisdictions that had completed integration or were well into the integration process none cited problems with human resource transitions, as virtually all moved within their own government or non-profit status. However, many cited more "soft" human resource transition issues (including opposition to change, culture clash and "learning new language") which are set forth in more detail in the following section.

Integration Hurdles

Interviewees were asked about specific challenges presented during integration of mental health and addictions services – both expected and unforeseen. Detailed responses are included in *Appendix 7.* Several recurring themes appeared:

- Culture: Stark differences between mental health and addictions staff needed to be bridged. Five respondents mentioned differences in language/vocabulary used by MH and Addictions staff. The scope of treatment was identified as an area of particular difference. Substance abuse providers are relatively specialized in the conditions which they treat, while mental health providers (generally) treat a wide variety of conditions.
- Budget: Several jurisdictions mentioned uncertainties in future funding, particularly with the state's transition of addiction services to fee for service payment through the Beacon Health ASO. While no one was able to cite specific budget shortfalls as all were in the process of working through these questions, there was general concern that the new funding mechanism would not provide for funding at the same level as previously, because of unfunded indirect costs.
- "Integration" with state transition to behavioral health. Four jurisdictions mentioned that it was challenging to integrate local services into a single behavioral health unit while the Maryland Behavioral Health Administration had integrated in name, yet still operates in a less-than-integrated fashion on several fronts, including requiring separate funding plans for mental health and addictions. It should be noted however that two jurisdictions petitioned and received approval to submit a single Behavioral Health Services plan in place of the two separate plans.
- Leadership: Does the right caliber of leadership exist within the existing ranks to lead a combined behavioral health service? Not only is the integrated service larger than the two legacy services, but it will have more complexity due to challenges of blending two cultures cited above.
- Right sizing: Securing economies of scale is imperative under an integrated structure, particularly as addictions services convert to fee for service and there will no longer be overhead coverage through addictions grants. Respondents noted that it can be challenging to eliminate

positions, particularly within a government structure, if positions are no longer needed in an integrated structure.

Another noteworthy concern was that of accreditation and licensure. Two respondents mentioned that addictions counsellors will need to return to school to pursue MSW or M. Psych. degrees in order to continue their counselling services in the FFS structure. One person cited a not-yet-published state regulation requiring accreditation (CARF, Joint Commission or other) for addictions programs that would require more advanced licensure for addictions counsellors. Interestingly, this challenge was seen as an opportunity by one jurisdiction which cited accreditation preparation as a catalyst for encouraging cooperation between its mental health and addictions services, paving the way for additional integration.

Integration Advice

When asked what advice they would give to other jurisdictions preparing to embark upon integration of behavioral health services, leaders offered a range of specifics that are detailed in *Appendix 8*. Recurrent themes were consistent with sound change management:

- Communicate early and often
- Involve stakeholders in change planning
- Identify "early adopters" or "champions" in both the MH and Addictions services who can help facilitate change management.
- Allow time and create opportunities for participants from both legacy organizations to get to know each other, not only as co-workers but in non-working situations as well.
- Address the issue of staff position elimination as soon as possible. Plan early on how you are going to deal with this situation.
- Use external stakeholders or joint projects as possible vehicles to facilitate integration. For example, Cecil County leaders described how they used the local hospital's interest in support for emergency department diversion to bring the mental health (CSA) staff and addictions (health department) staff together to collaborate on this initiative. In Charles County, leadership first introduced a new electronic medical record in the mental health and addictions clinics, requiring staff from these two areas to collaborate in setting up new forms and other documentation planning. The exercise has been valuable in breaking down barriers between divisions.
- If mental health and addictions programs are not co-located in common office space, do so as quickly as possible. This helps break down cultural barriers. Try to avoid setting up separate departments in same building. This only reinforces separation.
- Use board participation as an integration tool. And finally,
- **Keep all stakeholders focused on why you are integrating – i.e. to improve services for your constituents in need.**

Advantages and Disadvantages of Existing Structures

Interviewees were asked to comment on the pros and cons of their existing structure as well as the alternatives of locating behavioral health services within the local health department versus within a non-profit organization. While expressed in different ways (see *Appendix 9*), the most frequently mentioned comment was that locating BH services in a non-profit afforded greater flexibility in procurement, financing and general speed of operations, because such an organization is not hindered by prescribed procedures of a government based (i.e. health department) program. In contrast, several noted that non-profits are frequently hindered by tighter funding which may constrain their ability to attract top talent to a position. [NOTE: One [government employed] BH director noted that the posted salary for the Howard County Mental Health Authority executive director was equivalent to that of starting therapists in her jurisdiction.]

Advantages identified for a health department based model, where the CSA operates as a unit within the health department, include:

- Cross fertilization of ideas. People mentioned that employees of two closely aligned organizations of different structures bring different perspectives to problem solving that can be valuable to organizations charting new ground.
- May provide for the required firewall between oversight and direct provider organization.

Integration Best Practices

Following is a summary of items that were extracted from interviews that might be called "Integration Best Practices"

- Used NAITX learning collaborative from U. of WI to assist with transition. (http://www.niatx.net/Home/Home.aspx) (Carroll County)
- "Rename the Bureau" contest. To encourage participation in the planning and execution of integrated behavioral health service all members of the new bureau were invited to submit nominations to name the new bureau. Instead of becoming the Behavioral Health Bureau the new organization was named Bureau of Wellness Prevention and Recovery (Carroll County)
- Use hospital or other community stakeholder with behavioral health needs as lever for collaboration (see Cecil County)
- Pursue MOU to provide reciprocal LAA complaint adjudication services to neighboring county if own county provides direct services in addictions. (e.g. Cecil/Harford, Allegany/Garrett)
- Center for Continuous Learning: Offers training for providers, in particular co-occurring training. This proved valuable to get mental health and addictions providers comfortable practicing with each other. (http://www.montgomerycountymd.gov/HR/Resources/Files/Training/CCL_CATALOG_Fall_2015.pdf) (Montgomery County)
- Self-assessment (Compass tool) to prepare for integration. (Wicomico County)

Howard County Stakeholders

As mentioned above, five different stakeholders from Howard County were interviewed to gain their views on prospective models for behavioral health integration as well their ideas on the opportunities and challenges that such integration presents. Interviewed were Donna Wells, executive director of the Howard County Mental Health Authority (HCMHA) and co-chair of Howard County's 2014 Mental Health Task Force; Roe Rogers-Bonaccorsy, director of the Howard County Bureau of Behavioral Health; Stephen Liggett-Creel, HCMHA Board Chair; Elizabeth Edsall-Kromm, senior vice president of population health and community relations at Howard County General Hospital and health policy advisor to the previous county executive; and Nikki Highsmith-Vernick, president of the Horizon Foundation and co-chair of Howard County's 2014 Mental Health Task Force.

Opportunities of Behavioral Health Integration

Howard County behavioral health stakeholders agreed that opportunity exists with behavioral health integration to better serve the diverse local population's BH needs. All stated that integration of MH and Addiction services provides a significant benefit for patients, given the large number of patients with co-occurring conditions. They noted the strong overlap of needs of those suffering mental health and addictions issues, and the benefits of providing a single organization to address these needs. At least one mention was made of the "No Wrong Door" philosophy of accessing services that other integrated organizations (e.g. Carroll County) have employed. Most acknowledged the unique payer mix issue in Howard County with a relatively small public pay population, and a large private pay population served by few providers accepting private insurance. While the CSA and LAA are responsible for planning for the entire community's MH and addictions needs, local public health leaders indicated an integrated structure might provide opportunity for improving this effort.

Local BH officials noted that there is a level of collaboration now between the CSA and addictions services (e.g. co-funding of On Our Own) which has increased since HCMHA relocated into the HCHD offices in 2015. All recognize that opportunity exists to increase this collaboration to better serve patients. There was expressed an interest in expanding outcomes reporting to the wider community with respect to BH services.

Challenges Presented by Behavioral Health Integration

The specter of BH integration also highlights specific challenges for the Howard County Health Department and the Howard County Mental Health Authority. Most notably, as addictions services transition to fee for service payment the health department must make difficult decisions concerning continuation of HCHD based addictions services.

One respondent noted that integration might reduce the visibility (and perhaps influence) of health and behavioral health services amongst county leadership, because presently both the health officer and the executive director of the HCMHA sit on the County Executive's cabinet. There was concern about one of those seats being eliminated in an integrated structure.

As noted by leaders in other jurisdictions, integration or consolidation of Behavioral Health Services under one entity (either government or non-profit) could result in reduced access to funding, since certain grants are only available to government agencies while others are only available to private agencies. Two local leaders expressed concern over pending state regulations that would require

behavioral health agencies and providers to be accredited by a national organization. In particular, they were concerned that these regulations would diminish further a provider pool already in short supply. On the other hand, an integrated BH structure may be better positioned to plan for such impact.

Finally, local leaders observed, like their counterparts in other jurisdictions, that the state behavioral health system is not yet truly and completely integrated, which will inevitably create challenges at the local level. Until MH and addictions funds are blended at the state level there is local concern about administering these dollars.

Prospective Behavioral Health Integration Structures

When asked to comment on a prospective integrated behavioral health structure located within the HCHD or the HCMHA, local respondents favored a new integrated structure that would reside within their own legacy organization. Arguments offered for reorganizing within HCMHA centered around the nimbleness and flexibility that a non-profit enjoys over a governmental structure (with specific mention of procurement processes), as well as the access to funds that would be eliminated by consolidating under the local health department. It was also noted that HCMHA is not a provider organization, and if HCHD eliminates its direct provision of addictions services that CSA would be prepared to pick up the oversight responsibility for addictions. One interviewee suggested consideration of a structure similar to the Local Management Board (LMB) where the behavioral health board would do its own grant-making.

The benefits of consolidating behavioral health services under the health department which were cited by interviewees from jurisdictions outside of Howard County that had selected this approach were not echoed by the local stakeholders interviewed. These benefits, cited earlier and in Appendix 9, include:

- Financial strength – Despite financial challenges across the health care landscape, several jurisdictions mentioned the relative financial strength that a public jurisdiction offers relative to an independent non-profit.
- Depth of support resources – A public health department is able to draw upon its resources (contract management, planning, human resources, etc.) from other programs to support a core service agency and local addiction authority. An independent non-profit would be required to scale all of these support services if additional functional responsibilities were transferred from the health department, potentially adding overhead.
- Cross fertilization of ideas – Respondents noted that employees of two closely aligned organizations of different structures bring different perspectives to problem solving that can be valuable to organizations charting new ground.
- Because of its larger size relative to a small non-profit, a local health department may provide sufficient separation of functions to ensure the required firewall between oversight and direct provider organization.

Interestingly, the Garrett County consolidated both its CSA and LMB within the health department when it re-organized in 2008. Similarly, Montgomery County reorganized its health department around a human services organization model that includes social services (children, youth and family), aging and disability services, behavioral health and crisis, public health and special needs populations (homeless etc.) (Refer to *Appendix 10.i.i*, Montgomery County Department of Health and Human Services Organizational Chart).

In summary, local leaders cited opportunities for behavioral health integration to improve services. They recognized the same challenges that leaders in other jurisdictions who have completed or are contemplating BH integration have identified. Finally, there is not local consensus around a model for integration, but agreement that integration in some form is best for the consumers that the system is responsible to serve.

Recommendations

This survey of behavioral health integration shows that there is not one single "right" approach to accomplishing such integration. Rather the structure is a function of the unique needs of the jurisdiction, the local resources available to support the structure and the political realities at the time of integration.

With the perspective gained from the foregoing research, the author offers the following recommendations for consideration as Howard County contemplates integration of behavioral health services.

- Commit to integrate. Despite challenges of timing by the state, competing priorities and other potential barriers, there is near universal agreement by those jurisdictions that integrated that such reorganization is in the best interest of constituents served, and in the long run will provide for a more effective and [likely] more efficient operation.
- Structurally, integrate behavioral health services under the Howard County Health Department. While this may require foregoing certain future funding streams available only to non-profits, I believe such an organization is in the best interest of constituents. The financial strength of Howard County Government will support integrated behavioral health services within HCHD. Furthermore, Howard County government has a long history of successfully collaborating with state government on innovative approaches to tackling civic challenges. The strength of all partners, HCHD, HCMHA and HC government – is best leveraged using the Howard County Health Department as the umbrella organization to tackle the behavioral health challenges facing the community.
- Invest in planning and communications infrastructure to ensure a successful integration. Review the "advice" themes included in *Appendix 8* and summarized above. There was widespread agreement that the best integration efforts occurred when affected staff were involved in the planning and there was regular communication throughout the process. The author recommends two resources to underscore the importance of change management. First, a recent TED talk by Simon Sinek, *Start with "Why?"* offers a simple approach for framing change. (https://www.ted.com/talks/simon_sinek_how_great_leaders_inspire_action?language=en) Second, Our Iceberg is Melting, by John Kotter and Holger Rathgeber, offers an 8-point approach for managing change. Several interviewees suggested other resources which are listed in *Appendix 11*.
- Use tangible goals as beacons for leading change, such as the "No Wrong Door" access structure. This in particular addresses a concern mentioned by local leaders that local behavioral health services push beyond the "public mental health system" mandate to address very real needs of the broader Howard County community.

Conclusion

Public health services and behavioral health services in particular are daily tackling some of the most vexing issues facing local governments across Maryland. All of the individuals who contributed to this document clearly exemplify the spirit of community building that is so critical to carrying out this mission. Their willingness to experiment with new structures, new financing and new collaborations with organizations inside and outside of government is bedrock of future success.

All of those interviewed expressed a willingness to provide additional perspective and counsel as Howard County sets its course for behavioral health integration.

Appendix 1.

Interview Discussion Guide

1. Has your jurisdiction completed its integration of mental health and substance abuse services?

2. Describe your current (and planned if transition underway) structure for Mental health and substance abuse services.

3. Will you share an organizational chart?

4. Is the CSA housed in the HD or is it integrated (i.e. its budget is a line item in the LHD budget)?

5. When was your current structure implemented?

6. Approximately how long did it take) to plan and execute the reorganization?

7. In your opinion, what are the pros and cons of your county's behavioral health structure?

8. If you integrated how did you address the HR issues?

a. Were current staff brought on as new merit or contractual employees? Were new PINS (position identification #) created?

b. How did you address pay grade, accumulated sick leave, accumulated annual leave, years of service and retirement?

9. How did this re-organization affect your budget? Budget preparation? Do you have any recommendation on timing transition within the annual budget cycle to ensure resources are not lost?

10. What (if any) impact has this reorganization had on the level of support and assistance you have received from state agencies? How did you overcome them?

11. Were there any significant challenges that you encountered that you simply never anticipated?

12. Additional Comments/Advice/What would you do differently?

13. What should I have asked about but did not?

Appendix 2.

Introduction Email

On Tue, Feb 2, 2016 at 11:47 AM, Rossman, Maura <mrossman@howardcountymd.gov> wrote:

Dear Public Health Colleague,

I am writing to request your perspectives as the Howard County Health Department (HCHD) prepares to integrate mental health and substance abuse services into a single behavioral health structure.

As you know, following the State of Maryland's integration of Mental Health and Substance Use services into one Department, Behavioral Health Administration, Local Health Departments (LHD) are expected to fully integrate behavioral health over the next few years. Some LHDs have already integrated using one of two models:

- Core Service Agency (CSA) and Local Addictions Agency (LAA) are integrated within the LHD, or
- CSA and LAA are combined under a quasi-government non-profit

Howard County currently has the Mental Health Authority as the CSA, and HCHD as the LAA. HCHD wants to gain a better understanding of the pro and cons to each integration model so we can design the best system for Behavioral Health issues in Howard County.

We have engaged Paul Gleichauf (contact information below) to research current organizational structure of behavioral health services in other Maryland jurisdictions to help inform our restructuring. Paul will be contacting you during the next week to schedule a brief (15-20 minutes) telephone interview to learn about your behavioral health structure. When he calls I ask that you make time on your busy schedule to speak with him within the next two weeks if at all possible.

We are happy to share the results of this survey with you, as is may be helpful in your future planning needs.

Thank you for your assistance,

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Appendix 3.

Interviewees

ALLEGANY COUNTY	Patrick Panuska, Acting Health Officer Kristi Cuthbertson, Director of Behavioral Health Lesa Diehl, Director of Core Service Agency
ANNE ARUNDEL COUNTY	Adrienne Mickler Director, Anne Arundel County Mental Health Agency
BALTIMORE CITY	Crista Taylor, VP, Programs Ryan Smith, VP, Provider Relations Lynn Mumma, VP, Strategy Behavioral Health System Baltimore
BALTIMORE COUNTY	Phyllis Hall, Acting Director, Baltimore County Department of Health, Bureau of Behavioral Health
CALVERT COUNTY	David Gale, Director, Calvert County Core Service Agency
CAROLINE COUNTY	See "Mid-Shore"
CARROLL COUNTY	Sue Doyle, Director, Bureau of Prevention, Wellness, and Recovery
CECIL COUNTY	Ken Collins, Division Director for Addiction Services Gwen Parrack, Director of Special Populations (Division that includes CSA) Shelly Gulledge, Director, Cecil County Core Service Agency
CHARLES COUNTY	Dianna Abney, MD, Health Officer, James Bridges, MD, Deputy Health Officer
DORCHESTER COUNTY	See "Mid-Shore"
FREDERICK COUNTY	Dr. Barbara Brookmyer, Health Officer, Frederick County
GARRETT COUNTY	Rodney Glotfelty, Health Officer
HARFORD COUNTY	Beth Jones, Acting Director, Harford Co. Office of Drug Policy Control Behavioral Health Administration
HOWARD COUNTY	Donna Wells, Executive Director, HCMHA and co-chair of Howard County's 2014 Mental Health Task Force Roe Bonaccorsy, Stephen Liggett-Creel, Board Chair, HCMHA Stephen Liggett-Creel, HCMHA Board Chair, Elizabeth Edsall-Kromm, senior vice president of population health and community relations at Howard County General Hospital Nikki Highsmith-Vernick, president of the Horizon Foundation and co-chair of Howard County's 2014 Mental Health Task Force
KENT COUNTY	See "Mid-Shore"
MID-SHORE MENTAL HEALTH SYSTEMS, INC* (CSA for Caroline, Dorchester, Kent, Queen Anne's and Talbot Counties)	Holly Ireland, Executive Director, MSMHS, Easton
MONTGOMERY COUNTY	Scott Greene, Deputy Chief of Behavioral Health and Crisis Services (BHCS)
PRINCE GEORGE'S COUNTY	L. Christina Waddler, LICSW-C, Div. Director, Prince George's County Core Service Agency
QUEEN ANNE'S COUNTY	See "Mid-Shore"
SOMERSET COUNTY	See Wicomico County
ST. MARY'S COUNTY	Cynthia Brown, Director, St. Mary's County CSA
TALBOT COUNTY	See "Mid-Shore"
WASHINGTON COUNTY	Earl Stoner, Health Officer
WICOMICO COUNTY	Michelle Hardy
WORCESTER COUNTY	Jennifer LaMade, Director of Planning, Quality, Core Service

Appendix 4.

Integration Status and Structure

Jurisdiction	Integrated MH and SA?	Structure
ALLEGANY COUNTY	No. Planning for 7/1/2016 integration.	Behavioral Health is a division within health department. CSA is a non-profit which is located within health department. Cooperative agreement with Garrett County which provides oversight to Allegany County MH and SA services
ANNE ARUNDEL COUNTY	No.	CSA is non-profit; Health and Human Service Core Group - health, housing, social services, IT meet monthly to broach shared issues; Co-Occurring Disorders Task Force – provides virtual integration and standing forum for addressing MH/SA common issues; Joint provider meetings and training Joint training Contract for Crisis service
BALTIMORE CITY	Yes	Merged two non-profits into single non-profit
BALTIMORE COUNTY	Yes	Two Baltimore County Health Department (BCHD) legacy bureaus (MH and SA) were combined into the Bureau of Behavioral Health in BCHD
CALVERT COUNTY	Yes	CSA is bureau with health department
CAROLINE COUNTY	SEE MID-SHORE	
CARROLL COUNTY	Yes	Bureau of Prevention, Wellness and Recovery in CCHD. All patient care services provided through contracts. Support and referral services provided by bureau staff. All staff are state employees
CECIL COUNTY	No.	SA and CSA operate separately but both within health department. Addictions Services is single bureau. CSA is one department within the bureau of special populations
CHARLES COUNTY	No. In progress	Health Department is direct provider of both MH and addiction services. CSA is a separate division within health department. When integration is complete the CSA will take responsibility for LAA functions
DORCHESTER COUNTY	SEE MID-SHORE	
FREDERICK COUNTY	No	Very similar to Howard County. CSA operates as a separate non-profit, based in county regulation. Members of CSA board selected or approved by county government, but government does not authority over CSA activities. The local addictions authority (LAA) resides within the Frederick County Health Department
GARRETT COUNTY	Yes	CSA operates as unit within health department. Health department provides direct services in both mental health (fee for service) and addictions (grant funded). CSA provides oversight to addictions. LAA provides oversight to addictions. Health Department has MOU with Allegany County health department to secure complaint investigation for addictions services (to ensure firewall between complaints and direct service). Also has Local Management Board operate as a unit under the health

		department to take advantage of economies of scale.
Jurisdiction	**Integrated MH and SA?**	**Structure**
HARFORD COUNTY	No	Mental Health and addictions within HCHD, Behavioral Health Administration
HOWARD COUNTY	No	CSA is quasi-public non-profit. Addictions services organized within Howard County Health Department
KENT COUNTY	SEE MID-SHORE	Direct and contract services for MH and Addictions provided through KCHD
MID-SHORE MENTAL HEALTH SYSTEMS, INC* (CSA for Caroline, Dorchester, Kent, Queen Anne's and Talbot Counties)	No	MSMHS is a Private Not for Profit 501(C)(3) Organization, serving Caroline, Dorchester, Kent, Queen Anne's and Talbot Counties. MSMHS was incorporated in 1992 through a collaboration of the five county governments and mental health stakeholders. Core Service Agency (CSA) for 5 counties. Operate with letter of agreement with each 5 counties
MONTGOMERY COUNTY	Yes	CSA is housed within BHCS (see org. chart). LAA resides within CSA. County received funding for two positions for LAA, which were placed within CSA
PRINCE GEORGE'S COUNTY	Yes	CSA moved from Department of family services to health department
QUEEN ANNE'S COUNTY	SEE MID-SHORE	
SOMERSET COUNTY	See Wicomico	CSA for Wicomico and Somerset Counties resides within Wicomico County Health Department; Somerset has own LAA service.
ST. MARY'S COUNTY	No	Behavioral Health (MH and SA) are overseen by St. Mary's County Department of Aging and Human Services (SMCAHS). The CSA operates as a unit within the SMCAHS. No BH services in health department. • County commissioners also serve as county board of health.
TALBOT COUNTY	SEE MID-SHORE	
WASHINGTON COUNTY	No. Tried in 2004 but too contentious	CSA resides in separate 501© (3) non-profit. Has seat on the Washington County Board of Health (WCBH) which is advisory board only. [County Council serves as formal board of health]. MH and SA reside within health department. LHD employees are state employees paid by BHA
WICOMICO COUNTY	Yes	CSA for Wicomico and Somerset Counties resides within Wicomico County Health Department; Provides LAA services for Wicomico only.
WORCESTER COUNTY	Yes. Continue to refine	Mental Health and addictions operate as separate programs under the health officer. The CSA operates as a program within the Planning/Quality Assurance program.

Appendix 5.

Location of Core Service Agency

Jurisdiction	Integrated?	CSA Location
ALLEGANY COUNTY	No	Non-profit within HD
ANNE ARUNDEL COUNTY	No	Non-Profit
BALTIMORE CITY	Yes	Non-Profit
BALTIMORE COUNTY	Yes	Health Department
CALVERT COUNTY	Yes	Health Department
CAROLINE COUNTY	No	
CARROLL COUNTY	Yes	Health Department
CECIL COUNTY	No	Health Department
CHARLES COUNTY	No	Health Department
DORCHESTER COUNTY	No	
FREDERICK COUNTY	No	Quasi-Government Non-Profit
GARRETT COUNTY	Yes	Health Department
HARFORD COUNTY	No	Non-Profit
HOWARD COUNTY	No	Quasi-Government Non-Profit
KENT COUNTY	No	
MID-SHORE MENTAL HEALTH SYSTEMS, INC* (CSA for Caroline, Dorchester, Kent, Queen Anne's and Talbot Counties)	No	5-County Independent Non-Profit
MONTGOMERY COUNTY	Yes	Health Department
PRINCE GEORGE'S COUNTY	Yes	Health Department
QUEEN ANNE'S COUNTY		
SOMERSET COUNTY		
ST. MARY'S COUNTY	No	Unit SMC Aging & Humans Svc. Dept.
TALBOT COUNTY		
WASHINGTON COUNTY	No	Non-Profit
WICOMICO COUNTY	Yes	Health Department (Serving Wicomico and Somerset)
WORCESTER COUNTY	Yes	Health Department

Appendix 6.

Integration Issues

Jurisdiction	Integration Date	Time to Plan and Integrate?	Human Resource Issues?
ALLEGANY COUNTY	NA	NA	All are state employees within the health department.
ANNE ARUNDEL COUNTY	NA	Has been occurring over several years with joint task forces	NA
BALTIMORE CITY	2014	11 months	None. Two non-profits
BALTIMORE COUNTY	2009		No issues because both were/are departments within BCHD
CALVERT COUNTY	2014	Approximately 1.5 years; still work in progress	No issues because both were/are departments within CCHD. All county employees (i.e. not state) because of Baltimore County home rule.
CAROLINE COUNTY			
CARROLL COUNTY	4/1/2012	18 Months	None. All were state employees prior to and after integration.
CECIL COUNTY	NA	NA	NA. Both CSA and Addictions staff are CCHD employees.
CHARLES COUNTY	NA	18 Months from now. A multiyear process in total	No issues because both were/are departments within CCHD
DORCHESTER COUNTY			
FREDERICK COUNTY	Anticipate 2017	NA	Not yet addressed.
GARRETT COUNTY	Approx. 7-8 years ago	Do not recall	Employees of non-profit legacy CSA became state employees with new PINS. [Mr. Glotfelty can provide detail on transition if this route is selected]
HARFORD COUNTY	NA	NA	NA
HOWARD COUNTY	NA	NA	NA
KENT COUNTY			

Jurisdiction	Integration Date	Time to Plan and Integrate?	Human Resource Issues?
MID-SHORE MENTAL HEALTH SYSTEMS, INC* (CSA for Caroline, Dorchester, Kent, Queen ante's and Talbot Counties)	NA	NA	NA
PRINCE GEORGE'S COUNTY	Jul-14		None. PINS simply moved to a different agency within PGHD
QUEEN ANNE'S COUNTY			
SOMERSET COUNTY			
ST. MARY'S COUNTY	NA	NA	NA
TALBOT COUNTY			
WASHINGTON COUNTY	NA	NA	NA
WICOMICO COUNTY	2013	Approximately 1 year	None. All in WCHD.
WORCESTER COUNTY	2008 - CSA moved into health department (previously quasi-governmental non-profit); 2014 - CSA took over contracting for MH services in addition to its oversight role	6 years (lots of iterative steps)	All are now state employees within the health department. [could not get perspective on 2008 transition]

Appendix 7.

Integration Hurdles

Jurisdiction	Major Hurdles
ALLEGANY COUNTY	Insufficient budget relative to need; Insufficient providers; Getting MH staff "up to speed" on SA and vice versa. Both speak very different languages.
ANNE ARUNDEL COUNTY	
BALTIMORE CITY	Merging different cultures; two years in there are still divisions -• Trying to create something when the state has not merged yet; hurt us because state is not aligned;
BALTIMORE COUNTY	Education was required on both sides because MH team unfamiliar with Addictions issues and terminology and vice versa; needed time to learn each other's systems; Also, very different cultures in MH and addictions.
CALVERT COUNTY	Philosophical differences between MH and SA therapists. Getting both trying to provide the effective therapy. Getting everyone adjusted to changes. Understand new chain of command Also in accreditation role by CARF
CAROLINE COUNTY	
CARROLL COUNTY	Different vocabulary for MH and SA staff. Resistors to change (most eventually left).
CECIL COUNTY	
CHARLES COUNTY	Cultural challenges of blending two different treatment styles
DORCHESTER COUNTY	
FREDERICK COUNTY	- CSA does not have SA expertise; roles are different; MH assessments are critical because they determine - SA providers are specialized (to deal with particular diagnoses) whereas MH providers frequently provide services to patients with any MH diagnosis
GARRETT COUNTY	- Individual resistance to change. Consolidated leadership roles and converted non-profit staff to state employees
HARFORD COUNTY	
HOWARD COUNTY	
KENT COUNTY	
MID-SHORE MENTAL HEALTH SYSTEMS, INC* (CSA for Caroline, Dorchester, Kent, Queen Anne's and Talbot Counties)	

Jurisdiction	Major Hurdles
MONTGOMERY COUNTY	Oversight role is "awkward". CSA and LAA (within CSA) are overseeing complaints about direct service employees or contract organizations contracted through MC Department of Health and Human Services.
PRINCE GEORGE'S COUNTY	o Strongly encouraged by state to integrate BUT state has not yet integrated in name only. Still getting separate communications from state MH and SA and separate reporting is required for MH and SA
QUEEN ANNE'S COUNTY	
SOMERSET COUNTY	
ST. MARY'S COUNTY	
TALBOT COUNTY	
WASHINGTON COUNTY	
WICOMICO COUNTY	Unusually high staff turnover during transition
WORCESTER COUNTY	- Budgets are separate for CSA and LAA on state level; - When addictions transitions to FFS Addictions staff will struggle because of licensing issue; Addictions counselors are heading back in school for MSW or M Psych so they can bill under FFS model

Appendix 8.

Integration Advice

Jurisdiction	Advice
ALLEGANY COUNTY	NA
ANNE ARUNDEL COUNTY	
BALTIMORE CITY	• Consistent open communication • Change management • Recognize who are early adopters and leverage their energy • Manage change through all layers • Allow agency time to develop before marketing to external stakeholders • Process moved so quickly that we did not educate state on new organizations; did not communicate as well as possible to provider world; struggled with identity both internally and externally, • Get in the same space as quickly as possible • Leadership is key • Make the hard decisions early on; (are we going to eliminate positions?); open communications; reinforce the mission; • Advance planning: How will we make decisions; start with people or work;
BALTIMORE COUNTY	Allow staff time to understand each other's roles
CALVERT COUNTY	Recognize that staff positions may be eliminated as staff get dually qualified. HOWEVER, this may leave department short staffed relative to demand.
CAROLINE COUNTY	
CARROLL COUNTY	1. Create opportunities early to get people on each side to know each other at all levels. (e.g. regular all staff meetings PRIOR to integration, holiday party, etc.) 2. Understand everyone's strengths and play to them. 3. Make time to learn each other's language. (e.g. diversion means something different to MH and SA providers). 4.
CECIL COUNTY	Use local hospital as a support to integration. Union Hospital (Cecil Co) brought Addictions and CSA together to assist them with ED diversion
CHARLES COUNTY	Find champions in both MH and Addictions who can help lead the charge.
DORCHESTER COUNTY	
FREDERICK COUNTY	
GARRETT COUNTY	Line up support in advance; charge rent to all tenants in HD to ensure value attached to services. Can provide specific support concerning personnel transitions
HARFORD COUNTY	
HOWARD COUNTY	
KENT COUNTY	
MID-SHORE MENTAL HEALTH SYSTEMS, INC* (CSA for Caroline, Dorchester, Kent, Queen Anne's and Talbot Counties)	- strongly encourage integration of CSA and LAA functions; - recommend giving local health officer ex officio vote on CSA board; - advocates for non-profit structure due to additional funding options
MONTGOMERY COUNTY	- Anything to further integrate is moving in the right direction; - Addictions complaints go to health officer - Mental Health complaints go to BH and Crisis Services Chief

Jurisdiction	Advice
PRINCE GEORGE'S COUNTY	Include leadership in both organizations (CSA and HD) in planning integration
QUEEN ANNE'S COUNTY	
SOMERSET COUNTY	
ST. MARY'S COUNTY	NA
TALBOT COUNTY	
WASHINGTON COUNTY	
WICOMICO COUNTY	- Did self-assessment in 2012; COMPASS tool; helpful - Combined staff meetings; used time to discuss each program; education; - Transparency - Communication - Focus on better patient care as goal
WORCESTER COUNTY	- Keep focused on integration is best for patient. Best quality program with single intake - Health Officer vision for integration is invaluable; particularly when budgets get moved back and forth;

Appendix 9.

Advantages and Disadvantages of Alternate Structures

Jurisdiction	Advantages of Present Structure	Disadvantages of Present Structure
ALLEGANY COUNTY	BHA (state) runs contracts through CSA (non-profit) to take advantage of easier procurement processes	
ANNE ARUNDEL COUNTY	Financing and procurement easier in non-profit CSA; works well because of 1) strong collaborative relationship between health officer and CSA, 2) two multi-disciplinary task forces	
BALTIMORE CITY		
BALTIMORE COUNTY	o Cross fertilization of knowledge	- Lack of funding flexibility; there are funds for administrative staff and funds for services which cannot be shifted to areas of greatest need; - Allow staff time to understand each other's roles - CSA outside of LHD can do things more nimbly - move quicker, more flexible, can accept funding which government cannot.
CALVERT COUNTY		
CAROLINE COUNTY		
CARROLL COUNTY		
CECIL COUNTY	Currently collaborate on multiple levels including Drug and Alcohol Advisory Group, CSA Advisory Group, new service planning work groups, Co-occurring disorders work group, overdose review and fatality review teams, peer advocates	Being within government both CSA and Addictions constrained by challenges of governmental bureaucracy (e.g. procurement). Further, not eligible for certain grants that non-profit CSAs can pursue.
CHARLES COUNTY		
DORCHESTER COUNTY		
FREDERICK COUNTY		Presently no firewall between oversight and direct care for substance abuse services. Will be contracting with LAA from a neighboring county to provide reciprocal LAA Oversight responsibilities for each other's direct care SA services
GARRETT COUNTY	Streamlined decision making; economies of scale in management staff.	Resistance to change when structure to re-organize was presented.

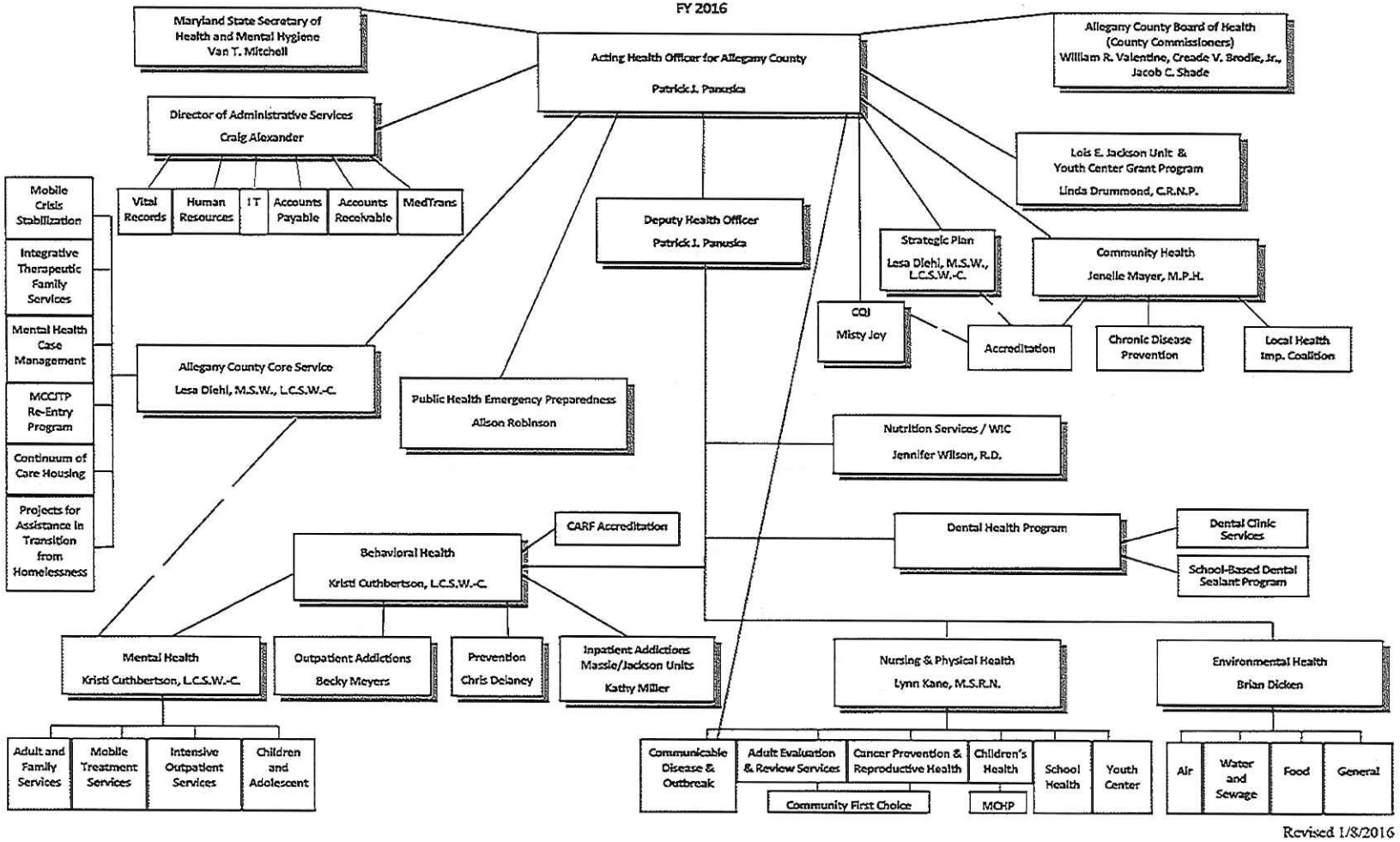
Jurisdiction	Advantages of Present Structure	Disadvantages of Present Structure
HARFORD COUNTY		
HOWARD COUNTY		
KENT COUNTY		
MID-SHORE MENTAL HEALTH SYSTEMS, INC* (CSA for Caroline, Dorchester, Kent, Queen Anne's and Talbot Counties)	- advocates for non-profit structure due to additional funding options	
MONTGOMERY COUNTY	- Stable workforce - Better pay scale than if non-profit - As part of MCHHS, 1/3 of funding is from state grant; 2/3 is funded by county general fund. Particularly advantageous in wealthy Montgomery County iv. Because we are part of HHS, not competing for limited resources.	- Advantage of privatization – procurement is much easier; public procurement slow - Potential for conflict of interest (oversight vs. direct provision of services) BUT... Benefits outweigh disadvantages
PRINCE GEORGE'S COUNTY	- SA and MH now co-located - Better services for residents	- Still spread out over 3 locations - Previous small agency (CSA) moved into much larger agency (LHD) - Several layers between CSA head and Health Office o Harder for CSA to "get the work done" as a part of the BH Division
QUEEN ANNE'S COUNTY		
SOMERSET COUNTY		
ST. MARY'S COUNTY	There is some integration insofar as a single fiscal specialist oversees grants for MH, SA, prevention, and the local management/ children's board. This proves helpful for cross funding opportunities.	• Must write two separate plans for MH and Addictions
TALBOT COUNTY		
WASHINGTON COUNTY		
WICOMICO COUNTY	Can provide more integrated services to patient; more united front; integrated service training for other staff; MH deals directly with SA staff, X training,	- Larger staff, difficult on managers; - Addition counsellors think SW are "taking over" because SWs don't need extra license
WORCESTER COUNTY		

Appendix 10.

Organizational Charts of Selected Health Departments and Behavioral Health Services

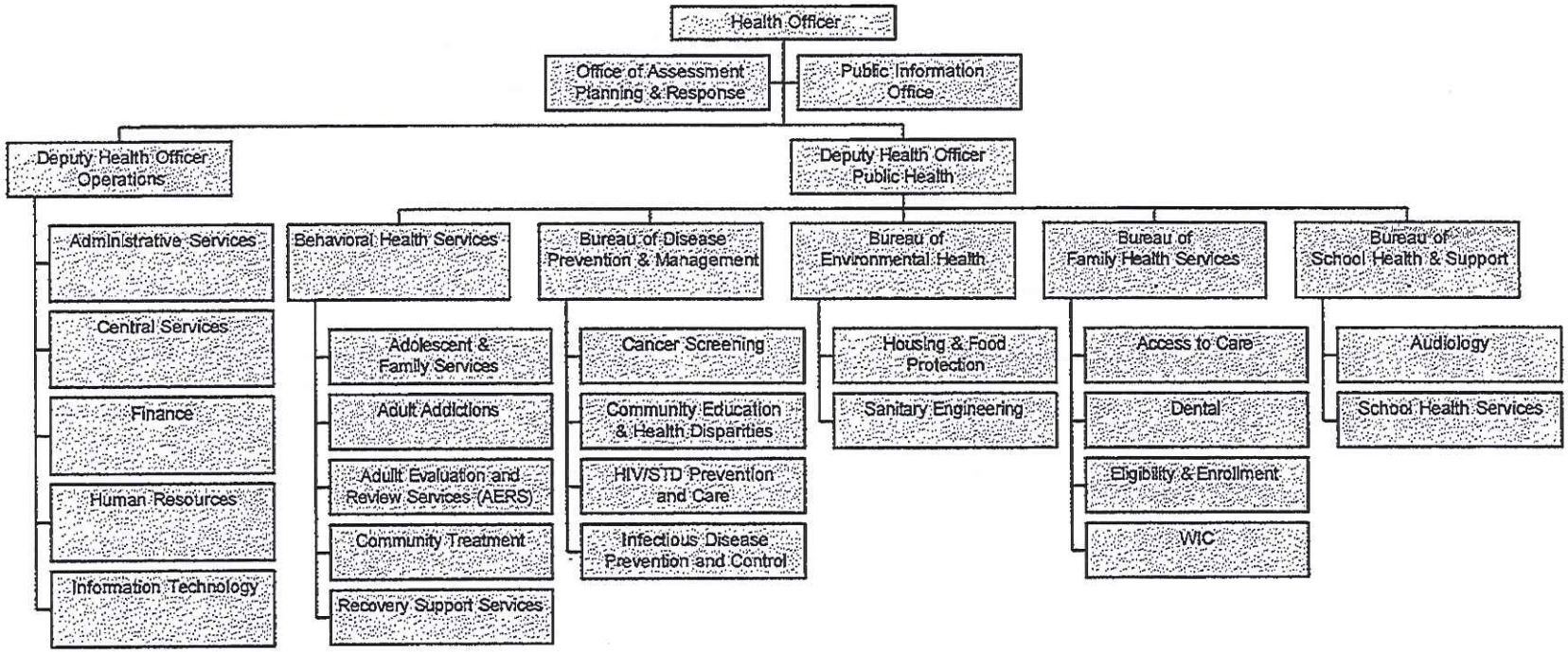
a) Allegany County
b) Anne Arundel County
   i) Health Department
   ii) AA Mental Health Agency
c) Baltimore County
   i) Behavioral Health
d) Calvert County
   i) Health Department
   ii) Core Service Agency
e) Carroll County
   i) Bureau of Prevention, Wellness and Recovery (i.e. Behavioral Health)
   ii) Behavioral Health Advisory Council (BHAC)
   iii) BHAC Subcommittee Descriptions
f) Cecil County
   i) Health Department
   ii) Division of Special Populations (includes CSA)
   iii) Division of Addiction Services
g) Frederick County
h) Garrett County
   i) Health Department
i) Harford County
j) Mid Shore Mental Health Systems, Inc. (CSA for Caroline, Dorchester, Kent, Queen Anne's and Talbot Counties)
k) Montgomery County
   i) Department of Health and Human Services
   ii) Behavioral Health and Crisis Services
l) Prince George's County
m) Wicomico County

ALLEGANY COUNTY HEALTH DEPARTMENT
FY 2016



Revised 1/8/2016

Anne Arundel County Department of Health
Organization Chart



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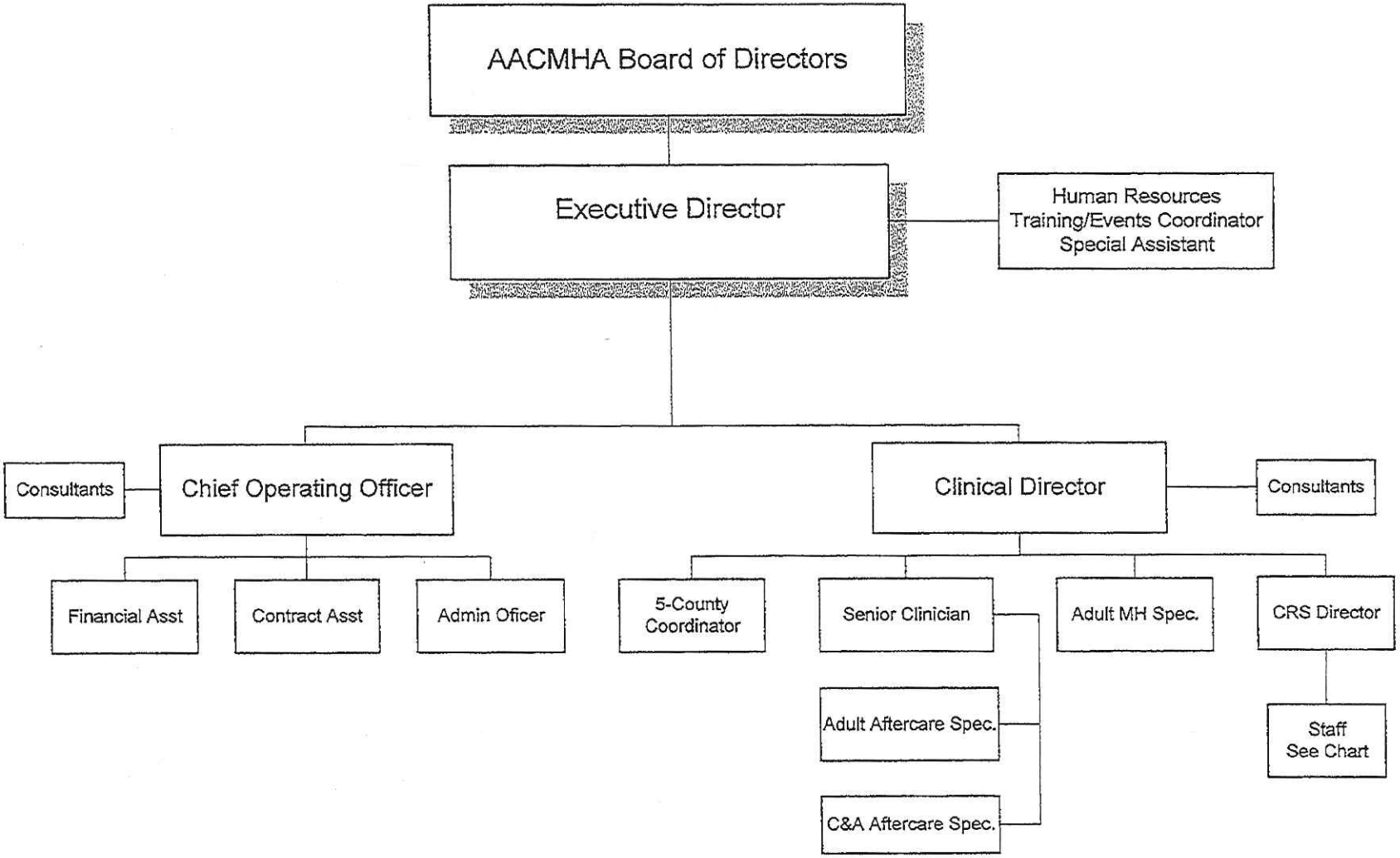
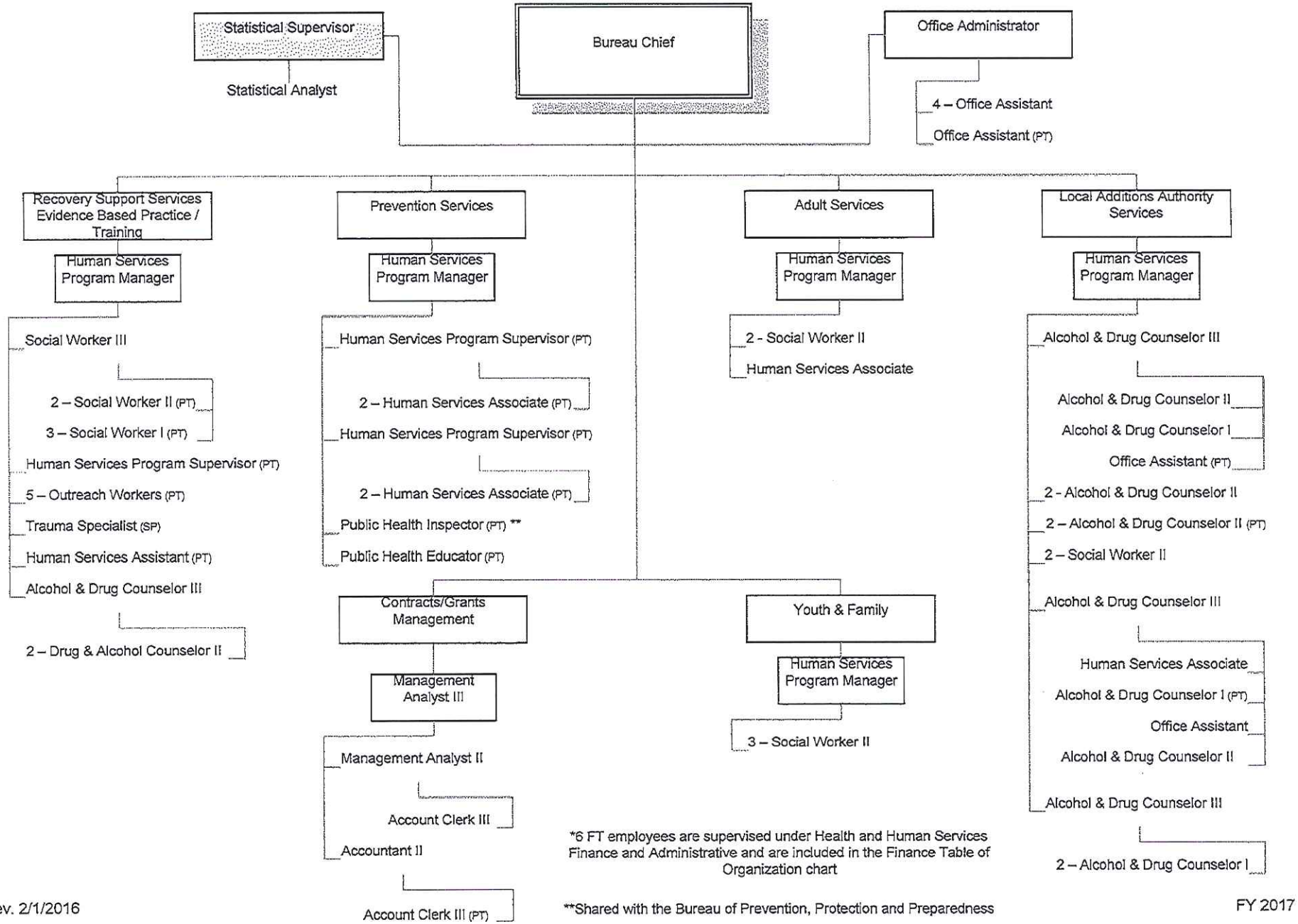
Anne Arundel County Mental Health Agency, Inc.



68 Employees
41 Full-Time
27 Part-Time

Baltimore County Department of Health
Bureau of Behavioral Health
Table of Organization



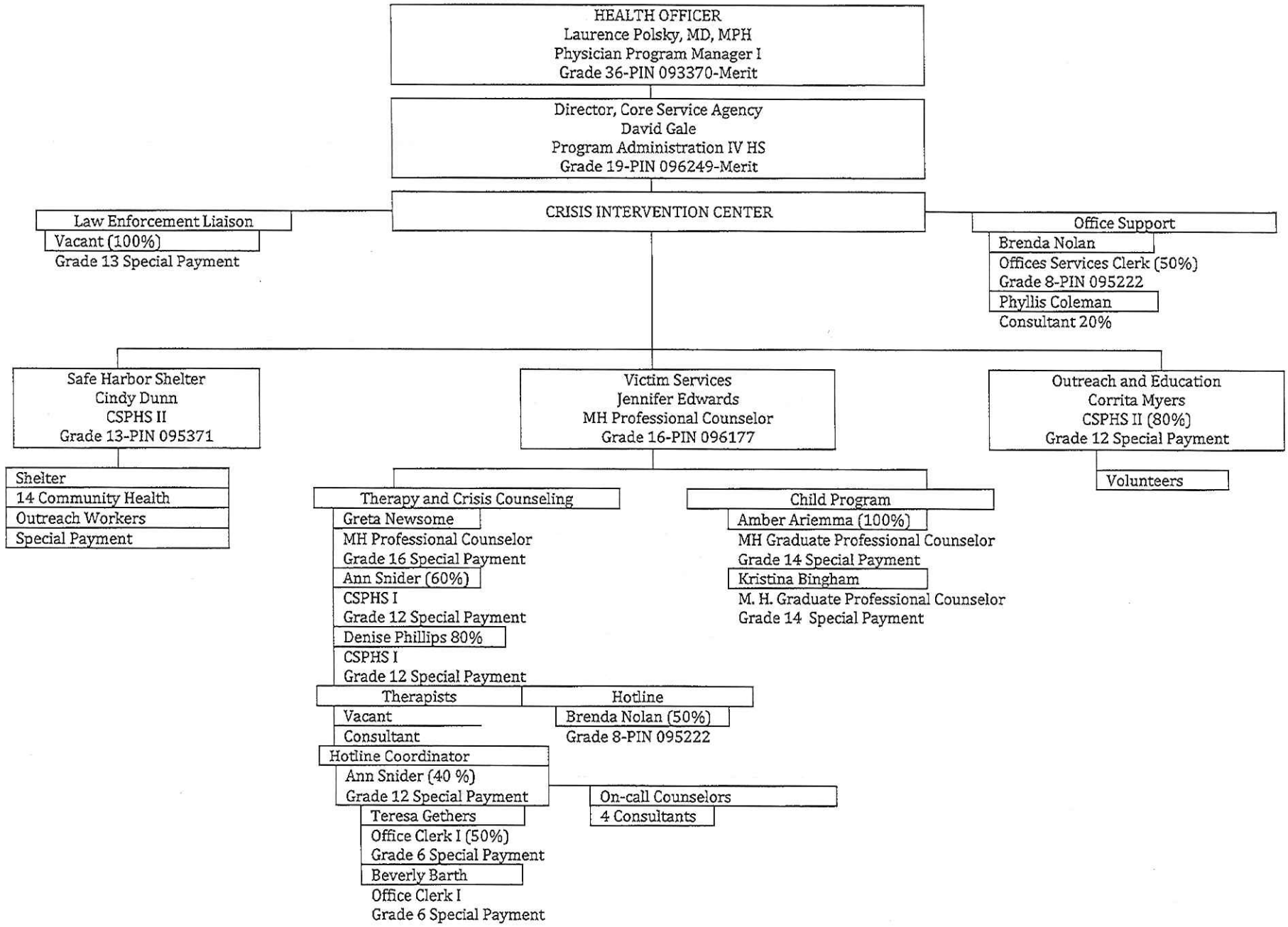
*6 FT employees are supervised under Health and Human Services Finance and Administrative and are included in the Finance Table of Organization chart

**Shared with the Bureau of Prevention, Protection and Preparedness

Rev. 2/1/2016

FY 2017

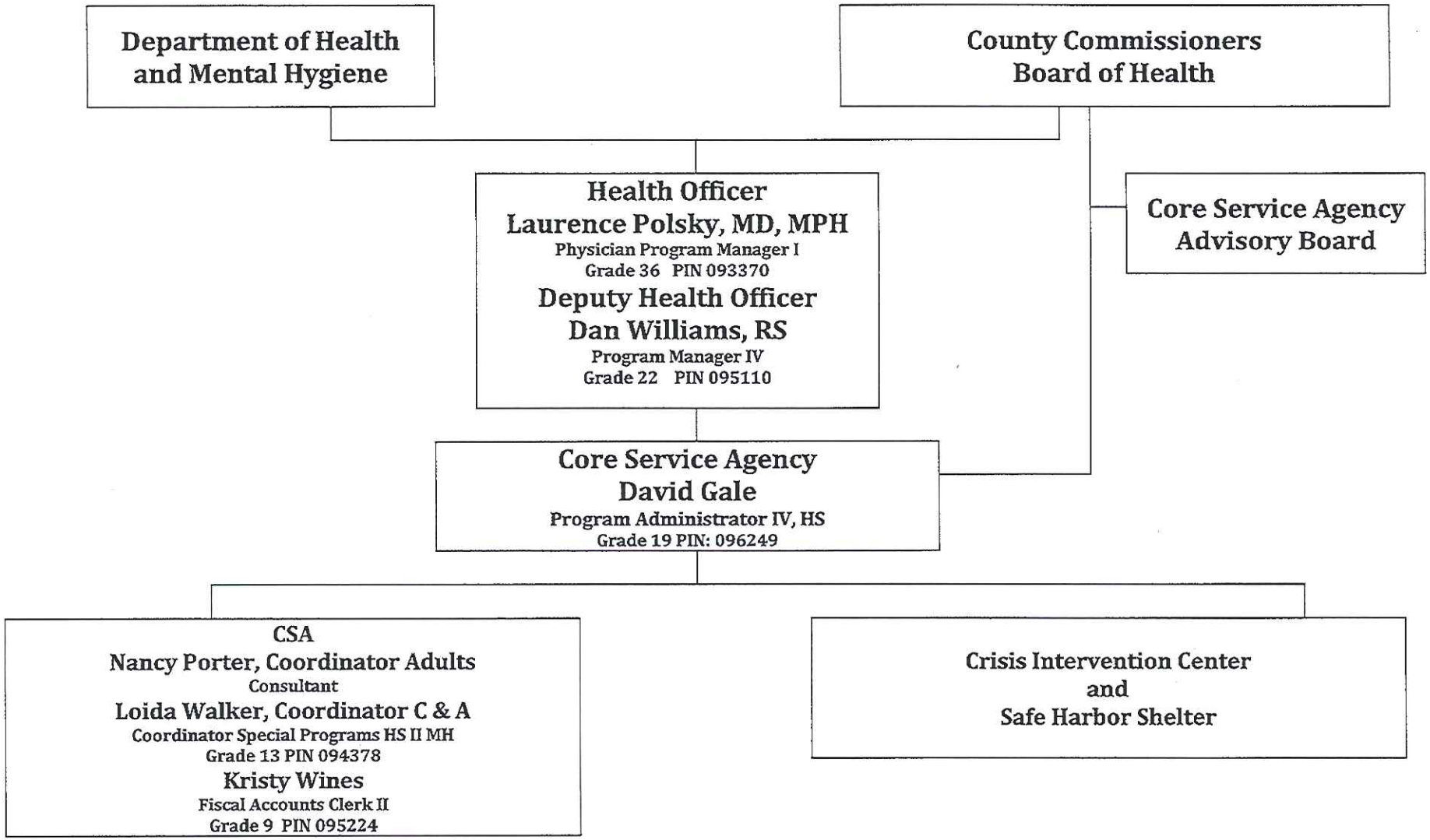
CALVERT COUNTY HEALTH DEPARTMENT – CRISIS INTERVENTION ORGANIZATION CHART



Laurence Polsky, Health Officer _____ Date _____

David Gale , Director _____ Date _____

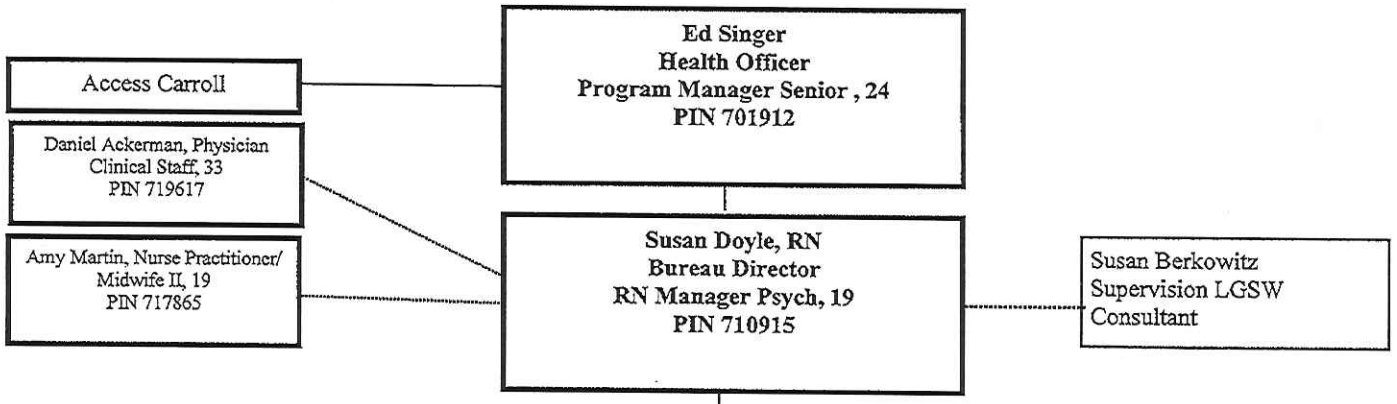
Organizational Chart for Core Service Agency



David Gale, Director Date

Laurence Polsky, Health Officer Date

Bureau of Prevention, Wellness and Recovery

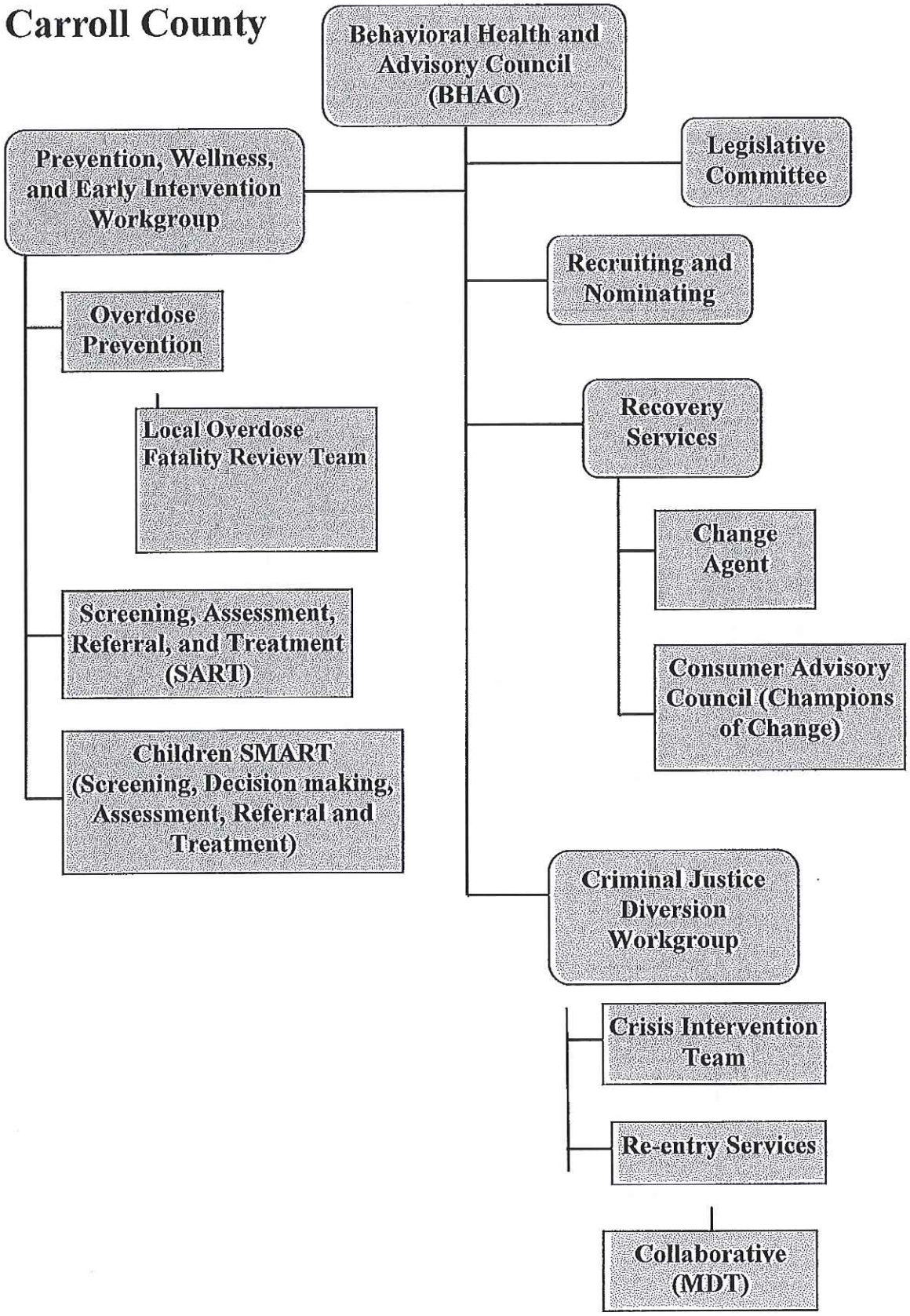


Services Include:
Recovery Services/Peer Support
Urgent Care
Shelter Plus Care/PATH
ATR/State Care
Crisis Intervention
Urgent Care
MCCJTP
Diversion

Services Include:
Contract Monitoring
Alcohol and Other Drug
Prevention
Underage Drinking
Education and Training
Children SMART
SART
Overdose Prevention
Crisis Intervention
Suicide Prevention
Mental Health First Aid

Services Include:
Outpatient Services
Detention Center Services
Reentry Services
Crisis Intervention
Medical Services
Administration/Operations

Carroll County



The BPWR maintains representation on all committees of the Council. Descriptions of each of the workgroups currently operating under the direction of the BHAC are as follows:

Recovery Services Steering Committee: This committee is a blending of the Comprehensive Continuous Integrated Systems of Care (CCISC) initiative and the Recovery Oriented Systems of Care (ROSC) efforts in Carroll County. The steering committee has been meeting for 4 years in Carroll County and continues to look at systems changes that will continue the efforts of creating a co-occurring capable system of care in our county. Evidenced based practices that are Strength based, person-centered and "no wrong door" are highlighted. Tom Godwin from the University of MD continues to provide technical assistance and updated information regarding co-occurring capability and other topics. This group serves as the ROSC Steering Committee and contains representation of BPWR, Access Carroll, Carroll County Youth Service Bureau, Mosiac, Moutain Manor Recovery Support Services, Villa Maria, On Our Own, Partnership for a Healthier Carroll County, Service Coordination (DDA)

Change agents:

This is a workgroup of Recovery Services, comprised of representatives of all participating providers for the purpose of integration of care. The change agent is a person from inside the organization who helps the organization transforms itself by focusing on such matters as organizational effectiveness, improvement, and development. In addition to the organizations, the change agents are also responsible for evaluating the role and the needs of the local system. Change Agents are representatives of the Recovery Services Steering Committee

Champions of Change (Consumer Advisory Council): In an effort to enhance our consumer participation the BPWR has continued to support the efforts of the Consumer Advisory Council. This workgroup aids in ensuring that the BPWR have consumer input for all initiatives of the BHAC in planning for resources in the community. This workgroup has identified two consumer participants to co-chair the group and provide representation at the quarterly BHAC meetings. "Champions of Change" have a logo that appears on business cards and literature and work to support efforts in Carroll County associated with Anti-stigma, Recovery Month and Mental Health Awareness activities as advocacy efforts throughout the community.

Criminal Justice Diversion: The role of this workgroup is to lead continued efforts around justice-involved individuals with behavioral health needs. This workgroup focuses on developing diversion efforts to include programs at all identified intercept points, from first contact with law enforcement through community corrections. This workgroup is comprised of criminal justice personnel, law enforcement, judicial staff, hospital staff, medical professionals, Division of Parole and Probation, NAMI, Office of the Public Defenders, State's Attorney personnel, BPWR, OOO and County Government personnel.

Crisis Intervention Team: This newly created workgroup will work on development of CIT services in Carroll County. They will assess the community, ensure representation of all necessary community partners, assess current services and develop and implement a plan to achieve all the milestones and goals required to have a successful crisis intervention team. This workgroup is comprised of staff from BPWR, Local Law Enforcement and hospital personnel.

Re-Entry Services: This group meets on an as needed basis and has representatives that address the re-entry needs of all criminal justice involved individuals to ensure a smooth transition back into the community that consists of linkages to all necessary services. Carroll County MCCJTP and Substance abuse representatives have membership in the committee.

Collaborative workgroup: This multidisciplinary workgroup contains members of Human Services in Carroll County as well as detention center staff who provide services consistent with the needs of the criminal justice population. This group meets monthly and reviews inmates who will be released within the next 30 days. The assessment of needs is reviewed and plans are confirmed with linkages to partnering agencies.

Crisis Response: Specific to Crisis Response planning CCHD, Bureau of Prevention, Wellness, & Recovery have begun to develop a work group who will be responsible to assess needs of the community, invite all necessary community partners, educate the community and develop a plan to create crisis response services in Carroll County.

Prevention and Early Intervention: This workgroup focuses on expanding Prevention and Early Intervention efforts for both substance abuse and mental health as well as efforts for at risk populations. The workgroup reviews both the local mental health and the substance abuse strategic plans to identify initiatives for prevention and early intervention to be carried out by the members of the workgroup. Co-chairs for this workgroup are representatives with expertise in mental health and substance abuse as well as prevention efforts.

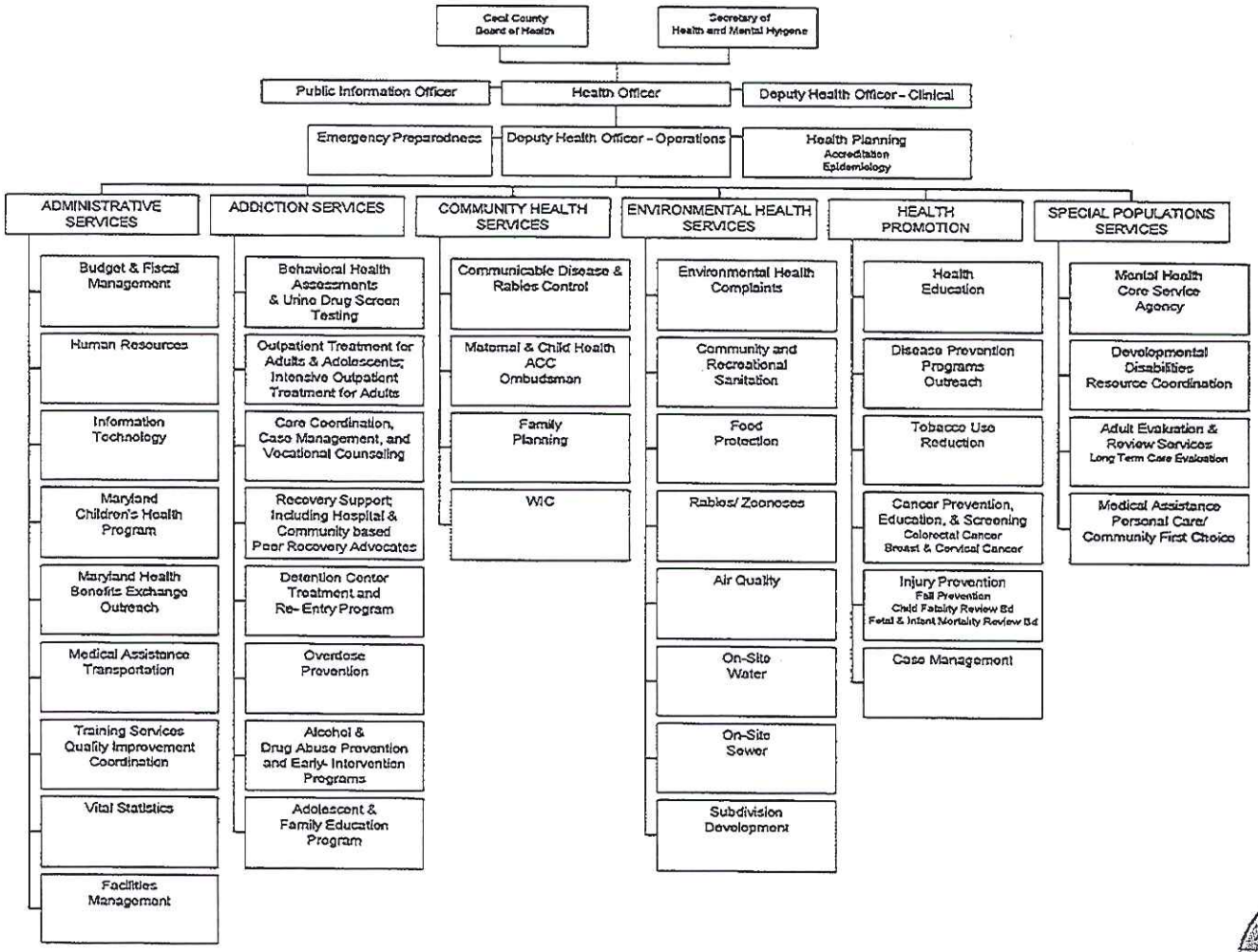
Overdose Prevention: The role of this group is comprised of personnel from the BPWR, local law enforcement, hospital staff, local behavioral health providers, Access Carroll, Peer Recovery Support Staff, State's Attorney Personnel to effectively identify needs and implement strategies to reduce the number of fatal and non-fatal overdoses that are a result of substance use. With the award of the new Opioid Misuse Prevention Plan funding, the group will continue to examine our state and local data and will also be developing a new plan.

Local Overdose Fatality Review Team: Carroll County's Health Officer has authorized the creation of an overdose fatality review team as is allowed in Health General. This group will review overdose deaths in Carroll County and will work to assess the issues, develop plans to address contributing factors and disseminate information to providers and the community at large.

Screening, Assessment, Referral, & Treatment (SART): This workgroup is focused on increasing education in the community to providers, professionals and citizens on the use of alcohol, drugs of abuse, tobacco, depression and domestic violence in pregnancy. Workgroup membership consists of local providers who have developed and signed onto a Qualified Service Agreement outlining the vision, foundation beliefs, and guiding principles of SART. The overall focus is to evade the number one preventable cause of mental retardation and birth defects in the United States. The goal of the SART Team is to identify pregnant women who use substances and/or are at risk for depression and domestic violence through the use of a uniform screening tool, referral of at-risk women to programs that will provide treatment and support services, and ultimately ensure that all children are brought home to safe and nurturing environments with ongoing supportive services.

Children SMART (Screening, decision Making, Assessment, Referral & Treatment): A work group with representation consisting of pediatricians, child psychiatrist, hospital leadership, nurses, community mental health and substance abuse providers and human services programs that serve or plan for the care of children services in Carroll County. This group has begun planning for developing a system of care that will identify high-risk children to receive services necessary for them to realize their fullest potential. The intent is to have those services available within the jurisdiction.

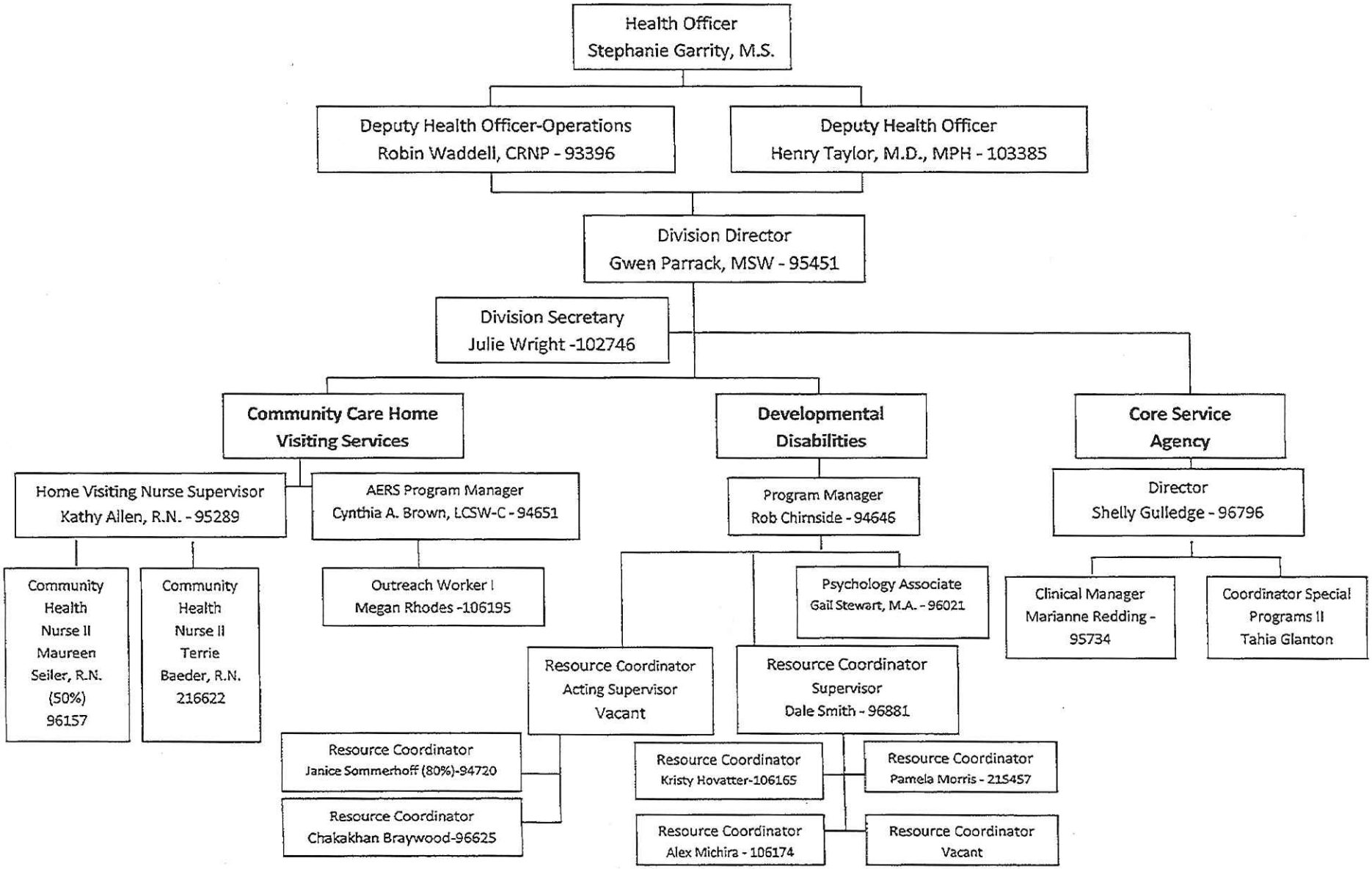
CECIL COUNTY HEALTH DEPARTMENT



7-2014

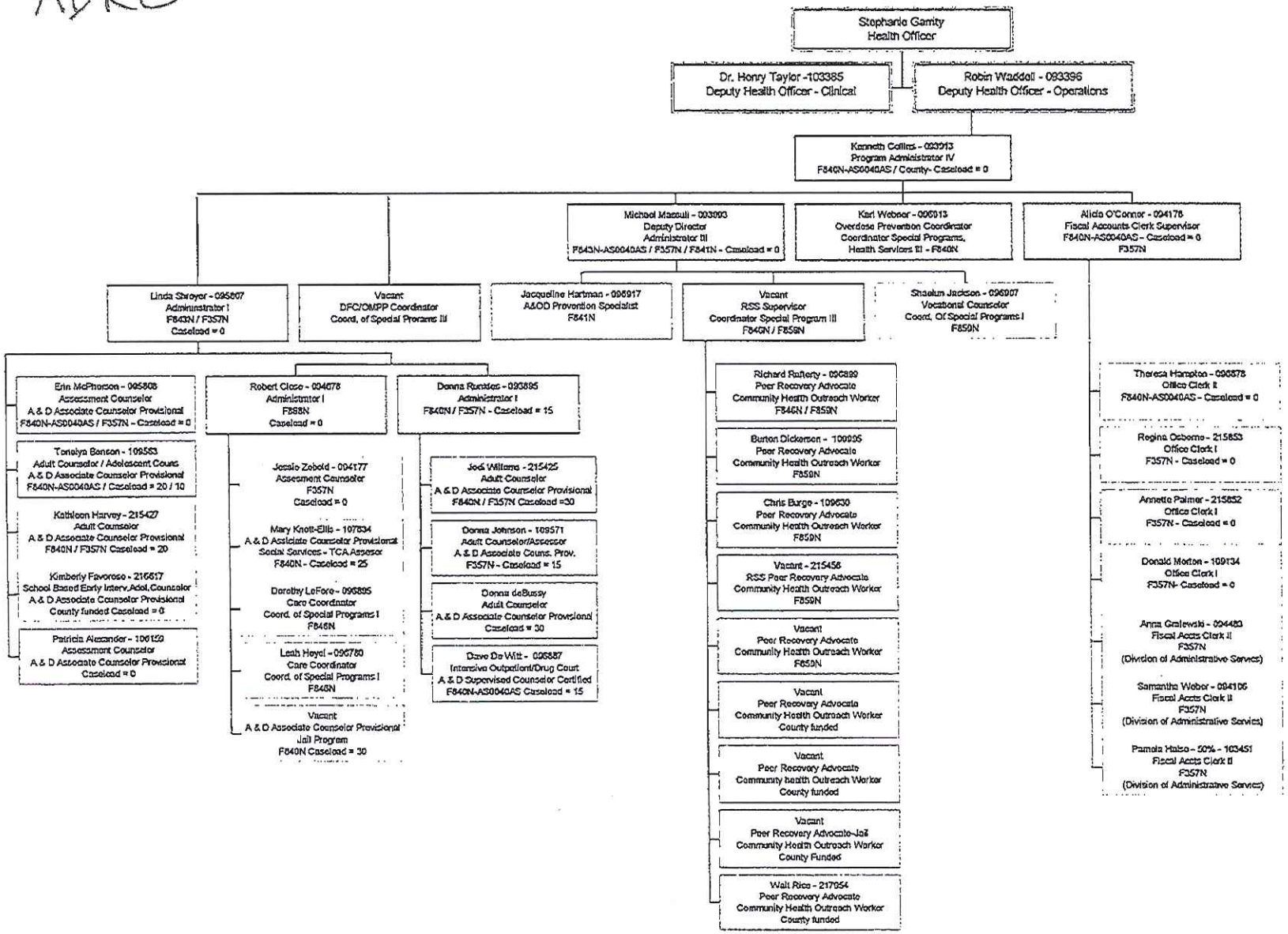
CECIL COUNTY HEALTH DEPARTMENT

CECIL COUNTY HEALTH DEPARTMENT
ORGANIZATIONAL CHART
Division of Special Populations Services



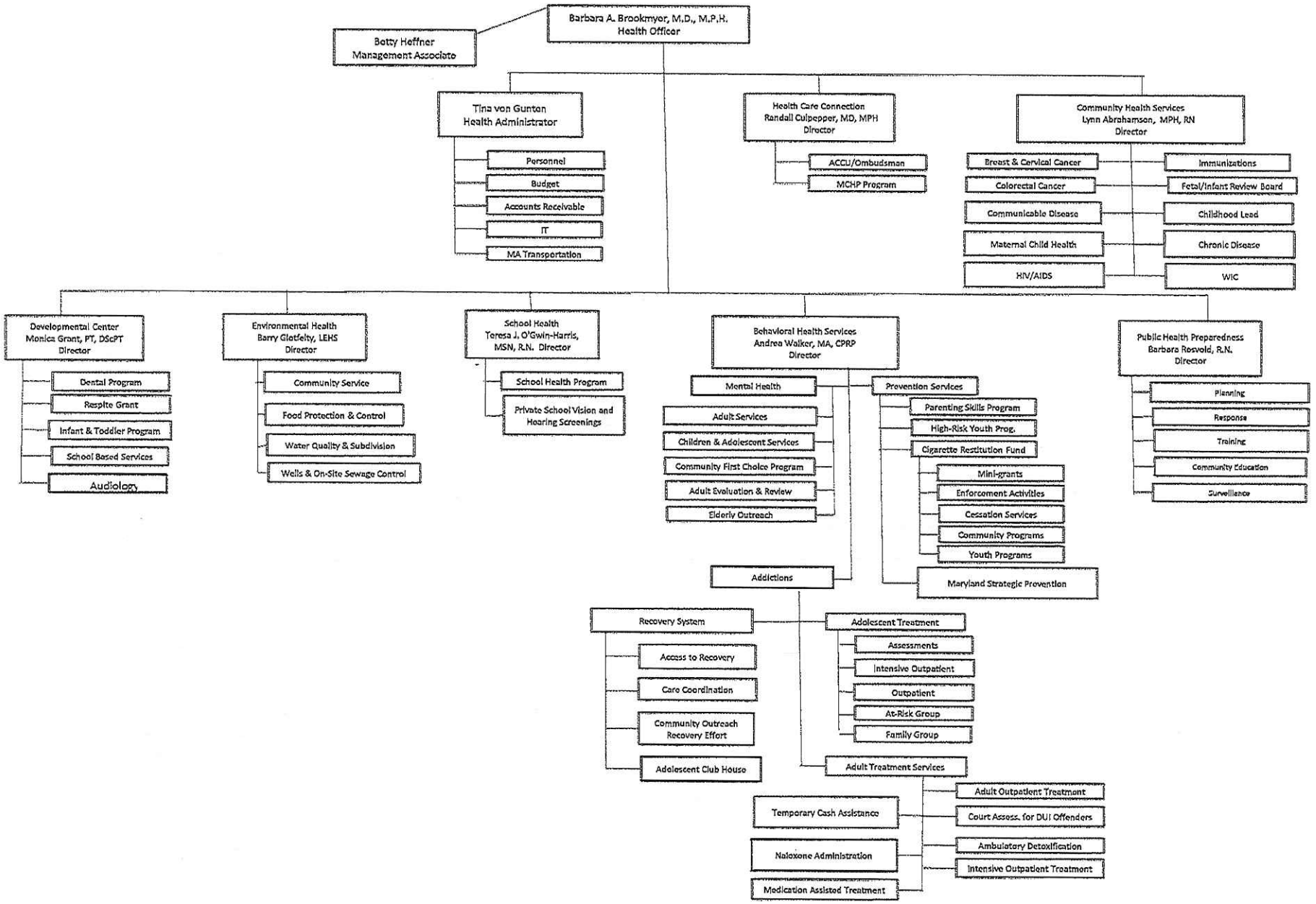
Updated: 9/9/15

ADRC



Updated 2015-09-10

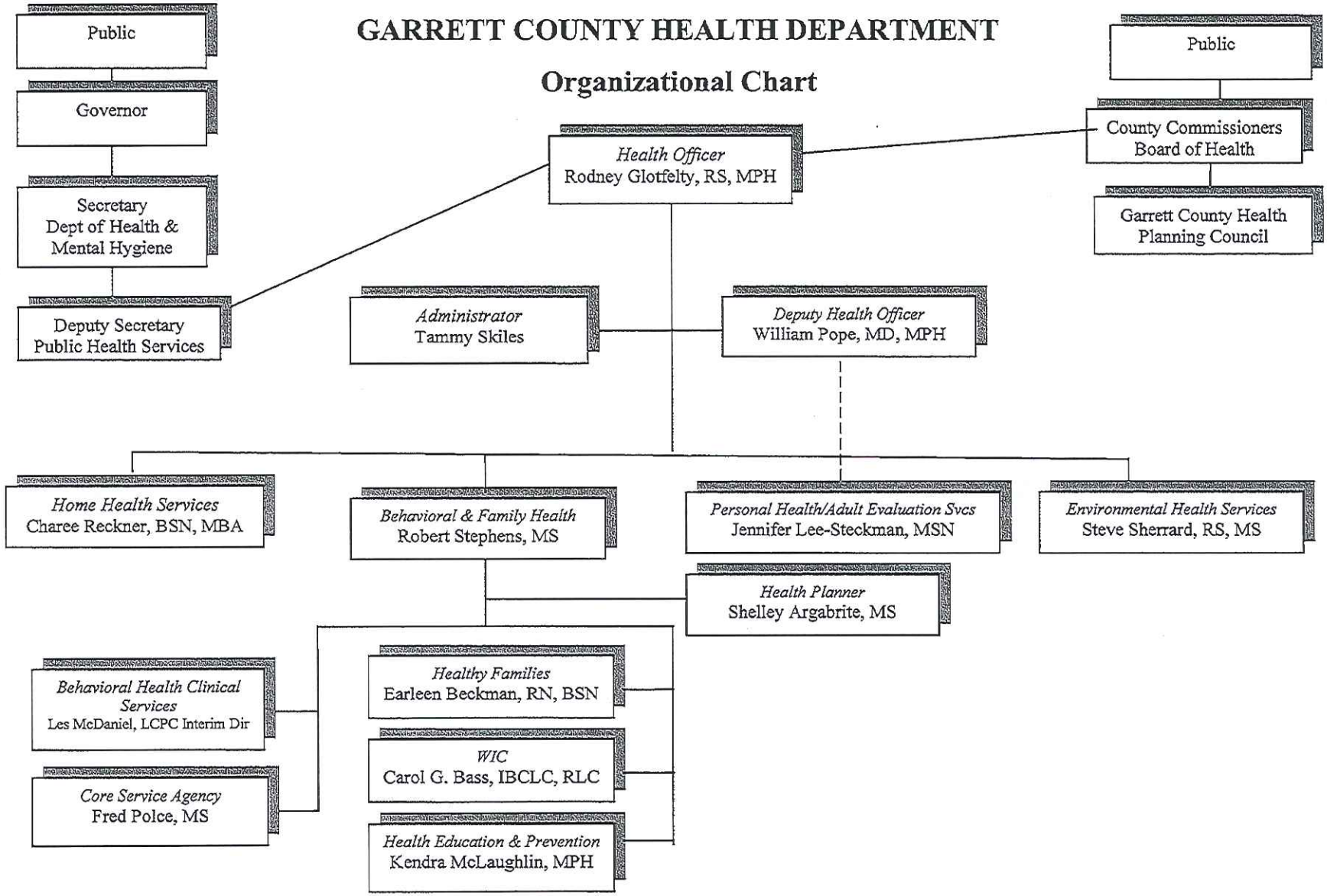
FREDERICK COUNTY HEALTH DEPARTMENT



Revised 9/01/15

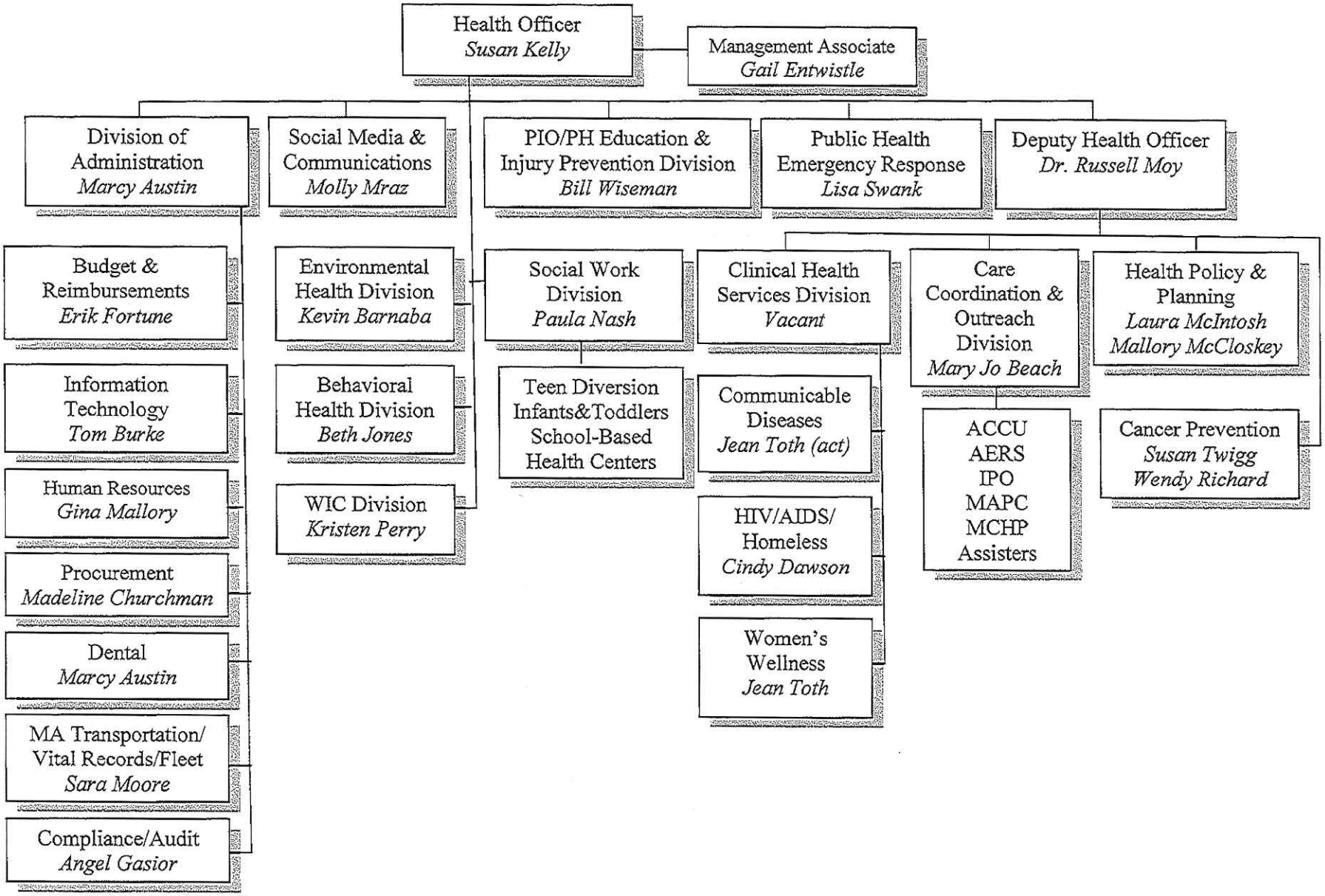
GARRETT COUNTY HEALTH DEPARTMENT

Organizational Chart

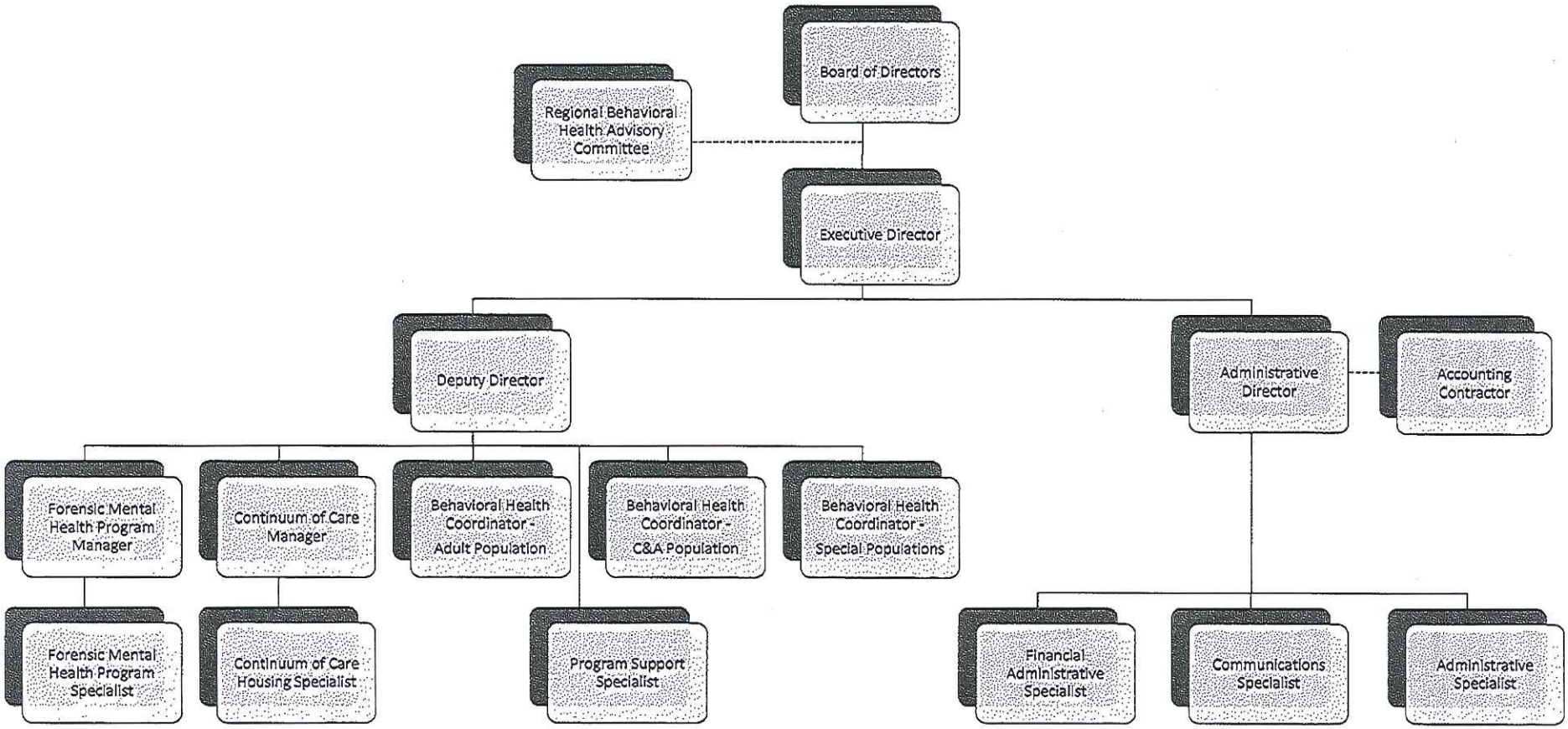


06/2015

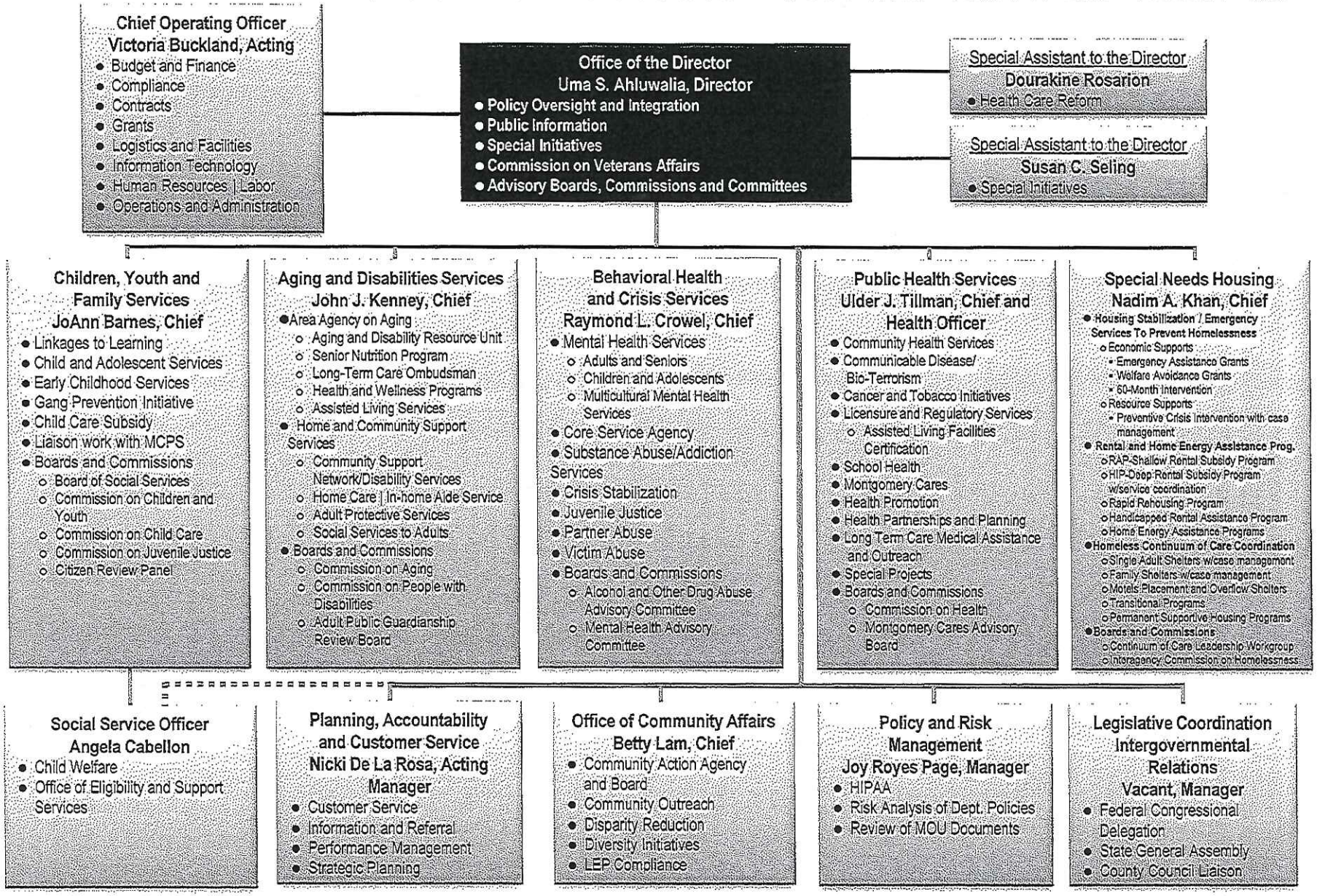
HARFORD COUNTY HEALTH DEPARTMENT
ORGANIZATIONAL CHART, JANUARY 2015



Mid-Shore Mental Health Systems, Inc.
Organizational Chart

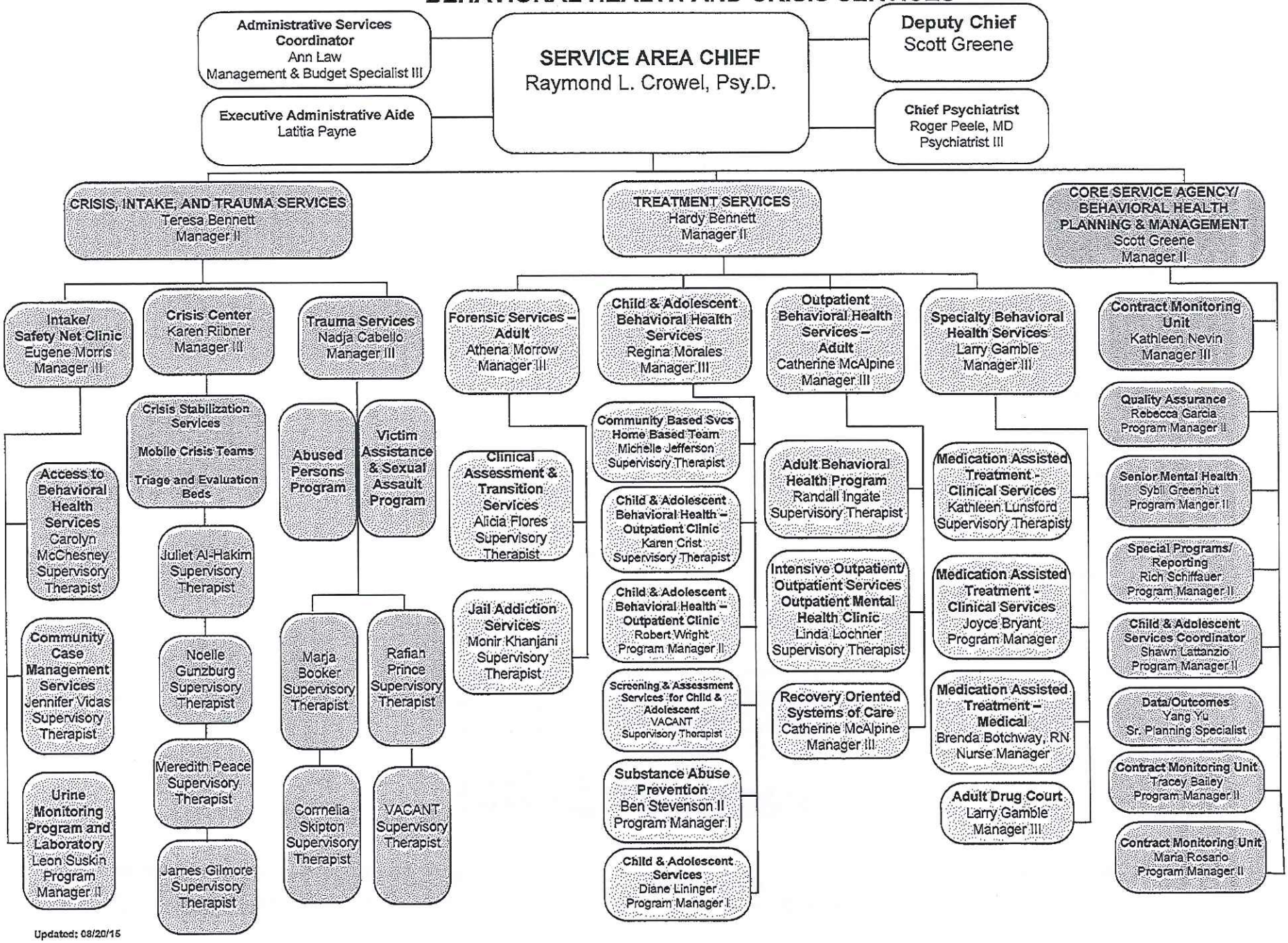


Department of Health and Human Services – Organizational Chart



Last Update 2.10.16

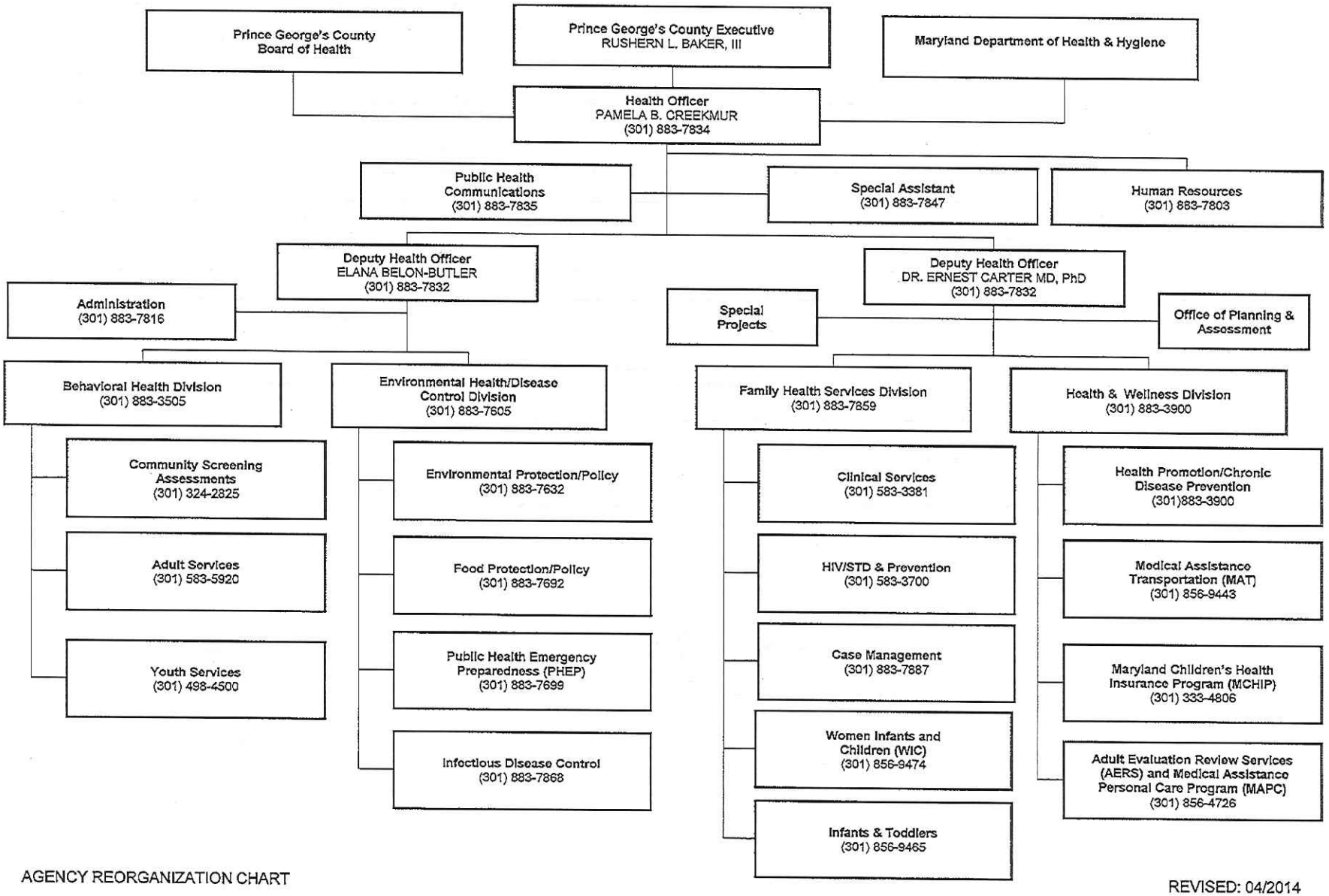
DEPARTMENT HEALTH AND HUMAN SERVICES
BEHAVIORAL HEALTH AND CRISIS SERVICES



Updated: 08/20/15

PRINCE GEORGE'S COUNTY HEALTH DEPARTMENT

Headquarters Building
1701 McCormick Drive, Largo, Maryland 20774
Telephone: (301) 883-7879

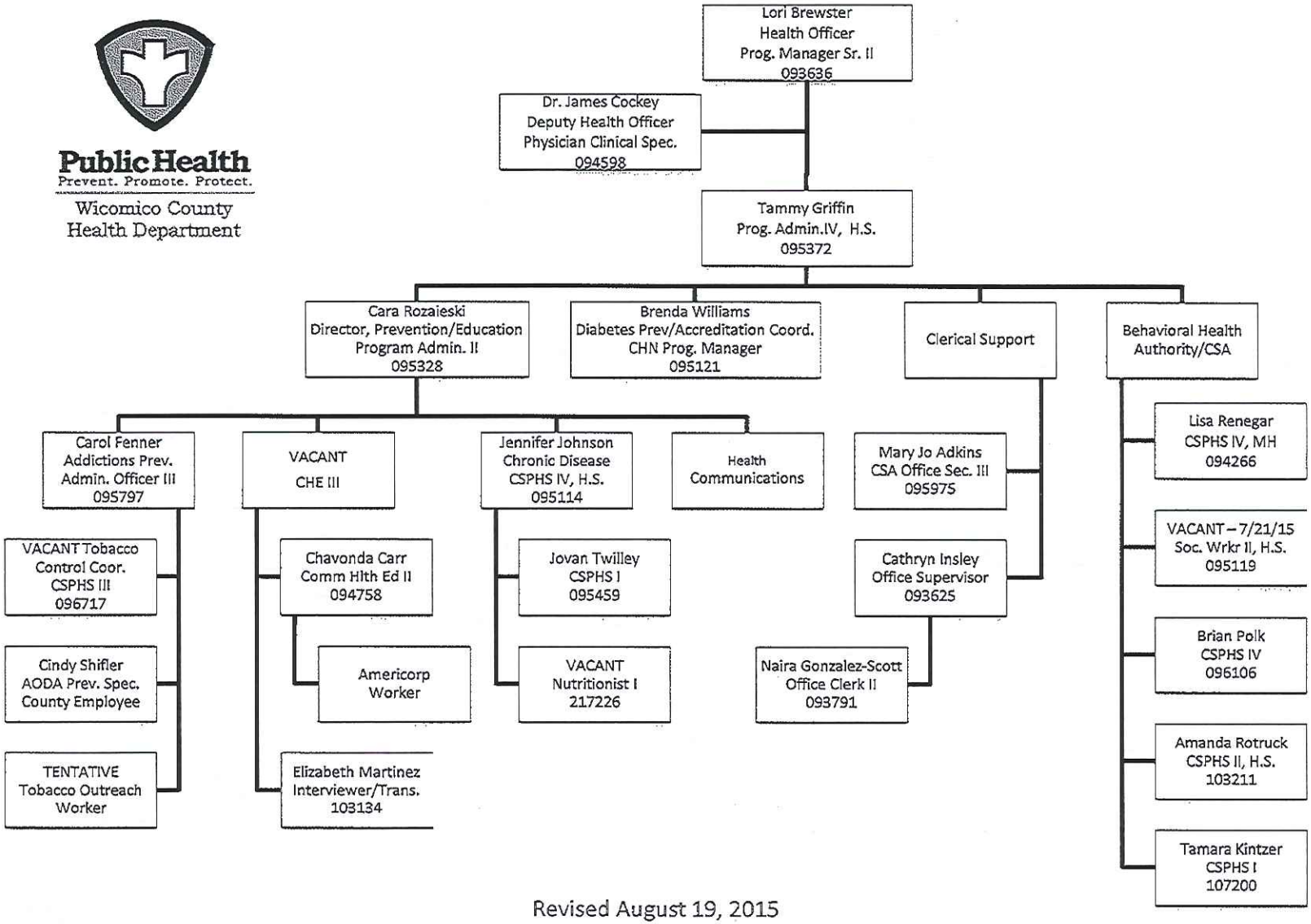


AGENCY REORGANIZATION CHART

REVISED: 04/2014

Wicomico County Health Department Office of Planning and Population Health

Public Health
Prevent. Promote. Protect.
Wicomico County
Health Department



Revised August 19, 2015

Appendix 11.

References

a) Behavioral Health in Montgomery County, Maryland Office of Legislative Oversight, 2015 (Report Number 2015-13, July 28, 2015)

b) Integration: A 2016 Beacon Health Options Whitepaper, Emma Stanton, MD, Beacon Health Options, 2016.

c) *Start with "Why?", TED Talk by* Simon Sinek, offers a simple approach for framing change. (https://www.ted.com/talks/simon_sinek_how_great_leaders_inspire_action?language=en)

d) Our Iceberg is Melting, by John Kotter Holger Rathgeber, 2014, St. Martin Press (http://us.macmillan.com/ouricebergismelting/johnkotter)

e) NAITX, University of Wisconsin learning collaborative, (http://www.niatx.net/Home/Home.aspx)