HHS COMMITTEE #1
April 26, 2013

MEMORANDUM

April 25, 2013

TO: Health and Human Services Committee

FROM: Linda McMillan, Senior Legislative Analyst

SUBJECT: **Worksession: FY14 Operating Budget - Department of Health and Human Services: Behavioral Health and Crisis Services**

Those expected for this worksession:
Uma Ahluwalia, Director, Department of Health and Human Services (DHHS)
Dr. Raymond Crowel, Chief, DHHS Behavioral Health and Crisis Services
Stuart Venzke, DHHS Chief Operating Officer
Patty Stromberg, DHHS Management and Budget
Deborah Lambert, Office of Management and Budget

Excerpts from the County Executive's Recommended Budget for Behavioral Health and Crisis Services are attached at © 1-5.

Behavioral Health and Crisis Services Overview

For FY14, the Executive is recommending funding of $39,216,928 for Behavioral Health and Crisis Services (BHCS). This is a 1.7% increase from the FY13 approved budget of $38,542,416 for this service area. The table on the following page shows budget trends since FY10. While there are some substantial shifts between program areas for management purposes, there is really no change to program for FY14.

Behavioral Health and Crisis Services Expenditures in $000's	FY10 Budget	FY11 Budget	FY12 Budget	FY13 Budget	FY14 Rec	Change FY13-14
Behavioral Health Planning and Management	7,512	7,898	9,139	9,019	7,748	-14.1%
Access to Behavioral Health Services	2,756	2,502	2,433	3,303	3,213	-2.7%
Treatment Services Administration	7,475	6,942	6,438	2,762	5,589	102.4%
Forensic Services - Adult	2,463	2,484	2,403	1,988	2,062	3.7%
Outpatient Behavioral Health Services - Adult	4,037	3,868	3,835	3,326	3,127	-6.0%
Outpatient Behavioral Health Services - Child	3,382	3,078	2,962	5,573	5,443	-2.3%
Trauma Services	2,614	2,595	4,853	4,782	4,629	-3.2%
24-Hour Crisis Center	4,300	4,154	3,987	4,252	3,992	-6.1%
Seniors/Persons w Disabilities Mental Hlth Services	1,855	627	609	675	689	2.1%
Abused Persons Program	3,252	3,043	-	-		
Specialty Behavioral Health Services	-	-	-	2,293	2,139	-6.7%
Service Area Administration	584	556	555	570	586	2.8%
TOTAL	**40,230**	**37,747**	**37,214**	**38,543**	**39,217**	**1.7%**

FY14 Recommended Budget Changes by Program

A. Behavioral Health Planning and Management

For FY14, the Executive is recommending funding of $7,748,021 and 15.5FTEs for this program area that houses services required of DHHS as the State-mandated local mental health authority (Core Service Agency). This program area provides programming for people with serious persistent mental illness and serious emotional illness and the development of the continuum of care that is focused on recovery and allowing people to live in the least restrictive clinically appropriate setting. Program and contract monitoring and compliance are also a part of this program.

1. Add the Homeless ID Grant
$72,345 and 0.0FTEs

DHHS has provided the following description of this grant:

Maryland Department of Health and Mental Hygiene awarded the grant ($72,345 in FY13) to the Core Service agency to fund a contract with People Encourage People, Inc. (PEP) to purchase state identity cards and/or birth certificates for individuals who are

homeless and have a mental illness or a co-occurring substance use disorder. The grant also calls for PEP to hire a case manager who will be SOAR (SSI/SSDI Outreach Access to Recovery) trained to assist homeless individuals in applying for social security and other benefits. This grant relates to the Departments goal of Healthy and Sustainable Communities by providing the uninsured with health care coverage and a regular source of care. Program will submit FY14 grant renewal to continue the project from July 1, 2013 to June 30, 2014.

Council staff recommends approval.

2. Multi-program Adjustments
-$1,343,252 and 0.0FTE

Multi-program adjustments account for compensation changes, annualizations and other items impacting more than one program. FTEs are the sum of full-time and part-time positions.

A part of the multi-program adjustments is a shift of ADAA Grant funding to Treatment Services to facilitate management of the grant. **Council staff recommends approval.**

3. Other Issue: Inflationary Adjustment to Residential Treatment Providers

As with the DD Supplement, the County provides a supplement to residential treatment providers for adults with serious mental illness. Generally, the Council has provided the same inflationary adjustment to these contracts as it does to the DD Supplement.

Residential Treatment	FY11	FY12	FY13	FY14 Rec
Family Services Inc.	189,965	189,965	193,764	193,764
Rock Creek Foundation	71,942	71,942	73,381	73,381
St. Luke's House	315,657	315,657	321,970	321,970
Threshold Services	323,750	323,750	329,020	329,020
TOTAL	**901,314**	**901,314**	**918,135**	**918,135**

A 1% adjustment would be $9,180. Council staff recommends the Committee put three 3% inflationary adjustments on the reconciliation list. If 3% is approved it would total $27,540.

B. Access to Behavioral Health Services

For FY14 the Executive is recommending funding of $3,213,381 and 31.5FTEs for this program that provides access to behavioral health services, assessment, and diagnostic evaluation. The program also provides immediate (but brief) case management, therapy, and medication services to people being discharged from a hospital or jail until they can be linked

into the community outpatient system. Urine monitoring and laboratory services are also provided through this program.

1. Multi-program Adjustments
-$89,367 and 0.0FTE

Multi-program adjustments account for compensation changes, annualizations and other items impacting more than one program. FTEs are the sum of full-time and part-time positions. **Council staff recommends approval.**

C. Treatment Services Administration

For FY14, the Executive is recommending $5,588,986 and 4FTEs for this program area that manages the federal and state alcohol and drug assistance grant and Medicaid funded community based programs. The program oversees the addiction continuum of care by private providers.

1. Multi-program Adjustments
$2,826,935 and 4FTEs

Multi-program adjustments account for compensation changes, annualizations and other items impacting more than one program. FTEs are the sum of full-time and part-time positions.

A part of the multi-program adjustments is a shift of ADAA Grant funding from Behavioral Health Planning and Management to facilitate management of the grant. **Council staff recommends approval.**

2. Other Issue: Overdose Prevention Plan

In January, the Department of Health and Mental Hygiene responded to trends in opiate and heroin use and overdoses in the State of Maryland by requesting that local health departments develop and submit Opioid Overdose Prevention Plans. Information from the State is attached at ©6-19. DHMH asks that the plans be completed by June 30.

Dr. Crowel will provide the Committee with an update on this effort. A planning committee has been convened and is currently working on a draft.

Given testimony the Council has received about the problem of heroin and opiate addiction and a number of deaths that are overdoses or where there is a contributing factor of heroin abuse, Council staff suggests that the HHS and PS Committees schedule a joint session in July to receive a briefing on the plan that is submitted.

3. Other Issue: Outpatient Treatment

The program performance measures for treatment services (©2) show a more than 50% decrease in the number of people served in Level 1 Outpatient Treatment in the public system. DHHS has provided the following response about the basis for this estimate they are expecting.

Response

This measure is of the number of uninsured persons receiving Level-I addiction services supported by General Funds or State grant. For FY-13 the projected reduced number reflects an increased focus on requiring providers to expedite enrolling eligible uninsured consumers in PAC. Once deemed eligible providers bill the state for services. Beginning in the third quarter of FY14 the PAC program will be phased out as the Affordable Care Act increases the numbers of persons who will be Medicaid eligible. Because there will remain persons who may not qualify for Medicaid we are projecting that we will still need to provide some level of support into FY-15.

The joint PS and HHS Committees held a session last June to be briefed on the substance abuse treatment system. The joint Committee had asked for further information on the average cost for a person served in the publicly funded system. The following information is based on FY12 actual data.

Response

The following "per client" data is based on allocated state grant / clients served under the grant

ASAM Levels	State Grant Funding	Clients Served Under grant	$/Client under grant	County Funding
Level 0.5 Early intervention	$94,028	465	$202.21	-
Level 1 Outpatient	$144,319	447	$322.86	$110,065
Level 2 Intensive Outpatient	$777,755	413	$1,883.18	$135,477
Level 3 Residential	$990,419	627	$1,579.62	$1,867,936
Level 4 Medical Inpatient Detox	-		N/A	$9,300

There is level 4 (Medical Detox) contract with Montgomery General Hospital thru Open Solicitation and it is covered by county fund. There were 3 referrals in FY12.

There are no specific recommended changes to capacity in the treatment system as a part of the FY14 Recommended Budget. However, as noted, there will be changes that come from the implementation of the Affordable Care Act.

D. Forensic Services - Adult

For FY14, the Executive is recommending $2,062,018 and 18FTEs for this program that provide the Clinical Assessment and Triage Services Team (CATS), Diversion and Re-Entry Services (DRES) program, and the Jail Addiction Service (JAS) program to people being booked into (CATS), released from (DRES), or residing at (JAS) the County jail.

1. Multi-program Adjustments
$74,460 and 1.0FTEs

Multi-program adjustments account for compensation changes, annualizations and other items impacting more than one program. FTEs are the sum of full-time and part-time positions. **Council staff recommends approval.**

E. Outpatient Behavioral Health Services – Adult

For FY14, the Executive is recommending $3,127,125 and 22FTEs for this program area that provides comprehensive outpatient treatment and intensive outpatient treatment for adult residents of the County. The program also houses the Adult Behavioral Health program that provides a comprehensive range of services to County residents with high need and who are in multiple systems but may not be eligible for care through the public mental health system.

1. Multi-program Adjustments
-$198,403 and 1.0FTE

Multi-program adjustments account for compensation changes, annualizations and other items impacting more than one program. FTEs are the sum of full-time and part-time positions. **Council staff recommends approval.**

F. Outpatient Behavioral Health Services – Child

For FY14, the Executive is recommending $5,442,503 and 28.25FTEs for this program that provides or supports comprehensive mental health treatment and care coordination services to children, youth, and their families. The program has three teams: the Child and Adolescent Outpatient Mental Health Services Team, the Home-based Treatment Team (supports Child Welfare Services), and the System of Care Development and Management Team. This program area also houses Juvenile Justice Services and SASCA.

1 .Enhance Maryland Strategic Prevention Framework
$33,475 and 0.0FTEs

The Maryland Strategic Framework is a five-year State Funded prevention strategy consisting of five steps:

- Assess prevention needs based on epidemiological data.
- Build prevention capacity.
- Develop a strategic plan
- Implement effective community prevention programs, policies and practices, and
- Evaluate their efforts for outcomes.

By accepting these funds, the county has agreed to:

- Prevent the onset and reduce the progression of substance abuse, including childhood and underage drinking.
- Reduce substance abuse-related problems in communities, and;
- Build prevention capacity and infrastructure at the State/Tribal/Territory and community levels.

The county's initial contract provider withdrew from the program in mid-2012 requiring us to establish a new contract. In February 2013 we executed a new contract with the Collaboration Council. The Council is now conducting the county's needs assessment and the planning process should begin in early FY14.

Council staff recommends approval.

2. Multi-program Adjustments
- $163,917 and 0.0FTEs

Multi-program adjustments account for compensation changes, annualizations and other items impacting more than one program. FTEs are the sum of full-time and part-time positions. **Council staff recommends approval.**

3. Other Issue: Contracts for Mental Health and bonding and Attachment Services for Children and Families Involved in Child Welfare Services

In FY12 budget, funding for contracts for the following contracts was eliminated:

- **Institute for Family Centered Services**: $21,210 for home-based mental health stabilization and crisis intervention services serving children and foster families and intact families. The services are designed to address crisis situations for children in foster care that may result in placement disruptions due to the Child's disruptive behaviors and to reduce re-placement rates for foster children and improve foster home retention rates. In addition, services are used to facilitate a child's transition back into the home of origin after removal.

- **Reginald S. Lourie Center:** $57,630 for attachment and bonding support for young children involved with Child Welfare Services. The services include court-ordered evaluations, therapy, and attachment bonding studies. The case feedback provided by

the Louie Center enables Child Welfare Services to recommend clinically appropriate permanency plans to the Juvenile Court and to give proper consideration to child-parent relationship issues when making determinations regarding reunification, placement options, termination of parent rights, etc.

Recognizing the importance of these services for vulnerable children involved with Child Welfare Services, the HHS Committee recommended placing funding for the contracts on the reconciliation list; however, the Council was unable to restore the funding.

Although there is no specific line item in the budget for these services, the Department has found funding to support these services in FY13 and FY14:

	FY13	FY14
Institute for Family Centered Services	$52,160	$ 8,500
Reginald Lourie Center	$34,500	$10,000

The Department reports that although services have not been eliminated, referrals have periodically been suspended until an additional funding source could be identified and funds encumbered.

The demand for the Lourie Center services in FY13 remains consistent with the FY12 level, and the demand for IFCS's services at the half-year mark in FY13 has already doubled the FY12 level.

	FY12 # served	FY13 (6 mos) # served
Institute for Family Centered Services	10	20
Reginald Lourie Center	20	8

Council staff recommendation:

The services under these contracts are critical to achieving the best outcomes for foster children and other children involved in Child Welfare Services -- some of the most vulnerable residents in the County. Council staff is concerned that by not having an adequate funding mechanism to support these services, the needs of children are compromised when referrals are suspended until additional funding sources are identified and encumbered. Moreover, the demand for the services demonstrated in FY12 and FY13 suggest that the amounts identified for the services in FY14 are inadequate.

Council staff recommends that the Committee place $52,160 for home-based mental health stabilization and crisis intervention services and $57,630 for attachment and bonding support services on the reconciliation list.

4. Other Issue: Child and Adolescent Clinic Wait List:

During FY13 there has been wait list for services at the child and adolescent clinic of between about 30 and 70 people. As a part of the FY13 budget, the Council added funding for an additional Therapist. The wait list is also linked to the issue of having staff that can serve people who do not speak English or for whom it is not their first language.

In her April 8 memo, Council President Navarro asked, "Given the shortage of bi-lingual therapists, as expressed by Director Ahluwalia, what steps can be taken to address this shortage?"

DHHS has provided the following response. As noted, the Committee has asked for a session on this issue and the challenges for social workers, which has been scheduled for June.

> This is a challenge for county and private service providers, with waiting list growing across the county. This is also a national challenge that will increase as health care reform is implemented.
>
> At present the county programs actively recruit bilingual therapists and offer salary differentials as incentives. In addition we have re-written the requirements for therapists in the county system to allow us to hire more recent graduates. This will significantly help with the staffing shortfall and builds a career ladder for therapists. We also maintain an active training relationship with our local and state Universities to orient and train graduate students as future therapists. In the past this has served as a professional pipeline.
>
> To deal with this growing gap will require that we rethink our service delivery models. Increasing the use of case management for example by care coordinators and not by therapists necessarily, employing B.A. level staff in those positions may serve to help address this gap. Creating career ladders for the staff serving the County's increasingly diverse populations that offer a path to certification and training is an option that will need to be considered. BHCS, with support from the state has established Peer Support and Recovery Services and is currently training community members as Peer Support Specialist, a service that is under consideration for reimbursement by the State and which will also help provide additional treatment resources. We will need to ensure that there is linguistic competency and cultural diversity in this group that matches the needs of the county. One strategy which has not been tried locally is the development of Human Service Academies – designed to promote the human service career interests in high school youth. HHS will provide a more comprehensive response to workforce strategies in the proposed June HHS committee session.

5. Conservation Corps Update

The Executive has recommended level funding of $500,000 for the Conservation Corps in FY14. The Department reports that the Maryland Multicultural Youth Centers (MMYC), a division of the Latin American Youth Center, was chosen via an RFP process as the provider of the Montgomery County Conservation Corps. MMYC has partnered with the Maryland Department of Natural Resources (DNR), a state department, to provide services to 20 out-of-school youth ages 17-24 years. The program will provide youth an opportunity to attain their

GED and gain hands on experience working in the field completing projects designed around conservation principles. The weekly schedule includes GED classes, one on one tutoring, life skills and job readiness training and project planning workshops. Corp members work in the field two days per week.

Outcomes that will be measured include the percent of participants that attain a GED, percent that are employed and/or involved in further education and training within 6 months of ending their Corp participation, and percent of Corp members have no further involvement in illegal activity (delinquent or criminal behavior, substance abuse, etc) while in the program. At this time there are no non-County revenue sources supporting the Conservation Corps.

The program began on March 1, 2013 with 20 youth. In responding to Council President Navarro's requested information about the cost per participant, the Department has responded that "because the program just began, and the FY2013 program budget is a 'start up' budget, it would be premature to assess a 'cost per participant' at this time."

There is the expectation that the Conservation Corps provider will locate additional funding sources including fee for service arrangements that supplement County program funding, thus increasing the number of participants in the program and reducing the per person County-funded cost over time.

G. Trauma Services Program

For FY14, the Executive is recommending $4,629,008 and 29.55FTEs for this program that provides integrated clinical services to domestic violence victims and offenders, sexual assault victims, and victims of general crime. Services are provided at the Family Justice Center and at Piccard Drive.

1. Multi-program Adjustments
-$153,006 and 0FTEs

Multi-program adjustments account for compensation changes, annualizations and other items impacting more than one program. FTEs are the sum of full-time and part-time positions. **Council staff recommends approval.**

H. 24-Hour Crisis Center

For FY14, the Executive is recommending $3,991,857 and 35.9FTEs for this program that provides telephone, walk-in, mobile crisis outreach, and residential services to people experiencing a situational, emotional, or mental crisis.

1. Multi-program Adjustments
- $260,690 and 0.0FTEs

Multi-program adjustments account for compensation changes, annualizations and other items impacting more than one program. FTEs are the sum of full-time and part-time positions. **Council staff recommends approval.**

I. Mental Health Services for Seniors and Persons with Disabilities

For FY14, the Executive is recommending $688,926 and 2.0FTEs for this program that provides outreach mental health services for seniors who cannot or will not access office based services as well as working with stressed caregivers. The program also provides mental health services to people who are hearing impaired.

1. Multi-program Adjustments
$13,789 and 0.0FTEs

Multi-program adjustments account for compensation changes, annualizations and other items impacting more than one program. FTEs are the sum of full-time and part-time positions. **Council staff recommends approval.**

2. Other Issue: Enhance Senior Mental Health Contractual Services

The Commission on Aging is recommending a $60,000 increase to senior mental health services to serve an estimated 28 homebound seniors. The SORT grant and related programs are administered by Behavioral Health and Crisis Services.

The SORT grant was reduced substantially in FY10. The County currently receives about $201,000. The Committee last had a specific discussion of SORT funding in FY12. At that time the State had reduced funding for hospital diversion (during FY11) and there was an abolishment of vacant positions including five Therapists. It was noted that the County continued to provide some services for this purpose through contract services. In FY10, 961 home visits were provided by the Senior Outreach Program and 427 home visits were provided by the Hispanic Outreach Program. In addition, 242 seniors attended "drop-in groups" provided at five senior centers and there were 143 consultations with staff from Aging and Disabilities. Some of the reduction in grant funded was also expected to shift to a fee-for-service model (this was the expectation for the Hospital Diversion program).

The SORT grant is not the only source of funding for senior mental health services and in FY13, the Executive recommended and the Council approved an additional $50,000 as a part of the Senior Initiative. The funding was expected to add a part-time therapist who would serve 85 seniors and coordinate medication with medical providers.

The following is the statement from the Commission on Aging about the need for services. Council staff also notes that DHHS data indicates that senior mental health program visits declined starting in October. The DHHS response follows:

"The mental health challenges of seniors need additional funds for the Senior Outreach Team (SORT) contract that aids homebound seniors with therapy and for care-giver support and respite care. More than 25% of those 65+ live alone; isolation fuels depression. The burdens on families trying to cope with depression and anxiety or Alzheimers disease are formidable and the problem is growing." The Commission's request is for $90,000 to provide 6,000 hours of respite care and $60,000 for the SORT contract to serve an additional 28 homebound seniors.

1. What is the reason for the decline in home visits?

   The number of visits declined due to the loss of two therapists (one for the Senior Outreach Program and one for the Hispanic Outreach Program). The statistics have continued to improve once these positions were filled and the new therapists were oriented

2. If additional funding were available for senior mental health, does the Department agree that the Commission has identified the most critical areas? If not, what does the Department think the next priority would be if additional funds were available for senior mental health?

   The Commission on Aging is correct in their priorities based on the population increase projected for this cohort and the fact that the prior Surgeon General Satcher had reported that one in five seniors have a mental health issue that is "not a normal part of aging". Each therapist is expected to carry a caseload of approximately 28 seniors.

J. Specialty Behavioral Health Services

For FY14, the Executive is recommending $2,139,442 and 19.5FTEs for this program that includes the Adult Drug Court, Medication Assistance Treatment program. The Medication Assisted Treatment program serves people who are opiate dependent, uninsured, and have not succeeded with other treatment.

1. Multi-program Adjustments
-$153,111 and -2.0FTEs

Multi-program adjustments account for compensation changes, annualizations and other items impacting more than one program. FTEs are the sum of full-time and part-time positions. **Council staff recommends approval.**

2. Other Issue: Adult Drug Court

In FY12, the Committee discussed that Adult Drug Court has been funded in part by a SAMHSA Capacity Expansion Grant which allowed the Adult Drug Court to grow from an original capacity of 30 to 100. This grant ended in 2011. The Council approved $59,000 to continue funding a Therapist position and staff to retain a Full-Time Therapist and a Behavioral Health Specialist. It was thought that the Drug Court could continue to operate at capacity. The

following information, requested by Council staff, show that the program continues to have a budgeted capacity of 100 although the current caseload is 82 and there are some identified problems with the program.

	FY10	FY11	FY12	FY13 YTD if possible
Capacity	100	100	100	100
Total Caseload	98	118	115	82 as of 8/28/2012
Waiting list #	0	0	0	5
Worker to Caseload ratio	1:20	1:20	1:20	1:20

In FY 2011, 118 clients were served, the highest number to date. In FY 2012 115 clients were served. At the current rate of admissions the expectation is that by the end of FY-13 the total number of clients served by the Adult Drug Court Program will surpass the number served in FY 2011.

Over the last few years there has been a decline in the quality of the programming due to budget cuts, increase in demand and position eliminations. While the program has not lost its licensure, the reviewers have documented deficiencies in the quality of the treatment plans developed and a training to improve in the development of person-centered treatment plans, a best practice principle, is currently concluding today. The licensure reviewers also noted a deficiency in the Adult Drug Court clients not consistently being provided 9 hours of treatment as required for those in the intensive phase of the program. At times, the staff has not been able to facilitate the number of required sessions due to operating over capacity, or when there has been a vacancy, no one is able to pick up the caseload and clinical tasks until a new therapist is hired.

Council staff suggests that if the HHS and PS Committee agree to schedule a session on the Opioid Overdose Prevention Plan that the joint Committee also discuss the Drug Court, including information on its effectiveness and what kind of improvement plan is needed to address the concerns of the reviewer. At this time there is a wait list of only 5 so it is unclear whether there should be adjustments around a lower capacity or to the current capacity of 100.

K. Service Area Administration

For FY14, the Executive is recommending $585,661 and 3.5 FTEs in this program that includes service wide administration.

1. Multi-program Adjustments
$15,254 and 0FTEs

Multi-program adjustments account for compensation changes, annualizations and other items impacting more than one program. FTEs are the sum of full-time and part-time positions. **Council staff recommends approval.**

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Behavioral Health and Crisis Services

FUNCTION

The mission of Behavioral Health and Crisis Services (BHCS) is to promote the behavioral health and well-being of Montgomery County residents. BHCS works to foster the development and to ensure access to a comprehensive system of effective services and support for children, youth and families, adults, and seniors in crisis or with behavioral health needs. BHCS is committed to ensuring culturally and linguistically competent care and the use of evidence based or best practices along a continuum of care. BHCS works with the State's public mental health and substance abuse system, other HHS service areas, county agencies and the community to provide strength-based and integrated services to persons in need.

PROGRAM CONTACTS

Contact Raymond L. Crowel of the HHS - Behavioral Health and Crisis Services at 240.777.1488 or Deborah Lambert of the Office of Management and Budget at 240.777.2794 for more information regarding this service area's operating budget.

PROGRAM DESCRIPTIONS

Behavioral Health Planning and Management

As the State mandated local mental health authority, this program is responsible for the planning, management, and monitoring of Public Behavioral Health Services for children with serious, social, emotional and behavioral health challenges, and adults with a serious and persistent mental illness. The functions include developing and managing a full range of treatment and rehabilitation services including services for persons with co-occurring mental illness and substance abuse disorders, homeless persons, and persons who have been incarcerated and/or are on conditional release. Services include the ongoing development of a resiliency and recovery oriented continuum of services that provide for consumer choice and empowerment. This program now manages all service area contracts as a result of the service area realignment. Juvenile Justice Services has shifted to Outpatient Behavioral Health Services-Child.

Program Performance Measures	Actual FY11	Actual FY12	Estimated FY13	Target FY14	Target FY15
Percent of adults served by the continuum of behavioral health services that demonstrate higher degree of social connectedness and emotional wellness as demonstrated by positive outcomes in housing, quality of life, legal encounter, and employment/education[1]	76.5	75.3	76.3	76.3	76.3
Percent of children served by the continuum of behavioral health services that demonstrate higher degree of social connectedness and emotional wellness as demonstrated by positive outcomes in housing, quality of life, legal encounter, and employment/education[2]	93.7	93.9	94.9	94.9	94.9

[1] Results are calculated using Outcome Measurement System (OMS) data released by DHMH.
[2] Results are calculated using Outcome Measurement System (OMS) data released by DHMH.

FY14 Recommended Changes	Expenditures	FTEs
FY13 Approved	**9,018,928**	**15.50**
Add: Homeless ID Grant	72,345	0.00
Multi-program adjustments, including negotiated compensation changes, employee benefit changes, changes due to staff turnover, reorganizations, and other budget changes affecting multiple programs.	-1,343,252	0.00
FY14 CE Recommended	**7,748,021**	**15.50**

Notes: Multi-program adjustments include a shift of the ADAA grant funding from the Behavioral Health Planning and Management program to the Treatment Services Administration program to facilitate the management of the grant.

Access to Behavioral Health Services

This program area includes Access to Behavioral Health Services, as well as Community Support Services and the Urine Monitoring Program and Laboratory Services, which shifted from the Treatment Services Administration. The Access to Behavioral Health Services program provides assessments for clinical necessity and financial eligibility for consumers needing outpatient mental health services including those with a co-occurring disorder, linkages to those eligible for the Public Mental Health System, or community resources. This Program also provides walk-in substance abuse assessments including co-occurring disorders and linkages to the range of services in the Addiction Services continuum for adult residents of Montgomery County. Safety Net Services (a service within Access to Behavioral Health Services) provides immediate, psychiatric, and case coordination services for eligible clients who are discharged from a psychiatric hospital/jail and who need immediate psychotropic medications until they can be linked to a

community outpatient mental health program. Community Support Services includes case management services, the Projects for Assistance in Transition from Homelessness program, and screening and assessment for individuals applying for Temporary Cash Assistance. The Urine Monitoring Program provides urine testing services to clients referred by the courts, child welfare, the criminal justice system, and others required to submit to urine surveillance or who require or request urine screening and testing. T Adult Behavioral Health program shifted to Outpatient Behavioral Health Services-Adult.

FY14 Recommended Changes	Expenditures	FTEs
FY13 Approved	**3,302,748**	**31.50**
Multi-program adjustments, including negotiated compensation changes, employee benefit changes, changes due to staff turnover, reorganizations, and other budget changes affecting multiple programs.	-89,367	0.00
FY14 CE Recommended	**3,213,381**	**31.50**

Treatment Services Administration

Provides overall management of the Federal and State Alcohol and Drug Abuse Administration grant and Medicaid funded community based programs and oversees operations of the addiction continuum of private providers. Behavioral Health Community Support Services, Urine Monitoring Program, and Laboratory Services were shifted to Access to Behavioral Health Services. Program Monitoring Unit shifted to Behavioral Health Planning and Management.

Program Performance Measures	Actual FY11	Actual FY12	Estimated FY13	Target FY14	Target FY15
Number of persons served in Level 1 Outpatient Treatment[1]	914	1,077	450	450	450
Percentage of decrease in substance abuse for patients completing treatment (Level 1 Outpatient Treatment)[2]	89	70.4	75	75	75

[1] Number of Level 1 served will be decreasing over the years as part of the implementation of the Patient Protection and Affordable Care Act, because clients will be able to self refer through their insurance and bypass the County.

[2] % Decrease in substance abuse is set at 75% per the State of Maryland.

FY14 Recommended Changes	Expenditures	FTEs
FY13 Approved	**2,762,051**	**3.00**
Multi-program adjustments, including negotiated compensation changes, employee benefit changes, changes due to staff turnover, reorganizations, and other budget changes affecting multiple programs.	2,826,935	1.00
FY14 CE Recommended	**5,588,986**	**4.00**

Notes: Multi-program adjustments include a shift of the ADAA grant funding from the Behavioral Health Planning and Management program to the Treatment Services Administration program to facilitate the management of the grant.

Forensic Services - Adult

Adult Forensic Services is composed of three programs: (1) Clinical Assessment and Transition Services (CATS), (2) Diversion and Re-Entry Services (DRES), and (3) Jail Addiction Services (JAS). CATS provides assessment and post-booking diversion services within 24 hours of booking to inmates with behavioral health issues upon entry into the Montgomery County Detention Center. DRES diverts individuals and/or supports early release from the Montgomery County Detention and Correctional Facilities. Staff provides release planning for inmates at the Montgomery Correctional Facility by assessing inmates' behavioral health needs and coordinating access to services in the community. JAS is an intensive jail-based residential addiction treatment program for inmates who suffer with substance related disorders at the Montgomery County Correctional Facility.

Program Performance Measures	Actual FY11	Actual FY12	Estimated FY13	Target FY14	Target FY15
Percentage of successful Jail Addiction Services clients who were not reincarcerated in the Montgomery County Correctional Facility within the next fiscal year following program completion	80	80	80	80	80

FY14 Recommended Changes	Expenditures	FTEs
FY13 Approved	**1,987,558**	**17.00**
Multi-program adjustments, including negotiated compensation changes, employee benefit changes, changes due to staff turnover, reorganizations, and other budget changes affecting multiple programs.	74,460	1.00
FY14 CE Recommended	**2,062,018**	**18.00**

Outpatient Behavioral Health Services - Adult

Outpatient Behavioral Health Services - Adult provides comprehensive and quality outpatient and intensive outpatient services to adult residents of Montgomery County, who are diagnosed with substance and mental health co-occurring disorders. Priority populations include people who are indigent, homeless, medically compromised, women who are pregnant or those with infants,

individuals involved with the criminal justice system, and people with HIV/AIDS.

The Adult Behavioral Health program moved from Access to Behavioral Health Services and provides a comprehensive range of mental health services including assessment, diagnostic evaluation, psychotropic medication evaluation, and medication monitoring. Individual, family, and group psychotherapy are available, as well as case management services. Eligibility is limited to Montgomery County residents who have a high level of acuity and are involved in multiple systems in the community. Many of these individuals are unable to receive Public Mental Health System services or the level of care necessary to effectively stabilize their illness. This program has the capacity to provide services to Limited English Proficiency clients and those with specialized cultural and language need.

Program Performance Measures	Actual FY11	Actual FY12	Estimated FY13	Target FY14	Target FY15
Percentage of clients showing improvement in functioning and decreased symptoms – based on the symptoms list[1]	87	81	82	82	82
Percentage of clients who completed treatment plan upon discharge (% is based on discharged clients)[2]	NA	42.8	44.5	46	47.5

[1] Projection is based on past 5 years.

[2] Due to a reorganization, this program reprots this measure separately from Specialty Behavioral Health Services. FY12 is the baseline year.

FY14 Recommended Changes	Expenditures	FTEs
FY13 Approved	**3,325,528**	**21.00**
Multi-program adjustments, including negotiated compensation changes, employee benefit changes, changes due to staff turnover, reorganizations, and other budget changes affecting multiple programs.	-198,403	1.00
FY14 CE Recommended	**3,127,125**	**22.00**

Outpatient Behavioral Health Services - Child

Children's Outpatient Behavioral Health Services is comprised of three components that provide or support comprehensive mental health treatment and care coordination services to children, youth, and their families that are individualized, culturally and linguistically appropriate and administered in the least restrictive, most conducive environment. The Child and Adolescent Outpatient Mental Health Service Team provides assessment, psychiatric, and therapeutic treatment to children and adolescents with serious emotional impairments. The Home-based Treatment Team provides specialized, evidence-based mobile treatment specifically for children and families involved with Child Welfare Services. The System of Care Development and Management Team collaborates with local and State partners to plan, develop, and manage publicly-funded (State and County) mental health and care coordination services for children and adolescents. All three components are guided by the principles that services should be child focused, family driven, and culturally competent.

This program area also now includes Juvenile Justice Services and the Conservation Corps (both programs shifted from Behavioral Health Planning and Management). Juvenile Justice Services (JJS) supports the County's comprehensive approach by integrating screening, assessment, case management, community services, and treatment with the juvenile justice legal process. JJS also provides substance abuse prevention, which provide support and education to promote healthy behaviors and lifestyles. The Conservation Corps is now administered through a contract that seeks to increase the employability of out-of-school, at-risk 17 to 24 year old youth by providing opportunities for personal growth, education, and training. The services provided through these programs, in particular Screening and Assessment Services for Children and Adolescents, are closely aligned with the Substance Abuse and Mental Health Services provided in Behavioral Health and Crisis Services.

Program Performance Measures	Actual FY11	Actual FY12	Estimated FY13	Target FY14	Target FY15
Percentage of clients who meet their treatment goals at the time of discharge[1]	71	78	73	73	73
Percentage of offenders under age 18 who are diverted to substance abuse education or mental health treatment programs who do not re-enter the correction system within 12 months of being assessed compliant with requirements[2]	88.0	89.0	88.0	88.0	88.0

[1] Percentage is based on number of cases closed and recorded.

[2] The correction system refers to the juvenile justice or adult correction systems. Assessment is done to determine compliance with requirements. This measure is by definition a 12 month follow-up of clients, so actual FY12 data reports recidivism rate of clients served in FY11.

FY14 Recommended Changes	Expenditures	FTEs
FY13 Approved	**5,572,945**	**28.25**
Enhance: Maryland Strategic Prevention Framework	33,475	0.00

	Expenditures	FTEs
Multi-program adjustments, including negotiated compensation changes, employee benefit changes, changes due to staff turnover, reorganizations, and other budget changes affecting multiple programs.	-163,917	0.00
FY14 CE Recommended	**5,442,503**	**28.25**

Trauma Services

The Trauma Services Program provides integrated clinical services to domestic violence victims and offenders, sexual assault victims, and victims of general crime. All victims may be assessed and receive short term counseling and psychiatric care, as well as a variety of specialty services geared to their particular need. Programming for domestic violence also includes information and referral, crisis intervention, safety planning, and placement in emergency shelter. Services are provided on-site at the Family Justice Center, as well as at 1301 Piccard Drive. Also provided at 1301 Piccard Drive is programming for victims of sexual assault, which includes outreach twenty-four hours a day and seven days a week through volunteer support to rape and sexual assault victims at hospitals and police stations, where they provide information, referrals, and assistance with crime victim compensation.

Program Performance Measures	Actual FY11	Actual FY12	Estimated FY13	Target FY14	Target FY15
Percentage of adult victims of sexual assault and general crime who show a decrease in symptoms after treatment (as measured by Post-Traumatic Stress Disorder Checklist – Civilian clinical scales)	85	88	87	87	87
Percentage of child victims of sexual assault and general crime who show a decrease in symptoms after treatment (as measured by the Child's Reaction to Traumatic Events Scale clinical scales)	93	94	83	83	83
Percentage of clients receiving therapy who demonstrate improvement on a domestic violence rating scale	73	93	88	88	88

FY14 Recommended Changes	Expenditures	FTEs
FY13 Approved	**4,782,014**	**29.55**
Multi-program adjustments, including negotiated compensation changes, employee benefit changes, changes due to staff turnover, reorganizations, and other budget changes affecting multiple programs.	-153,006	0.00
FY14 CE Recommended	**4,629,008**	**29.55**

24-Hour Crisis Center

This program provides telephone, walk-in, mobile crisis outreach, and crisis residential services to persons experiencing situational, emotional, or mental health crises. The Crisis Center provides all services, twenty-four hours/day seven days/week. Much of the work of the Crisis Center focuses upon providing the least restrictive community-based service that is appropriate to the client's situation. Many of the services provided are alternatives to more traditional mental health services. Psychiatric crisis resources are used to prevent hospitalizations and suicides. Disaster mental health services include crisis management and consultation for disasters and community crises. The Crisis Center coordinates the mental health response during disasters and community critical incidents. During the off-hours (after 5:00 p.m., weekends, and holidays), crisis back-up services are provided for various health and human services needs when the clients' primary service providers are not available.

FY14 Recommended Changes	Expenditures	FTEs
FY13 Approved	**4,252,547**	**35.90**
Multi-program adjustments, including negotiated compensation changes, employee benefit changes, changes due to staff turnover, reorganizations, and other budget changes affecting multiple programs.	-260,690	0.00
FY14 CE Recommended	**3,991,857**	**35.90**

Mental Health Services: Seniors & Persons with Disabilities

This program provides outreach mental health services for seniors who cannot or will not access office-based services as well as persons experiencing caregiver stress. It provides Prevention and Early Intervention services for seniors by providing drop in groups at senior centers, psycho education, consultation to assisted living providers, Housing Opportunities Commission resident counselors and senior center directors, and mental health training for providers of services for seniors. This program also provides mental health services to persons who are deaf or hearing impaired.

Program Performance Measures	Actual FY11	Actual FY12	Estimated FY13	Target FY14	Target FY15
Percentage of surveyed homebound seniors reporting an improvement in their quality of life as measured by Mental Health Statistics Improvement Program Consumer Survey Scale[1]	85	94	80	80	8

[1] Starting in FY12, this measure is reported as a weighted percentage of both Senior Outreach program and Hispanic Outreach program.

FY14 Recommended Changes	Expenditures	FTEs
FY13 Approved	**675,137**	**2.00**
Multi-program adjustments, including negotiated compensation changes, employee benefit changes, changes due to staff turnover, reorganizations, and other budget changes affecting multiple programs.	13,789	0.00
FY14 CE Recommended	**688,926**	**2.00**

Specialty Behavioral Health Services

Behavioral Health Specialty Services now includes the Adult Drug Court Program and the Medication Assisted Treatment-Clinical/Vocational Services shifted from Outpatient Behavioral Health Services-Adult. The Adult Drug Court program provides outpatient, intensive outpatient, case management and follow-up. Medication Assisted Treatment (MAT) services are provided to adults residents of Montgomery County, who are diagnosed with substance use disorders. Individuals served in the MAT program are opiate dependent, uninsured, and have not been able to succeed in other venues of treatment.

FY14 Recommended Changes	Expenditures	FTEs
FY13 Approved	**2,292,553**	**21.50**
Multi-program adjustments, including negotiated compensation changes, employee benefit changes, changes due to staff turnover, reorganizations, and other budget changes affecting multiple programs.	-153,111	-2.00
FY14 CE Recommended	**2,139,442**	**19.50**

Service Area Administration

This program provides leadership, oversight, and guidance for the administration of Behavioral Health and Crisis Services.

FY14 Recommended Changes	Expenditures	FTEs
FY13 Approved	**570,407**	**3.50**
Multi-program adjustments, including negotiated compensation changes, employee benefit changes, changes due to staff turnover, reorganizations, and other budget changes affecting multiple programs.	15,254	0.00
FY14 CE Recommended	**585,661**	**3.50**

PROGRAM SUMMARY

Program Name	FY13 Approved Expenditures	FY13 Approved FTEs	FY14 Recommended Expenditures	FY14 Recommended FTEs
Behavioral Health Planning and Management	9,018,928	15.50	7,748,021	15.50
Access to Behavioral Health Services	3,302,748	31.50	3,213,381	31.50
Treatment Services Administration	2,762,051	3.00	5,588,986	4.00
Forensic Services - Adult	1,987,558	17.00	2,062,018	18.00
Outpatient Behavioral Health Services - Adult	3,325,528	21.00	3,127,125	22.00
Outpatient Behavioral Health Services - Child	5,572,945	28.25	5,442,503	28.25
Trauma Services	4,782,014	29.55	4,629,008	29.55
24-Hour Crisis Center	4,252,547	35.90	3,991,857	35.90
Mental Health Services: Seniors & Persons with Disabilities	675,137	2.00	688,926	2.00
Specialty Behavioral Health Services	2,292,553	21.50	2,139,442	19.50
Service Area Administration	570,407	3.50	585,661	3.50
Total	**38,542,416**	**208.70**	**39,216,928**	**209.70**

STATE OF MARYLAND
DHMH

Maryland Department of Health and Mental Hygiene
201 West Preston Street • Baltimore, Maryland 21201
Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – Joshua M. Sharfstein, M.D., Secretary

January 9, 2013

Memorandum

To: Ulder Tillman, MD MPH, Health Officer, Montgomery County Health Department
Hardy Bennett, Acting Behavioral Health Manager Montgomery County Health Department
Raymond Crowel, Director, Montgomery County Core Service Agency/Behavioral Health Planning and Management

From: Gayle Jordan-Randolph, MD, Deputy Secretary for Behavioral Health and Disabilities, Department of Health and Mental Hygiene
Kathleen Rebbert-Franklin, Acting Director, Alcohol and Drug Abuse Administration

RE: Overdose Prevention Plan

Drug overdoses are a major public health problem in Maryland. In 2011, more than 600 Marylanders died from a drug or alcohol-related overdose – more than 50% more than the number of Marylanders whose deaths were ruled a homicide.

From 2007 to 2011, the number of fatal drug and alcohol overdose deaths dropped by approximately 20%.[1] Preliminary data from the first half of 2012, however, suggests that the overdose death rate may be rising again.

As discussed in a recent fact sheet titled "Heroin Overdose Deaths on the Rise, Rx Opioid Overdose Deaths Down,"[2] a decline in prescription opioid-related deaths is occurring at the same time as an increase in heroin-related fatalities.

We recognize that many existing efforts in Montgomery County work to reduce the number of fatal drug overdoses. This memo requests additional assistance from the Montgomery County

[1] Maryland Department of Health and Mental Hygiene, "Fact Sheet: Drug and Alcohol Intoxication Deaths in Maryland, 2007-2011; Overall Decline, with Shift to Deaths Involving Prescription Drugs." August, 2012.
[2] http://adaa.dhmh.maryland.gov/Documents/content_documents/PDMP/StatewideOverdoseDeathTrendFactsheetFINAL.pdf

Health Department, substance abuse treatment council and core service agency to address this public health problem.

State Public Health Actions

Public health actions to address drug-and alcohol-related overdoses include:

- Supporting broad access to substance use disorder treatment, including treatment of opioid dependence with buprenorphine and methadone;
- Expanding surveillance activities related to overdose deaths;
- Implementing the Prescription Drug Monitoring Program to improve assessment and referral to treatment for individuals with prescription drug-related substance use disorders and further reduce illegal diversion;
- Providing clinical education and guidance to physicians on appropriate prescribing;
- Strengthening the Department's Controlled Dangerous Substances Integration Unit to improve information sharing related to problematic prescribing and coordinating action among public health authorities, licensing agencies, law enforcement, and healthcare providers;
- Adopting appropriate policies for opioid medications within the Medicaid program; and
- Creating an Emergency Response Plan to help support responses to abrupt changes in prescribing at the local level.

The Department of Health and Mental Hygiene's activities are detailed further in the Maryland Opioid Overdose Prevention Plan, which is being released today and which is attached.

Local Plans for Overdose Prevention

There is a strong local role in overdose prevention. Localities best understand the unique circumstances that put Marylanders at risk for overdose in their jurisdictions, and are able to bring together both public and private efforts for prevention.

To best mobilize this response, the Department is requesting that the local health department, local substance abuse treatment council, and local core service agency come together with others in their communities to develop an Overdose Prevention Plan by June 30, 2013.

The plan should have four components:

1. **Review and analysis of data**. The Department's Virtual Data Unit will provide information on overdose trends for the jurisdiction or region, as appropriate, by early February, 2013. Other data may be available from local sources.

2. **Education of the clinical community**. Based on the analysis of local or regional data, the plan should provide a strategy for engagement with the medical community as well as mental health and substance use disorder treatment providers about overdose and opportunities for effective intervention.

3. **Outreach to high-risk individuals and communities.** Based on the analysis of local or regional data, the plan should provide a strategy for identifying high-risk individuals and situations and intervening with education, appropriate referrals and any other steps considered appropriate by the locality.

4. **Performance metrics.** The plan should include at least five performance metrics to assess the implementation and effectiveness of the actions adopted.

In addition to these required plan elements, the Department, on a pilot basis and under specified circumstances, will make available detailed information about overdose deaths in the jurisdiction. A formal memorandum of understanding that establishes the confidentiality of this information, and a formal plan for multidisciplinary review of the information, will be required for the pilot jurisdictions.

The Department will host a conference on overdose prevention for staff to learn about this public health problem and steps that jurisdictions can take to address the challenge. This conference will take place in March 2013. Topics covered will include:

- Best practices in community-based overdose prevention from other states
- Overdose surveillance using federal, state and local data sources
- Promoting Screening, Brief Intervention and Referral to Treatment (SBIRT) among community physicians
- Current opioid prescribing guidelines
- Prescription Drug Monitoring Program
- Community-based overdose prevention training and education
- Naloxone

We request a draft plan be submitted by April 30, 2013 for comment from the Department and a final plan by June 30.

Thank you for your service to Marylanders with substance use disorders and for your participation in this new initiative. Please address questions to Michael Baier, Alcohol and Drug Abuse Administration, at 410-402-8643 or michael.baier@maryland.gov.

Maryland Opioid Overdose Prevention Plan

January 2013

Executive Summary

Drug overdoses are a serious public health challenge in Maryland and across the country. During the past decade, national increases in the number of fatal overdoses have been driven primarily by an epidemic of pharmaceutical opioid abuse. In Maryland, deaths related to pharmaceutical opioids increased during this time, while those involving illicit drugs declined. However, in 2012, Maryland experienced a shift from pharmaceutical opioids to heroin, mirroring a trend being reported in other states. This emerging trend underscores the importance of continuing to provide support for substance use disorder treatment and recovery services while simultaneously meeting new challenges.

The Department of Health and Mental Hygiene (DHMH) is coordinating a number of key initiatives to help reduce opioid-related overdoses in Maryland, including:

- Analyzing data on overdose and opioid abuse trends;
- Supporting broad access to substance use disorder treatment, including evidence-based treatment of opioid dependence with methadone and buprenorphine;
- Instituting a public health focus on opioid overdose that includes local, multidisciplinary reviews of fatal overdose incidents;
- Pursuing initiatives that focus on reducing pharmaceutical opioid-related overdoses, including clinical guidance and education for prescribers and dispensers, the Prescription Drug Monitoring Program (PDMP) and the Controlled Dangerous Substance Integration Unit (CDSIU);
- Developing a plan to address public health emergencies created by an abrupt change in the prescribing, dispensing or use of opioids at the community level; and,
- Supporting jurisdictions that seek to implement overdose prevention activities involving naloxone.

As part of the state's public health approach, jurisdictions will be required to develop a local overdose prevention plan based on local data, a local needs assessment, and identification of specific interventions and responses.

Purpose & Problem Definition

The goal of the Maryland Opioid Overdose Prevention Plan is to reduce unintentional, life-threatening poisonings related to the ingestion of opioids, including both illicit opioid drugs (i.e. heroin) and pharmaceutical opioid analgesics. The plan encompasses efforts to reduce poisonings related to the ingestion of opioids alone or in combination with other substances, as well as both fatal and non-fatal poisonings. The term "overdose" is used to describe poisonings that meet these criteria.

Data used to determine all overdose death figures for Maryland presented herein were provided by the Office of the Chief Medical Examiner (OCME). The methodology used to determine Maryland overdose death figures was developed by the Vital Statistics Administration in consultation with OCME; the Alcohol and Drug Abuse Administration (ADAA); the Maryland Poison Center at the University of Maryland, Baltimore, School of Pharmacy; and the Baltimore City Health Department.[1]

[1] The methodology is available online at http://dhmh.maryland.gov/vsa/Documents/Methods--drug-report.pdf and included below as Appendix C.

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Epidemiology of Opioid Overdose

Review of national- and state-level data indicates that opioid overdose is a serious and growing public health problem. Although heroin-related overdoses declined in Maryland from 2007 to 2011, the state witnessed a significant rise in overdoses related to pharmaceutical opioid analgesics during this period. Early data from 2012 suggests resurgence in heroin-related overdoses concurrent with the first reduction in pharmaceutical opioid-related overdoses in years.[2] Chronic opioid use at high dosage levels is a primary risk factor for overdose,[3] as is simultaneous multi-drug use. Individuals with substance use disorders and co-occurring mental-health disorders are at high risk.[4] Persons with pharmaceutical opioid-related substance use disorders are disproportionally white, female, young and residents of rural communities compared to those with substance use disorders related to illicit drugs.

The Department will publish a more detailed review of the epidemiology of overdose in Maryland in February, 2012.

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[2] Maryland Department of Health and Mental Hygiene Fact Sheet, "Heroin Overdose Deaths on the Rise, Rx Opioid Overdose Deaths Down," December, 2012. See Appendix B, below. Also available online at: http://adaa.dhmh.maryland.gov/Documents/content_documents/PDMP/StatewideOverdoseDeathTrendFactsheetFINAL.pdf

[3] Bohnert, et. al., 2011.

[4] Hall, et. al., 2008.

Key Initiatives

1. Enhanced Epidemiology

The Department's Virtual Data Unit (VDU), housed within the Vital Statistics Administration, will oversee enhanced surveillance of overdoses. The VDU will coordinate with multiple DHMH administrations and other state entities to increase access to and analysis of overdose-related datasets at the state and local level. Specific efforts will include:

- A review of statewide overdose fatality data from OCME including jurisdiction- and region-specific breakdowns, as appropriate, to be published by early February, 2013;
- More detailed review of OCME data to identify patterns of overdose activity and key risk factors; and,
- Development of ongoing overdose surveillance through the DHMH Electronic Surveillance System for the Enhanced Notification of Community-Based Epidemics (ESSENCE), the Maryland Poison Center, the Maryland Institute for Emergency Medical Services Systems (MIEMSS) and other sources of data, to include nonfatal overdose information.

2. Substance Use Disorder Treatment

Treating individuals with substance use disorders is the foundation of Maryland's approach to reducing opioid-related overdoses. In FY2012, nearly 50,000 persons received treatment services supported through Medicaid or grant-funded opportunities. According to the 2011 Joint Chairmen's Report, Medicaid payments for outpatient treatment are projected to increase 190% from $33,663,362 in FY2009 to $97,520,628 in FY2012. The total number of individuals accessing services either through the Medicaid system or the ADAA grant-funded system has increased by 32% over a three-year period, from 63,834 (FY2009) to 84,429 (projected FY2012).

Of special relevance to the reduction in overdose is expansion of treatment capacity using evidence based therapies including methadone and buprenorphine.

A large body of evidence supports the effective treatment of opioid dependence with methadone, particularly when combined with counseling. However, this form of treatment is only available in heavily regulated, specialized treatment programs. Buprenorphine is approved for the treatment of opioid dependence in an office-based setting as part of general medical

care, therefore providing greater flexibility compared to methadone. Buprenorphine, a partial opioid agonist, offers a lower potential for overdose than methadone, a full opioid agonist. In 2008, ADAA launched a Statewide Buprenorphine Initiative to increase the availability of buprenorphine maintenance treatment and create links with counseling and care coordination services. Nearly 3,600 treatment admissions involved administration of buprenorphine in FY2012, up 11% from the previous year. From July 2010 to July 2012 the number of Medicaid enrollees filling prescriptions for buprenorphine increased by 38%.

Maryland will seek continued expansions of access to treatment and will monitor access as the behavioral health care system evolves.

3. Public Health Focus on Overdoses

Reducing drug-induced deaths is a key health outcome for Maryland as part of the State Health Improvement Process (http://dhmh.maryland.gov/SHIP). Many localities have programs in place to prevent opioid overdoses. These include creating a multi-disciplinary overdose prevention coordination council, incorporation of overdose prevention education into treatment plans for mental health and substance use disorder clients, working with local hospitals to institute Screening, Brief Intervention and Referral to Treatment (SBIRT) in the emergency department and establishing fixed medication drop boxes for the collection and disposal of unused or expired prescription drugs.

To support local action, DHMH will provide regular updates to Maryland counties on overdoses within their jurisdictions or regions, as appropriate. These updates will be sent to the health officers as well as to the addiction coordinators.

In addition, DHMH will require jurisdictions to develop a local overdose prevention plan, based on local data, a local needs assessment, and identification of specific interventions and responses.

4. Efforts to Address Overdoses of Pharmaceutical Opioids

Clinical Education and Training

The Board of Physicians is planning to provide guidance to physicians on appropriate prescribing of opioid analgesics and associated medications. This guidance is expected to

describe a "safe harbor" for appropriate and necessary prescribing for pain as well as explain red flags for inappropriate prescribing.

The University of Maryland, School of Pharmacy, under contract with the Division of Drug Control, is developing clinical guidance to aid pharmacists in making determinations regarding the appropriateness of controlled dangerous substance (CDS) dispensing. This will include instruction on the clinical uses of CDS in pain management and the treatment of other medical conditions, tools to identify fraudulent prescriptions, access to and use of the PDMP and resources for information sharing.

Prescription Drug Monitoring Program

Housed within ADAA, Maryland's PDMP will monitor the prescribing and dispensing of Schedule II-V CDS, including most commonly used opioid analgesics, and make comprehensive patient CDS prescription history information available in real-time to healthcare providers that prescribe or dispense CDS. Importantly, data disclosure to providers will take place through the statewide health information exchange (HIE), thereby combining two major public health initiatives and facilitating the integration of PDMP data access into provider workflow. The PDMP will also make prescription information available, upon authorized request, to law enforcement agencies, health professional licensing boards and four units of DHMH[5] to support investigations into improper professional practice, prescription fraud and illegal CDS diversion. De-identified PDMP data will be available for research, public education and reporting purposes. In collaboration with the Advisory Board on Prescription Drug Monitoring; the Boards of Physicians, Nursing and Pharmacy; the University of Maryland, School of Pharmacy; the Governor's Office of Crime Control & Prevention (GOCCP); Chesapeake Regional Information System for Our Patients (CRISP); and other DHMH agencies and professional organizations, ADAA will provide PDMP training and education on issues related to prescription drug abuse and overdose to an array of stakeholders, including healthcare providers, law enforcement, public health professionals and the general public.

The estimated timeframe for implementation of a fully operational PDMP is 3rd Quarter, 2013.

[5] Office of the Chief Medical Examiner, Office of Health Care Quality, Office of the Inspector General and Maryland Medical Assistance

Controlled Dangerous Substance Integration Unit

The CDSIU has been implemented within DHMH as a "fusion center" for the sharing and analysis of information relating to the prescribing, dispensing and use of controlled substances. The purpose of forming a CDSIU is to:

- Identify the prescription CDS-related data sets and indicators of potentially problematic prescribing, dispensing and use currently available to each relevant administrative unit of the Department;
- Identify the policies and procedures in place within each unit that govern the analysis of these data sets and indicators and the responses taken;
- Establish policies and procedures for data sharing between units that take into account current restrictions on disclosure and properly balance the need to protect confidential information with the Department's responsibility to protect public health;
- Conduct strategic planning and implement comprehensive responses to identified CDS-related public health threats; and,
- Establish policies and procedures for data disclosure to and operational coordination with external public health authorities, healthcare providers and federal, state and local law enforcement agencies that have concordant CDS-related responsibilities.

Medical Assistance Quality Assurance/Fraud Detection Programs

Maryland Medical Assistance (MA), in both the Fee-For-Service Program (FFS) and Managed Care Organizations (MCO), currently employs procedures to identify and remedy activities of both recipients and providers that could contribute to the misuse of pharmaceutical opioids. Although these programs have been developed primarily for the purpose of quality assurance, cost containment and fraud detection, they will be utilized as a component of strategies to reduce opioid overdose. These programs include a corrective care management program and prospective drug utilization review.

5. Naloxone

Naloxone, an opioid antagonist long used in emergency medicine to rapidly reverse opioid related sedation and respiratory depression, is being made available to opioid users through community-based harm-reduction programs (including needle-exchange and community-health programs), substance use disorder treatment providers and others that have contact with high-

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risk populations. These programs typically train opioid users on risk factors associated with overdose, overdose recognition, naloxone administration and overdose response techniques (including differentiating between beneficial responses like rescue breathing and contacting emergency services and ineffectual/potentially harmful "street remedies" like ice baths, burning fingers and slapping/hitting). Users are also provided with a prescription for and kit containing naloxone (IM injection or intranasal administration). As of 2010, there were 48 known programs in the United States representing 188 community-based sites in 15 states and Washington, DC.

Since 2004, the Baltimore City Health Department's Staying Alive Drug Overdose Prevention and Response Program (the only program in Maryland) has trained more than 3,000 injection drug users, drug-treatment patients and providers, prison inmates, and corrections officers about how to prevent drug overdoses using naloxone, with more than 220 documented overdose reversals. The Department will work with localities interested in exploring clinical and public health approaches to naloxone.

6. Emergency-Response Plan

The University of Maryland, School of Pharmacy, under contract with ADAA, is developing a plan for coordination between state and local public health authorities, healthcare providers, professional organizations, law enforcement agencies and other stakeholders in response to public health emergencies created by an abrupt change in the prescribing, dispensing or use of opioids at the community level. Emergency situations could include a significant disruption of the heroin market in a region or the closure of a medical practice, opioid treatment program or other provider due to DHMH administrative enforcement actions, the death of a practitioner, natural disaster, etc. The plan will be tailored to geographic areas (particularly rural counties), include a mechanism to identify at-risk individuals and coordinate the provision of overdose treatment and prevention services.

The plan will also address critical issues including timely access to patient medical records and identification of treatment capacity in the area.

Timeline

Activity	Date
Maryland Opioid Overdose Prevention Plan released and notification memo sent to jurisdictional health officers, substance use disorder treatment coordinators and Core Service Agency directors	January 2013
Jurisdictional/Regional Overdose Report: The DHMH Virtual Data Unit will disseminate an analysis of OCME data to each jurisdiction.	February 2013
Overdose Fatality Review Pilots: DHMH will establish process to disclose OCME investigative reports and other available information related to overdose incidents to authorized jurisdictional review teams.	February 2013
Conference: DHMH will hold a conference on overdose prevention best practices and plan development for jurisdictional leaders.	March 2013
Draft Jurisdictional Overdose Prevention Plans Due	April 30, 2013
Final Jurisdictional Overdose Prevention Plans Due	June 30, 2013

Appendix A: National Epidemiology

In 2008, poisoning became the leading cause of injury death in the United States with nearly 9 out of 10 poisoning deaths caused by drugs. During the past three decades, the number of drug poisoning deaths increased six-fold, from about 6,100 in 1980 to 36,500 in 2008. In 2008, about 77% of drug poisoning deaths were unintentional, 13% were suicides, and 9% were of undetermined intent.[6]

Although heroin use continues to be a significant risk factor for overdose across the United States, chronic non-medical use/abuse of pharmaceutical opioid analgesics is likely the most significant single factor in the increasing number of overdose deaths.[7] Drug poisoning deaths involving opioid analgesics more than tripled from about 4,000 in 1999 to 14,800 in 2008. Opioid analgesics were involved in more than 40% (14,800) of all drug poisoning deaths in 2008, up from about 25% in 1999.[8] The number of heroin-related deaths has been relatively stable for nearly a decade.

Importantly, multi-drug intoxication, including concurrent use of alcohol, non-opioid pharmaceuticals (sedative-hypnotics, muscle relaxers, and anxiolytics such as benzodiazepines) and other illicit street drugs with heroin and/or pharmaceutical opioids, appears to be a factor in the majority of fatal overdoses.[9]

Of particular note is the impact of methadone. The number of drug poisoning deaths nationally involving methadone increased seven-fold from about 800 deaths in 1999 to roughly 5,500 in 2007. Between 2007 and 2008, the number of deaths involving methadone decreased by nearly 600, the first decrease since 1999.

The large increase in the prescribing of methadone for the treatment of pain (rather than opioid dependence) has been the primary factor contributing to the increasing number of

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[6] Data from the National Vital Statistics System as reported through the Centers for Disease Control and Prevention's online WONDER system.

[7] Webster, et. al., 2011; Green, et. al., 2011.

[8] For about one-third (12,400) of the drug poisoning deaths in 2008, the type of drug(s) involved was specified on the death certificate but it was not an opioid analgesic. The remaining 25% involved drugs, but the type of drugs involved was not specified (for example, "drug overdose" or "multiple drug intoxication" was written on the death certificate). From 1999 to 2008, the number of drug poisoning deaths involving only unspecified drugs increased from about 3,600 to about 9,200. Some drug poisoning deaths for which the drug was not specified may involve opioid analgesics.

[9] CDC, "CDC Grand Rounds...", 2012; Webster, et. al., 2011; Green, et. al., 2011; Warner, et. al., 2011.