

# Healthy Montgomery Behavioral Health Action Plan Report

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improve behaviors identified inequities content Expected  
Include End source treatment  
Specify database support  
estimated service organizations Committee potential  
health services  
use including linkages  
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families among Board system action  
efforts grant Objective  
serious explore Date  
Quantify Services Action appropriate formal step easily  
Start Health data individuals BHWG create  
behavioral  
Steering implement force Advisory assist Access  
Collaboration mechanisms  
clients cost outcomes Healthy months  
infoMontgomery agreement Within  
develop sources re convene CSCTF  
work coordinated community  
Lead intervention/strategy Setting task  
referral HMSC protocols creation barriers  
conditions payment List strategies members  
time Behavioral strategy full best available consumer  
specific LHIA Task agencies; Status  
telephone systems plan implementation Strategy Funding  
meet  
basic Force resources identify shared  
developed agency providers Council New  
emergency needs consumers client County  
planning based care BHITF social  
funding Goal information unhealthy staff  
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business partnership-based marketing within

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# Executive Summary

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## Executive Summary

In June, 2012 the Healthy Montgomery Steering Committee (HMSC) convened the Behavioral Health Action Planning Work Group (BHWG) and charged it with developing recommendations to improve the overall behavioral health of county residents, including mental health and substance abuse, with a focus on leveraging existing assets and capabilities in the County. The group moved immediately to achieve two objectives: to expand the BHWG membership to include key stakeholders from additional related systems such as services for the homeless and substance abuse treatment, and, to more narrowly define the action planning scope to reduce it to a feasible scale with recommendations that could be realistically achieved. In doing so, the BHWG elected not to single out each of the many groups that have a need for behavioral health services but rather to focus on those with the most serious problems. BHWG members discussed the specific needs of many groups including diverse racial and ethnic populations, seniors, children and adolescents, college students, and persons involved in the criminal justice system. The BHWG considered all of these groups in its planning but the group determined that the Plan would have the greatest impact if action strategies focused on the broader behavioral health system.

In developing the strategies described in this Action Plan, the BHWG was also mindful of its directive from the HMSC to explore ways of supporting and expanding existing efforts, collaborations and strengths, and to create efficiencies and identify opportunities to better serve Montgomery County residents *utilizing existing financial and other resources*. Consequently, the work group determined the most effective approach would be systems-based. More specifically, it involves developing strategies to increase access to information about publicly available behavioral services in the County (*infoMontgomery*). Additionally, improving providers' ability to communicate among themselves about their consumers to assure warm handoffs and coordinated services for consumers was also a priority of the BHWG. The BHWG believes this systems approach will have a broad impact, including improved outcomes for those individuals within the groups, mentioned above, who have specific needs.

Through a series of meetings held across the County, the BHWG reached consensus on three Local Health Issue Areas (**LHIAs**) with corresponding goals, objectives, and strategies to resolve those issues.

- **LHIA 1.** There is a need for consumers, families, referral agencies, and behavioral health providers to have ready access to basic information about treatment protocols, the full range of available services, payment mechanisms and how to access services;
- **LHIA 2.** There is a need to develop improved mechanisms for providers to communicate among themselves regarding shared consumers and to create effective linkages for consumers (warm hand-offs) as they move between providers or levels of care;
- **LHIA 3.** There is a need to explore the creation of a coordinated system of care or other formal partnership-based business agreement to meet the needs of individuals with more serious behavioral health conditions.

The BHWG ultimately determined there are three actionable strategies to recommend for immediate implementation, one for each of the LHIAs. The work group identified additional longer-range strategies that should be considered for action after progress is made on the initial actionable strategies.

### Actionable Strategies

The **first actionable strategy** is to use existing technology and expand *infoMontgomery* to enhance information about the availability of behavioral health services to the public and to referral agencies and include basic and useful advice on how to use the information. For example, a parent whose child has had a sudden and unexplained change in behavior may need some general guidance on potential causes and how to

get an evaluation and professional assistance. The group proposed that a task force work to build upon the *info*Montgomery site managed by the Collaboration Council on Children, Youth, and Families. While this does involve financial resources, the consensus was that it would be at a moderate level for which, once defined, funding sources could be identified. Two other strategies, developing printed (hard copy) and telephone-based versions of *info*Montgomery, are recommended as follow-on activities.

The **second actionable strategy** was derived from extensive discussion of the current behavioral health resources available in the County. While many consider Montgomery County to be rich in behavioral health resources, it is sometimes “systems poor.” There was agreement that many people enter the behavioral health system but subsequently get lost through transfer from inpatient to community-based services, failure to connect following a referral from another setting such as primary care, schools, or corrections, and because of the person’s inability to navigate the system without intensive community-based case management support.

Problems in the system derive from two significant sources. One was identified as the inability of people to mobilize their personal resources to deal with a problem, a common issue with mental health and substance abuse consumers, hence the need for case management. The other source identified was the lack of full connection among the providers who constitute the service network of the County. This latter source has an organizational component with many providers in the system, a technological barrier relative to electronic records, and a legal hurdle in terms of releases and shared behavioral health information. The concern about connectivity among providers consumed much of the discussion.

The BHWG identified two viable strategies to address the lack of full organizational connection. First, establish a task force to develop protocols that will facilitate transfer of consumers from institutional settings (in-hospital, emergency departments, detention centers, schools, etc.) to community behavioral health organizations. This is immediately actionable and can be achieved without major new resources. Second, establish adequate mechanisms for providers communicating among themselves regarding shared consumers and consumer linkages. This requires further definition of the project and costing-out the funding requirements.

The **third actionable strategy** is to convene a task force to formulate a framework to establish a coordinated system of care in Montgomery County, identify grant funding source(s), and submit a grant proposal to develop such a system. This third actionable strategy is intended to achieve a higher state of success, building upon the linkages created in the strategies recommended to address LHIA 2. Essentially, in better connecting community resources for the good of the consumer, there could then be a move toward a virtual coordinated system of care based more on values than on specific financial risk for consumer health outcomes. In brief, providers in the system would assume some collective responsibility to manage a consumer’s full array of services. This would include agreeing to a joint approach to measuring improvement in key areas such as inpatient utilization, employment, recovery from substance abuse, and improvements in functions of daily life while dealing with the symptoms and consequences of living with one or more behavioral health issues. On a consumer and provider level, this might translate into a shared care management plan that can be viewed and used across agencies. Providers would agree to collectively evaluate system issues and take responsibility for closing gaps or improving certain aspects of the community system to function more efficiently within the limits of available resources.

## **Implementing the Behavioral Health Action Plan**

To ensure implementation of these actionable strategies, the BHWG is proposing that an advisory board oversee development and management of three task forces that will plan and execute the implementation of the strategies. Existing BHWG members would provide leadership and continuity in the implementation of the strategies by being placed on the advisory board and/or on one or more of the task forces. The Healthy

Montgomery Steering Committee will serve as the Advisory Board and, as such, may require some additional affiliations determined to be critical to implementation of the Plan (including representatives of Montgomery County Public Schools, Montgomery College, public safety (police, sheriff, fire rescue, and corrections) and representatives of the workforce and housing fields). Consistent with the existing HMSC membership, representatives from additional affiliations should be in positions that can affect change.



# Section 1: Introduction

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**What is Healthy Montgomery?**

Healthy Montgomery is the community health improvement process for Montgomery County, Maryland. This community-based process builds upon previous and current health assessment efforts and integrates community input through an ongoing, consensus-driven approach to identify and improve priority health and well-being areas in our community.

Healthy Montgomery is governed by a Steering Committee, which is comprised of members from the broad local public health system, including government agencies and commissions, hospitals, community-based health and social service agencies, the County planning agency, and development agencies.<sup>1</sup>

**Healthy Montgomery History**

Prior to the launch of Healthy Montgomery in 2008, the most recent Montgomery County Department of Health and Human Services (DHHS) community needs assessment was completed in 2001. Since then, DHHS and its diverse community partners have recognized the need to conduct timely, comprehensive, data-based health needs assessments in order to better determine health and human services needs in the various communities and populations in the County. Data-based needs assessment identifies disparities in health status among the County's communities and populations, identifies unmet needs, and allows for the development, implementation, and evaluation of strategies to meet the needs.

In June 2008, the Montgomery County Collaboration Council for Children, Youth and Families sponsored a community meeting to engage the members of the local public health system in a one-day structured series of brain-storming sessions. The purpose was to identify the strengths and weaknesses of the local public health system in carrying out the ten essential public health functions, using a tool from the National Public Health Performance Standards Program of the Centers for Disease Control and Prevention, and facilitated by the National Association of City and County Health Officials (NACCHO).

This process elucidated the “need for a mechanism to coordinate the efforts of public and private organizations to identify and address health and health-related issues in the County.”<sup>2</sup> Additional areas for improvement included:

- Community-wide use of community health assessment or community health profile data;
- Establishment of a community health improvement committee;
- Review of community partnerships and strategic alliances;
- Review of public health policies;
- Establishment of a community health improvement process;
- Implementation of strategies to address community health objectives; and

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<sup>1</sup> Visit <http://www.healthymontgomery.org/index.php?module=htmlpages&func=display&pid=5000> for a list of the current Healthy Montgomery Steering Committee members.

<sup>2</sup> Local Public Health System Performance Assessment: Report of Results, Local Public Health System Assessment Retreat, June 10, 2008. Accessed at: [http://www.healthymontgomery.org/javascript/htmleditor/uploads/Montgomery\\_County\\_LPHSA\\_Combined\\_Report\\_FIN\\_5\\_14\\_2009.pdf](http://www.healthymontgomery.org/javascript/htmleditor/uploads/Montgomery_County_LPHSA_Combined_Report_FIN_5_14_2009.pdf)

- Use of the Local Public Health System Assessment evaluation to guide community health improvement activities.

Healthy Montgomery was designed to respond to many of these needs.

Coincidentally, as part of several new requirements of the Patient Protection and Affordable Care Act signed into law on March 30, 2010, tax-exempt hospitals are now required to conduct a Community Health Needs Assessment every three years, including implementation plans on actionable strategies, effective for taxable years beginning after March 23, 2012. The state of Maryland has had a requirement for several years that each non-profit hospital submit to the state a Community Benefit Report in order to justify its non-profit status. While each hospital has conducted its own assessments, it is apparent that a joint effort at community health assessment will permit a better coordinated effort to improve the health status of the community.

### **The Healthy Montgomery Steering Committee**

The Healthy Montgomery Steering Committee (HMSC) is broadly representative of the community, including our most vulnerable residents, and of the organizations involved in the delivery of health care services, social services, and services related to the social determinants of health.

Affiliations on the HMSC include:

- The four County hospital systems:
  - Adventist HealthCare (Shady Grove Adventist Hospital and Washington Adventist Hospital)
  - Holy Cross Hospital
  - MedStar Montgomery Medical Center
  - Suburban Hospital
- Montgomery County Department of Health and Human Services
  - African American Health Program
  - Latino Health Initiative
  - Asian American Health Initiative
- Montgomery County Health Officer
- Maryland County Planning Department, Maryland-National Park and Planning Commission
- Montgomery County Recreation
- Montgomery County Commissions and Committees:
  - Commission on Health
  - Commission on Aging
  - Commission on People with Disabilities
  - Mental Health Advisory Committee
- Montgomery County Collaboration Council for Children, Youth and Families
- Kaiser Permanente
- Georgetown University School of Nursing and Health Studies
- Primary Care Coalition of Montgomery County

The HMSC identified its overarching mission, goals and objectives to carry out its community health improvement work.<sup>3</sup>

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<sup>3</sup> Visit [http://assets.thehcn.net/content/sites/montgomery/HM\\_Overview\\_updated\\_FINAL\\_10\\_14\\_13.pdf](http://assets.thehcn.net/content/sites/montgomery/HM_Overview_updated_FINAL_10_14_13.pdf) for an overview of Healthy Montgomery: The Montgomery County Community Health Improvement Process.

***The mission of Healthy Montgomery is to achieve optimal health and well-being for Montgomery County, Maryland, residents. The Healthy Montgomery process is based upon an ongoing sustainable community and consensus-driven approach that identifies and addresses key priority areas that ultimately improve the health and well-being of our community.***

As approved by the Steering Committee, the three overarching goals of Healthy Montgomery are to:

- I. Improve access to health and social services;
- II. Achieve health equity for all residents; and
- III. Enhance the physical and social environment to support optimal health and well-being.

The Healthy Montgomery objectives are to:

- Identify and prioritize health needs in the County as a whole and in the diverse communities within the County;
- Establish a comprehensive set of indicators related to health processes, health outcomes and social determinants of health in Montgomery County that incorporate a wide variety of County and sub-County information resources and utilize methods appropriate to their collection, analysis and application;
- Foster projects to achieve health equity by addressing health and well-being needs, improving health outcomes and reducing demographic, geographic, and socioeconomic disparities in health and well-being; and
- Coordinate and leverage resources to support the Healthy Montgomery infrastructure and improvement projects.

## Process

The Healthy Montgomery community health improvement process is based on four phases<sup>4</sup>

Phase 1: Compiling of available quantitative data and establishment of an accessible Web-based database. (See [www.healthymontgomery.org](http://www.healthymontgomery.org));

Phase 2: Collection of qualitative data and development of a comprehensive community health needs assessment;

Phase 3: Setting of health priorities and development of action plans to address identified priorities; and



<sup>4</sup> [www.healthymontgomery.org](http://www.healthymontgomery.org)

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Phase 4: Implementing, monitoring and evaluation as well as preplanning for the next iteration of the process.

All four phases of work are supported by the data systems and related infrastructure. The Healthy Montgomery process relies on techniques that are sustainable and adaptable to the growing and changing needs of the community over time. Healthy Montgomery builds efficiencies into its multi-disciplinary approach by aligning partners to eliminate redundancies and maximize returns on investment.

### The Healthy Montgomery Timeline

Year	Activity	Time Frame
	NPHPSP Local Public Health System Performance Assessment identifies need for community health improvement process (CHIP, a.k.a. Healthy Montgomery)	June 2008
Year 1	Healthy Montgomery launch	June 2009
	Environmental scan complete	December 2009
Year 2	Healthy Montgomery Website content development	June 2010-February 2011
	• Healthy Montgomery indicators selected	December 2010
	• Healthy Montgomery Website public launch	February 2011
Year 3	Healthy Montgomery Needs Assessment released	September 2011
	Healthy Montgomery priority-setting process completed	October 2011
	Healthy Montgomery priorities chosen	November 2011
	Work Groups formed for action plan development	May-June 2012
Year 4	Local health issue areas and strategies identified	November 2012
Year 5	Implementation and evaluation plans completed:* Behavioral Health Obesity	September 2013 December 2013
	Implementation and evaluation plans receive public comment : Behavioral Health Obesity	Nov.- Dec. 2014 January-February 2014
	Implementation begins	April 2014
Year 6	Performance measurement/planning for next cycle begins	June 2014 and onward

\* Delays due to staffing issues

### Environmental Scan

At the December 2010 HMSC meeting, the Healthy Montgomery Environmental Scan was submitted to the HMSC for their review and approval.<sup>5</sup> The compiled set of resources served as the baseline knowledge of all past and current efforts related to the health and well-being of residents in Montgomery County.

<sup>5</sup> 2010 Environmental Scan Updated Nov2010. Available at:  
[http://assets.thehcn.net/content/sites/montgomery/Appendix\\_XX\\_2010\\_Environmental\\_scan\\_data\\_sources\\_Updated\\_Nov2010\\_RMH\\_8\\_19\\_13.pdf](http://assets.thehcn.net/content/sites/montgomery/Appendix_XX_2010_Environmental_scan_data_sources_Updated_Nov2010_RMH_8_19_13.pdf)

**Needs Assessment**

By September 2011 the Montgomery County Community Needs Assessment was drafted for the Healthy Montgomery Steering Committee to use in its priority-setting process.<sup>6</sup> The assessment consolidated the most currently available health and well-being data and identified key findings for the HMSC to take under consideration in its process. “Community conversations” were held across the County to capture qualitative input from residents to inform the priority-setting process as well.

**Priority Setting Process**

In October 2011, the HMSC held a half-day retreat to choose the strategic priority areas for improvement activities.<sup>7</sup> The priority-setting process utilized an online survey tool<sup>8</sup> that the Steering Committee members completed prior to the retreat to enable them to independently evaluate potential priority areas by five criteria:

- I. How many people in Montgomery County are affected by this issue?
- II. How serious is this issue?
- III. What is the level of public concern/awareness about this issue?
- IV. Does this issue contribute directly or indirectly to premature death?
- V. Are there inequities associated with this issue? (Health inequities are differences in health status, morbidity, and mortality rates across populations that are systemic, avoidable, unfair, and unjust.)

The survey results were compiled for each member and for the entire HMSC. The results were ranked and provided at the retreat<sup>9</sup>. Through multi-voting and consensus discussion, the Steering Committee narrowed the top-ranked priority areas to be the following:

- Behavioral Health;
- Cancers;
- Cardiovascular Health;
- Diabetes;
- Maternal and Infant Health; and
- Obesity

In addition to selecting the six broad priorities for action, the HMSC selected three overarching themes that Healthy Montgomery should address in the health and well-being action plans for each of the six priority areas: lack of access; health inequities, and unhealthy behaviors.

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<sup>6</sup> Healthy Montgomery 2011 Needs Assessment. Available at: <http://www.healthymontgomery.org/index.php?module=InitiativeCenters&func=display&icid=7> Accessed on September 5, 2013.

<sup>7</sup> <http://www.healthymontgomery.org/index.php?module=InitiativeCenters&func=display&icid=2>

<sup>8</sup> Healthy Montgomery Priority Setting Tool. Available at: [http://www.healthymontgomery.org/javascript/htmleditor/uploads/HM\\_PSP\\_tool\\_FINAL.pdf](http://www.healthymontgomery.org/javascript/htmleditor/uploads/HM_PSP_tool_FINAL.pdf) Accessed on September 5, 2013.

<sup>9</sup> Healthy Montgomery Priority Setting Tool: Summary of Results. Available at: [http://www.healthymontgomery.org/javascript/htmleditor/uploads/HM\\_OnlinePSP\\_tool\\_Group\\_Results\\_October\\_23\\_2011.pdf](http://www.healthymontgomery.org/javascript/htmleditor/uploads/HM_OnlinePSP_tool_Group_Results_October_23_2011.pdf). Accessed on: September 5, 2013.

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Healthy Montgomery Action Plan Report: Behavioral Health

Because of limited resources to support the work groups, at the March 5, 2012 meeting, the Steering Committee chose behavioral health and obesity as the initial two focus areas to complete action planning, starting in June 2012 with the intention of phasing in the remaining four areas as staffing resources would permit.

By June 2012, membership had been finalized on the initial action planning work groups. Their task was to develop, execute, and evaluate specific action plans designed to improve the health and well-being of the residents of Montgomery County.

The Work Groups continued to meet regularly until February of 2013. Each Work Group analyzed existing data bases to create indicator tables focusing on each of their issue areas, created an inventory of resources, reviewed the status of related activities, programs, services, and policies, including identifying gaps in resources, data and coordination of activities and began writing its respective Action Plan Reports. In February, however, the Work Groups' activities were suspended due to staffing issues. Work resumed in June 2013, with the final draft of the Behavioral Health Action Plan Report being submitted to the Healthy Montgomery Steering Committee in September 2013. The final draft of the Obesity Action Plan Report will be submitted to the Committee in December, 2013. After a public comment period on both reports concludes, the final action plans on both behavioral health and obesity will be implemented; thereafter, monitoring and evaluation on their effectiveness will be accomplished through prescribed evaluation plans.

## Section 2: Data Summary

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The Behavioral Health Action Planning Work Group (BHWG) reviewed and evaluated the most current population-based health and well-being data to identify specific local health issue areas on which strategies could be planned.<sup>1</sup>

To get an accurate situational awareness, the work group reviewed the 2011 Needs Assessment and the updated 2012 Behavioral Health Data Profile drafted specifically to provide updated and expanded information about behavioral health obtained subsequent to the 2011 Needs Assessment using the most recent available data.

### Healthy Montgomery Needs Assessment

In 2011, Healthy Montgomery compiled a comprehensive needs assessment in order to prioritize the health and well-being needs of Montgomery County residents.<sup>1</sup> The Behavioral Health narrative within the Health Section of the Needs Assessment summarized the key findings for mental health and mental disorders, as well as substance abuse, including tobacco use.

### 2012 Behavioral Health Data Profile Update

In June 2012, in preparation for the action planning phase for Healthy Montgomery in Behavioral Health, an update on county-specific behavioral health data were compiled and reviewed by the Healthy Montgomery Behavioral Health Action Planning Work Group.

Key findings from the updated profile were summarized and were considered in the identification of key local priority issue areas for which strategies were developed. The summary of findings is listed below.

### Figure 1. Summary of Key Data Findings from 2011 Needs Assessment

#### Mental Health and Mental Disorders

- Adults, 18-44 years, reported most often having more than two days in a month when their **mental health was poor**, compared with Adults 45-64 and the elderly. Hispanic/Latino adults (35.8%) and White adults (20.4%) had the highest percent of adults reporting more than 2 days of poor mental health in a month.
- Rates of **suicide** among males are approximately 2.5 times higher (9.6/100,000 population) than females (4.2/100,000 population). Whites have a rate that is almost 50% higher (7.9/100,000 population) than the African American/Black population (4.3/100,000 population).
- One in 14 adolescents (12-17 years) reports experiencing a **major depressive episode** in the past year. The rate increases with age among the non-elderly with one in seven adults, 18-44, years, and one in five adults, 45-64 years, reporting experiencing **depression** in the past year. Women have higher rates (18.6%) of self-reported depression than men (14.9%).
- *Community Perspectives:* As expressed by members of the Vietnamese community, **access to mental health care** and the **need for bilingual mental health providers** ranked high on their list, as well as concerns around multi-generational relationships due to acculturation of the younger generation.

#### Substance Abuse

- Montgomery County has the lowest percent of persons (15.5%), 12 years and older, who reported **cigarette use** in the past month, use of any tobacco product in the past month and had the highest percent of people with a perceived great risk from smoking one or two packs of cigarettes a day when compared to other regions within Maryland.
- The Montgomery County prevalence for **alcohol dependence** and **illicit drug dependence** is lower than the Maryland and U.S. rates.
- **Marijuana use** is almost three-fold higher (15%) among Montgomery County young adults (18-25 years) than the overall Montgomery County population (5.6%).

<sup>1</sup> This data summary is based on data that were available to the Behavioral Health Work Group as of August 2012.

## 2012 Behavioral Health Data Profile Findings

- In the 2009 BRFSS, one in ten Montgomery County adults reported being diagnosed with an **anxiety disorder**.
- In the 2009 BRFSS, 16.8% of Montgomery County adults reported being diagnosed with a **depressive disorder**.
- In the 2009 BRFSS, 80% of Montgomery County adults reported having two or fewer days of poor mental health in the month preceding the survey. **Hispanic/Latino adults were least likely to report having two or fewer days of poor mental health.**
- In the 2009 BRFSS, 83.3% of Montgomery County adults reported **receiving the social and emotional support as often as they needed**. Greater numbers of Asians and Hispanics reported receiving the social and emotional support less often than they needed when compared to other racial/ethnic groups.
- Montgomery County Medicaid recipients who received inpatient, outpatient, and/or professional services for **episodic mood disorders** in 2011 were more likely to be adults, 21-40 years of age, than individuals of any other age, and these adults were more likely to be White than of another race/ethnicity group.
- In 2010, there were 741.2 visits per 100,000 County residents to **emergency rooms for behavioral health conditions**.
- The rate of hospital discharges per 10,000 County residents with a principal **diagnosis of bipolar disorder doubled for adolescents** (from 6.9 to 14.3) and **increased 40 percent for adults** (from 9.7 to 13.6) from 2000 to 2009.
- During 2007-2009, the **age-adjusted suicide rate** in Montgomery County was 7.0 deaths/100,000 population.
- In the 2009 BRFSS, 14.2% of Montgomery County adults reported engaging in **binge drinking**. Males were more likely than females to report engaging in binge drinking and White adults were more likely than adults of other race/ethnicity groups to report engaging in binge drinking.
- **Substance abuse behaviors** in Montgomery County remained relatively level at 6 percent for illicit drug use in the past month during the years 2004-2008. Montgomery County **adults, ages 18-25, were three times (18.5%) more likely to report past month illicit drug use** than Montgomery County residents overall.
- In the 2010 BRFSS, 7.9% of Montgomery County adults reported being a current smoker and having **smoked more than 100 cigarettes in their lifetimes**. Men were more likely than women to report being a current smoker, and African Americans/Blacks were more likely to report being current smokers than adults of other race/ethnicity groups. Nearly one in five Montgomery County high school students reported using any kind of tobacco month in the month preceding the Maryland Youth Tobacco Survey in 2010.
- 3.4% of Montgomery County respondents to the NSDUH in 2006-2008 reported **using pain relievers for non-medically prescribed reasons** in the previous month, compared to 3.9% of all Maryland residents. The prevalence of reported non-medical use of pain relievers remained level between 2006-2008 and 2008-2010. **Almost 10 percent of 18-25-year-old respondents** reported using pain relievers for non-medically prescribed reasons in the past month—about 2-3 times more than any other age group.

## Hospital Utilization Trends in Montgomery County, 2000-2009

In addition to the key findings in the 2012 Behavioral Health Data Profile that updated population-based health metrics from the Maryland Vital Events (Deaths), Maryland Behavioral Risk Factor Surveillance System (BRFSS) and the U.S. SAMHSA National Survey on Drug Use and Health (NSDUH), hospital utilization data were newly compiled from the Maryland Health Services Cost Review Commission (HSCRC) that were not available for the 2011 Healthy Montgomery Needs Assessment. These new findings are listed separately below.

### Mood Disorders

The HSCRC classifies the broad diagnosis of mood disorders as bipolar disorders and depressive disorders. Some noteworthy utilization trends are provided below.

- The rate of hospital discharges with a **principal diagnosis of mood disorders** for adults, 20 years and older, who were readmitted **within 31 days of a previous hospital inpatient admission rose almost two-fold** from 1.2 admissions per 10,000 residents in 2000 to 2.3 admissions per 10,000 residents in 2009.
- For adolescents (ages 10-19), the rate of hospital discharges for a **principal diagnosis of mood disorders** per 10,000 County residents **was volatile over the years, 2000-2009**, ranging from 15.8 to 25.1. Readmission data for adolescents, ages 10-19, for hospital discharges with a principal diagnosis of mood disorders were not available for the years 2000-2009.

### Bipolar Disorders

- The rate of hospital discharges for adolescents, ages 10-19, with a **principal diagnosis of bipolar disorders** per 10,000 County residents **increased** from 6.9 discharges per 10,000 County residents in 2000 to 14.3 discharges per 10,000 County residents in 2009.
- The rate of hospital discharges with a principal **diagnosis of bipolar disorders** for adults, ages 20 and older, per 10,000 County residents **increased** from 9.7 discharges per 10,000 population in 2000 to 13.6 discharges per 10,000 population in 2009.
- The rate of hospital discharges with a **principal diagnosis of bipolar disorders for adults, ages 20 and older, who were readmitted within 31 days** of a previous hospital inpatient service, per 10,000 County residents **rose over two-fold** from 0.5 to 1.2 admissions per 10,000 residents during the period 2000-2009.

### Depressive Disorders

- Adult (age 20 and older) hospital discharges per 10,000 County residents with a **principal diagnosis of depressive disorders decreased** from 15.0 discharges per 10,000 population in 2000, to 11.7 discharges per 10,000 population in 2009.
- The rate of hospital discharges with a principal **diagnosis of depressive disorders for adults who were readmitted within 31 days of a previous hospital inpatient service** ranged from a low of 0.4 per 10,000 County residents to a high of 1.4, over the period 2000-2009.
- From 2004-2008, there was a decrease in the rate of hospital discharges with a **principal diagnosis of a depressive disorder** for young adults, ages 10-19, per 10,000 County residents. This may have reflected a reduction in the incidence of depressive episodes

and/or an increase in the availability of non-hospital treatment modalities for adolescent depression<sup>2</sup>.

- Overall, the rate of **hospital discharges for depressive disorders among adolescents** in Montgomery County decreased from 12.2 per 10,000 in 2000 to 7.0 per 10,000 in 2008, and then increased to 10.0 per 10,000 in 2009. Readmission data for hospital discharge data for adolescents with a principal diagnosis of depressive disorders were not available for 2000-2009.

### Psychotic Disorders

- The rate of hospital discharges with a **principal diagnosis of schizophrenia and other psychotic disorders for adults**, ages 20 years and older, per 10,000 County residents **has remained relatively stable** during the years 2000-2009, at around 12.0 discharges per 10,000 population.
- The rate of hospital discharges with a **principal diagnosis of schizophrenia and other psychotic disorders for adults**, ages 20 years and older, who were readmitted within 31 days of a previous hospital inpatient service **increased** slightly during the years 2000-2009.
- The rate of hospital discharges with a **principal diagnosis of schizophrenia and other psychotic disorders for adolescents**, ages 10-17, per 10,000 County residents **is nearly three-fold lower than it is for adults**. Readmission data for the rate of hospital discharges with a principal diagnosis of schizophrenia and other psychotic disorders for adolescents were not available for the years 2000-2009.

### Alcohol-Related

- The rate of hospital discharges with a **primary diagnosis of a mental disorder that was an alcohol-related disorder for adults** per 10,000 County residents **increased 25 percent** from 6.7 discharges per 10,000 Montgomery County residents in 2000 to 8.4 in 2009.
- The rate of hospital discharges with a **primary diagnosis of an alcohol-related disorder for adults who were readmitted within 31 days** of a previous hospital inpatient service, per 10,000 County residents, during 2000-2009 follows a similar pattern as the hospital discharge rates during this same period, increasing from 0.2 to 0.5 discharges per 10,000 Montgomery County residents.

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<sup>2</sup> According to the NSDUH, during the period 2006 - 2008, 7.2% of Montgomery County youth, ages 12 - 17, said they had experienced a depressive episode. This was a decrease from 9.0% in 2004-2006. During 2006-2008, 7.5% of all Maryland youth who were surveyed said they had experienced a depressive episode in the year preceding the survey.

**Summary Table of Healthy Montgomery Behavioral Health Indicators**

INDICATORS (SOURCE/YEAR)	COUNTY BASELINE	MARYLAND BASELINE	COUNTY COMPARED TO MARYLAND	MARYLAND SHIP 2014 TARGET	COUNTY COMPARED TO MARYLAND SHIP TARGET	UNITED STATES	COUNTY COMPARED TO UNITED STATES	HEALTHY PEOPLE 2020	COUNTY COMPARED TO HEALTHY PEOPLE 2020
<b>Mental Health And Mental Disorders</b>									
Adequate Social and Emotional Support (BRFSS, 2010 )	83.3 %	82.9%	SLIGHTLY BETTER						
Age-Adjusted Death Rate due to Suicide per 100,000 population (VSA, 2007-2009)	7.1	9.6	BETTER	9.1	BETTER	11.3	BETTER	10.2	BETTER
Percentage of Self-Reported Diagnosis of Anxiety ( BRFSS, 2009)	10.6 %	12.4%	BETTER						
Percentage of Self-Reported Diagnosis of Depression ( BRFSS, 2011)	12.4 %	13.5%	BETTER						
Percentage of Self-Reported Good Mental Health (BRFSS, 2011)	77.2 %	75.8 %	BETTER						
Percentage of Youth who had a Major Depressive Episode ( SAMHSA, 2008-2010)	7.6 %	7.5%	NO DIFFERENCE	N/A	N/A	8.1%	BETTER	7.4 %	TARGET NOT MET
Percentage of Adults who reported ever being diagnosed with depressive disorder ( BRFSS, 2011)	12.4%	13.6%	BETTER						
<b>Substance Abuse</b>									
Alcohol Use (SAMHSA, 2008-2010)	55.7 %	53 %	WORSE			51.7%	WORSE		
Cigarette Smoking (SAMHSA, 2008-2010)	14.3 %	19.8%	BETTER	14.7 %	TARGET MET	23.5%	BETTER		
Adults who currently smoke (BRFSS 2008-2010)	7.8%	15.2%	BETTER	13.5%	BETTER	20.6%	BETTER		
Use of any tobacco product in the past 30 days among high school students (9-12 grade) ( MYTS, 2010)	19.2%	24.8%	BETTER	22.3%	BETTER	26.0%	BETTER		
Illicit Drug Use ( SAMHSA, 2008-2010)	6.22 %	7.57 %	BETTER			8.61%	BETTER		
Marijuana Use ( SAMHSA, 2008-2010)	4.6 %	5.7%	BETTER			6.6%	BETTER		
Nonmedical Use of Pain Relievers ( SAMHSA, 2008-2010)	3.3%	4%	BETTER			4.9%	BETTER		

INDICATORS (SOURCE/YEAR)	COUNTY BASELINE	MARYLAND BASELINE	COUNTY COMPARED TO MARYLAND	MARYLAND SHIP 2014 TARGET	COUNTY COMPARED TO MARYLAND SHIP TARGET	UNITED STATES	COUNTY COMPARED TO UNITED STATES	HEALTHY PEOPLE 2020	COUNTY COMPARED TO HEALTHY PEOPLE 2020
Rate of drug-induced deaths per 100,000 population (VSA 2007-2009)	5.9	13.4	BETTER	12.4	BETTER	12.6	BETTER		
Persons who Binge Drink ( SAMHSA, 2008-2010)	20.4 %	20.9 %	NO DIFFERENCE			23.4 %	BETTER		
Adults who reported being binge drinkers (BRFSS, 2011)	15.5%	18.0%	BETTER						
Emergency department visits for a behavioral health condition per 100,000 County Residents (MHSCRC, 2010)	741.2	1,206.3	BETTER	1,146.0	BETTER				
<b>Mental Disorders Related Hospital Utilization</b>									
<b>Adults</b>									
Age-Adjusted Hospitalization Rate due to Alcohol Abuse per 10,000 County Residents (18+ Years) (MHSCRC 2008-2010)	7.6								
Age-Adjusted ER Visits Rate due to Alcohol Abuse for Population (18+ years) per 10,000 population (VSA, 2008-2010)	22.1								
Hospital Discharges Rate due Alcohol Related Disorders (20+) per 10,000 population (MHSCRC, 2010)	8.4								
Hospital Readmission Rate due Alcohol Related Disorders (20+) per 10,000 population (MHSCRC, 2009)	0.5								
Hospital Discharges Rate due Substance-Related Disorders (20+) per 10,000 population (MHSCRC, 2009)	2.7								
Hospital Readmission Rate due Substance-Related Disorders (20+) per 10,000 population (MHSCRC, 2009)	0.2								

INDICATORS (SOURCE/YEAR)	COUNTY BASELINE	MARYLAND BASELINE	COUNTY COMPARED TO MARYLAND	MARYLAND SHIP 2014 TARGET	COUNTY COMPARED TO MARYLAND SHIP TARGET	UNITED STATES	COUNTY COMPARED TO UNITED STATES	HEALTHY PEOPLE 2020	COUNTY COMPARED TO HEALTHY PEOPLE 2020
Rate of Hospital Admissions related to dementia/Alzheimer's per 100,000 population (MHSCRC 2010)	9.4	17.3	BETTER	16.4	BETTER				
Mental Disorders Discharge (20+) Rate Per 10,000 population (MHSCRC, 2009)	54.8								
Mental Disorders Readmission (31 days of prior admission) Rate Per 10,000 population (20+ Years) (MHSCRC, 2009)	4.5								
Bipolar Disorders Discharge (20+ Years) Rate Per 10,000 population (MHSCRC, 2009)	13.6								
Bipolar Disorders Readmission (31 days of prior admission) Rate Per 10,000 population (20+ Years) (MHSCRC, 2009)	1.2								
Mood Disorders Discharge (20+) Rate per 10,000 population (MHSCRC, 2009)	25.3								
Mood Disorders Discharge Readmission Rate per 10,000 population (20+ Years) (MHSCRC, 2009)	2.3								
Anxiety Disorders Discharge Rate per 10,000 population (20+ Years) (MHSCRC, 2009)	0.8								
Depressive Disorders Discharge Rate per 10,000 population (20+ Years) (MHSCRC, 2009)	11.7								
Depressive Disorders Readmission Rate per 10,000 population (20+ Years) (MHSCRC, 2009)	1.1								
Schizophrenia and Other Psychotic Disorders Discharge Rate per 10,000 population (20+ years) (MHSCRC, 2009)	11.9								

INDICATORS (SOURCE/YEAR)	COUNTY BASELINE	MARYLAND BASELINE	COUNTY COMPARED TO MARYLAND	MARYLAND SHIP 2014 TARGET	COUNTY COMPARED TO MARYLAND SHIP TARGET	UNITED STATES	COUNTY COMPARED TO UNITED STATES	HEALTHY PEOPLE 2020	COUNTY COMPARED TO HEALTHY PEOPLE 2020
Schizophrenia and Other Psychotic Disorders Readmission Rate per 10,000 population (20+ years) (MHSCRC, 2009)	1								
<b>Children (Ages 10-19 Years)</b>									
Mental Disorders Discharge Rate Per 10,000 population (MHSCRC, 2009)	34.1								
Mental Disorder Readmission Rate Per 10,000 population (MHSCRC, 2009)	1.6								
Mood Disorders Discharge Rate Per 10,000 population (MHSCRC, 2009)	24.3								
Bipolar Disorders Discharge Rate Per 10,000 population (MHSCRC, 2009)	14.3								
Depressive Disorders Discharge Rate per 10,000 population (MHSCRC, 2009)	10								
Schizophrenia and Other Psychotic Disorders Discharge Rate per 10,000 population (MHSCRC, 2009)	3.2								
Hospital Discharges Rate due Substance-Related Disorders (10-19) per 10,000 population ((MHSCRC, 2009)	1.2								
Attention Deficit, Conduct, and Disruptive Behavior Disorders Rate for Ages (10-14 years) per 10, 000 population (MHSCRC, 2009)	1								
<b>Montgomery County Maryland Medicaid Recipients Who Received Outpatients, Inpatients, and/or Professional Services</b>									
ADHD and ADD (MMIS, 2011)	1.5%	3%	BETTER						
Episodic Mood Disorders (MMIS, 2011)	3.5%	6.0%	BETTER						
Depression (MMIS, 2011)	1.7%	3.1%	BETTER						
Substance Abuse (MMIS, 2011)	0.7%	2.4%	BETTER						

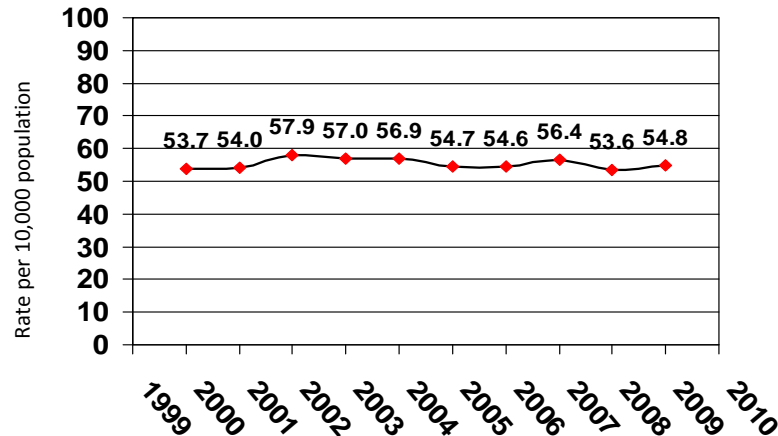


INDICATORS (SOURCE/YEAR)	COUNTY BASELINE	MARYLAND BASELINE	COUNTY COMPARED TO MARYLAND	MARYLAND SHIP 2014 TARGET	COUNTY COMPARED TO MARYLAND SHIP TARGET	UNITED STATES	COUNTY COMPARED TO UNITED STATES	HEALTHY PEOPLE 2020	COUNTY COMPARED TO HEALTHY PEOPLE 2020
Tobacco Abuse (MMIS, 2011)	0.1%	0.2%	BETTER						

MATCH Maryland Assessment Tool for Community Health  
 BRFSS Maryland Behavioral Risk Factor Surveillance System  
 VSA Vital Statistics Administration, Maryland Department of Health and Mental Hygiene  
 SAMHSA National Survey on Drug Use and Health, Substance Abuse and Mental Health Administration  
 MYTS Maryland Youth Tobacco Survey  
 MHSCRC Maryland Health Services Cost Review Commission  
 MMIS Maryland Medicaid Management Information System, Maryland Department of Health and Mental Hygiene

## Behavioral Health Chartbook

Hospital Discharges With Principal Diagnosis of Mental Disorders  
For Adults (20+ years) per 10,000 County Residents, 2000-2009



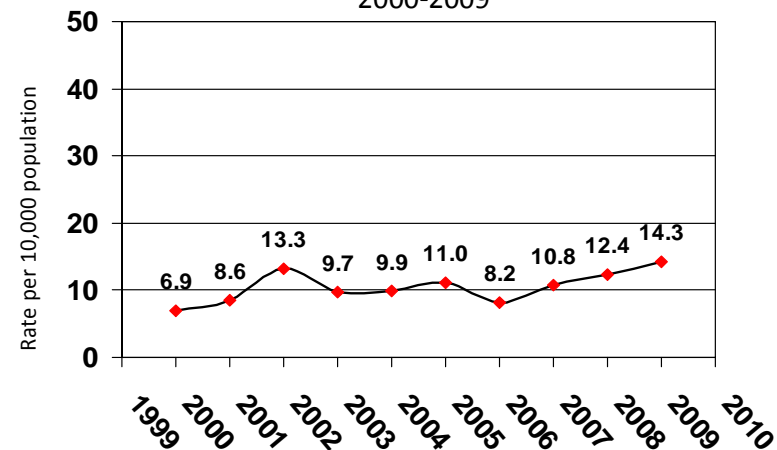
### Mental Disorders Hospital Discharges: Young Adults (10-19)

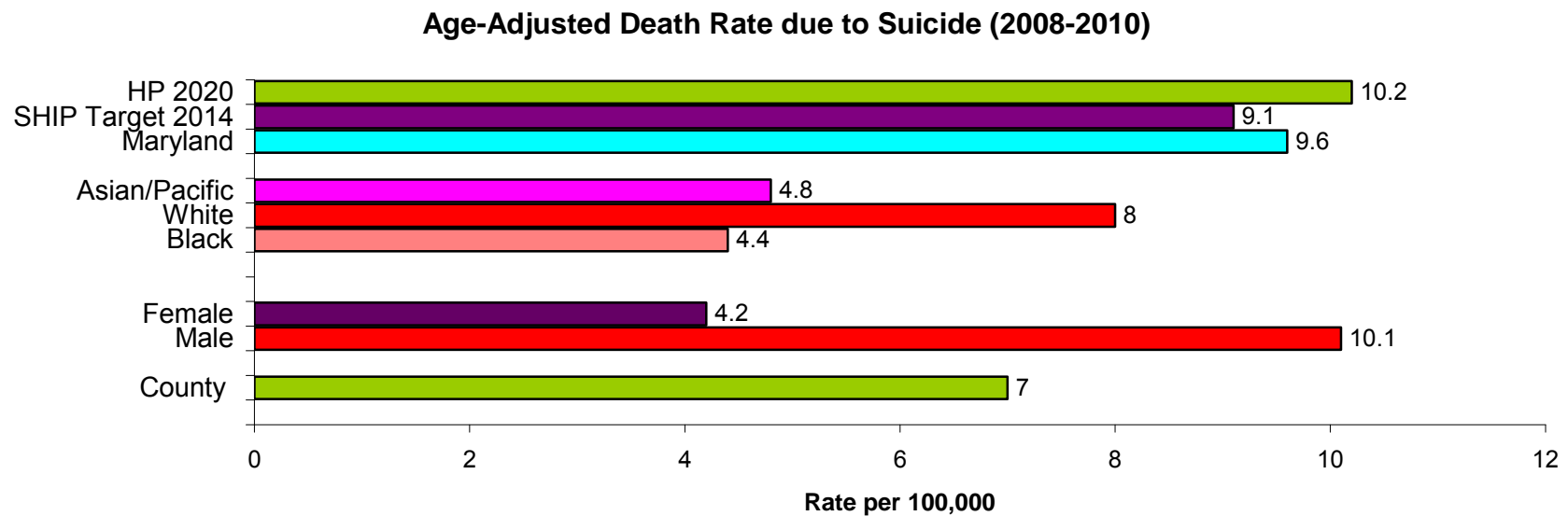
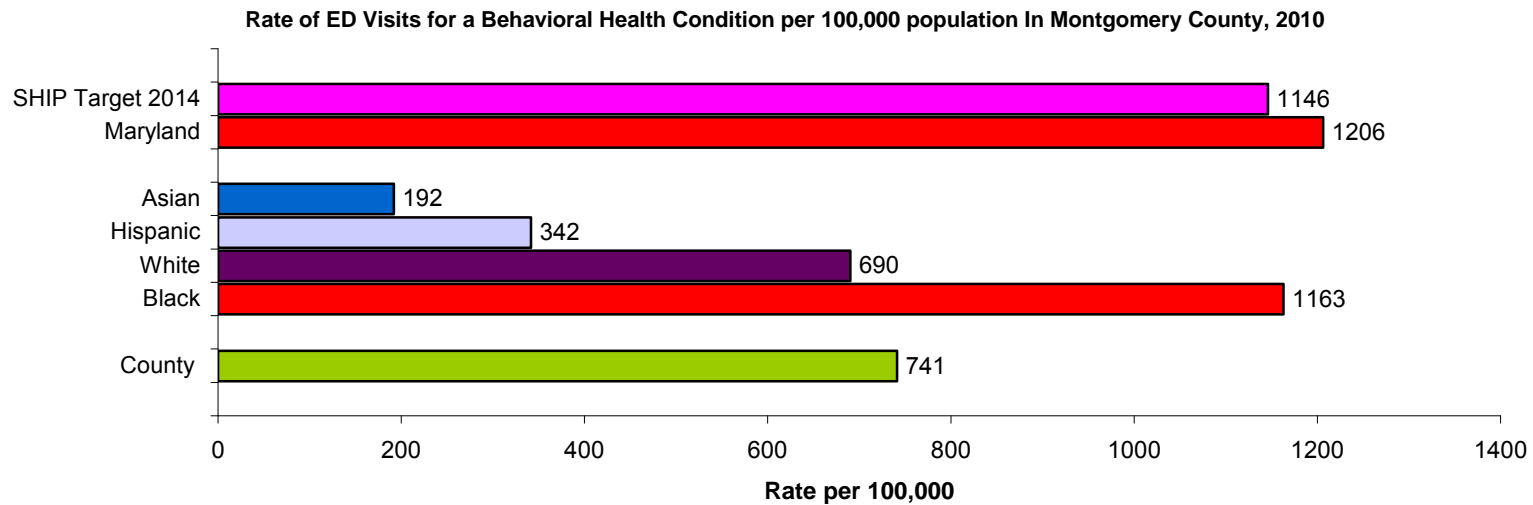
**Trends:** In Montgomery County, the rate of hospital discharges with a principal diagnosis of bipolar disorders for adolescents 10-19 years has doubled from 6.9 in 2000 to 14.3 per 10,000 County residents in 2009.

### Mental Disorders Hospital Discharges: Adults (20+ years)

**Trends:** In Montgomery County, the rate of hospital discharges with a principal diagnosis of any mental disorder for adults (ages 20 and older) has remained at around 54.0 discharges per 10,000 County residents for the years, 2000-2009.

Hospital Discharges With Principal Diagnosis of Mental Disorder:  
Bipolar Disorders For Ages 10-19, per 10,000 County Residents,  
2000-2009





## Data Sources

- Maryland Assessment Tool for Community Health (MATCH), Maryland Health Services Cost Review Commission (MHSCRC), 2009 and 2010.
- Maryland Behavioral Risk Factor Surveillance System (MD BRFSS), 2009, 2010, 2011.
- Maryland Medicaid Management Information System, Maryland Department of Health and Mental Hygiene (DHMH), 2011.
- Maryland State Health Improvement Process Measures (SHIP), 2010.
- National Survey on Drug Use and Health (NSDUH), Substance Abuse and Mental Health Administration (SAMHSA), 2008-2010.
- Vital Statistics Administration, Maryland Department of Health and Mental Hygiene (VSA, DHMH) 2007-2009, 2008-2010.

## References

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<sup>1</sup> Healthy Montgomery 2011 Needs Assessment, Healthy Montgomery. Accessed on the Healthy Montgomery website on April 5, 2013 at:

<http://www.healthymontgomery.org/index.php?module=InitiativeCenters&func=display&icid=7>.

## Section 3: Putting the Behavioral Health Action Plan in Context

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### **Charge from the Healthy Montgomery Steering Committee to the Behavioral Health Action Planning Work Group**

At the March 5, 2012 Healthy Montgomery Steering Committee (HMSC) meeting,<sup>1</sup> the Committee formulated the following charge to the Behavioral Health Action Planning Work Group (BHWG):

*Within behavioral health, achieve optimal health and well-being for Montgomery County, Maryland residents while addressing lack of access, health inequities, and unhealthy behaviors.*

The HMSC identified key activities of the action planning process for the work group:

- Conduct an updated scan that compiles existing efforts in the focus area;
- Identify organizations/stakeholders/partners;
- Identify current activities and potential evidence-based best practices;
- Identify current and potential resources to support efforts;
- Develop metrics to monitor activities, evaluate process, measure the performance and outcomes of efforts; and
- Evaluate opportunities and challenges within the focus areas.

The HMSC offered the following additional guidance:

- Build on existing strengths;
- Maximize collaboration;
- Build efficiencies across sectors;
- Fill gaps that are critical to improving outcomes; and
- Develop an evaluation plan that measures impact of strategies on outcomes and performance measures.

Furthermore, the work group was instructed to develop an action plan that builds on existing efforts to improve access, reduce health inequities, and change unhealthy behaviors.

The BHWG was formed in June 2012 with Thom Harr, Executive Director of Family Services, Inc., serving as the HMSC member liaison to the BHWG. The group was comprised of individuals who have subject-matter expertise in mental health and substance abuse as well as experience in providing behavioral health-related services and advocating for vulnerable populations disproportionately affected by poor behavioral health outcomes. Thom Harr and Kevin Young, President of Adventist Behavioral Health, served as co-chairs of the BHWG. BHWG member responsibilities included attending semi-monthly meetings for approximately six months, preparing for meetings, and carrying out assignments between meetings to keep work group activities on schedule. The BHWB membership included:

- Thom Harr (Family Services, Inc.) Co-Chair
- Kevin Young (Adventist Behavioral Health) Co-Chair
- Betsy Bowman (Threshold Services, Inc.)
- Larry Epp (Linkages to Learning)
- Hope Hill (Montgomery County Collaboration Council for Children, Youth and Families, Inc.)
- Beth Kane Davidson (Suburban Hospital)

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<sup>1</sup> Healthy Montgomery Steering Committee Meeting, March 5, 2012. Online electronic handout packet, page 4. Accessed on April 5, 2013 at [http://www.healthymontgomery.org/javascript/htmleditor/uploads/March\\_5\\_2012\\_HANDOUTS.pdf](http://www.healthymontgomery.org/javascript/htmleditor/uploads/March_5_2012_HANDOUTS.pdf)

- Gene Morris (Montgomery County Department of Health and Human Services, Access to Behavioral Health)
- Jennifer Pauk (Montgomery Cares Behavioral Health)
- Arleen Rogan (Family Services, Inc.)
- Jose Segura (Identity, Inc.)
- Susanne Sinclair-Smith (Montgomery County Coalition for the Homeless)
- Katherine Slye-Griffin, (NAMI Montgomery County)
- Anthony Sturgess (Montgomery County Department of Corrections)
- Ceclia Young (Montgomery College)

### **Community Resources Related to Behavioral Health in Montgomery County**

To ensure that the behavioral health action plan would reflect and build upon existing programs, services and resources, the Work Group conducted an environmental scan to construct a comprehensive picture of the behavioral health environment. It also reviewed several foundational strategic planning documents as well as reference documents related to behavioral health.

As part of the environmental scan, an inventory tool, entitled “Inventory of Behavioral Health-Related Programs in Montgomery County,”<sup>2</sup> was utilized to document programs, services, and initiatives within Montgomery County. Drawing from the literature on community health assessment and improvement processes as well as previously published community health improvement action plans, the tool includes individual-level and environmental level interventions and best practices currently within Montgomery County. Environmental-based interventions included existing or proposed policies, regulations, or laws that create an environment in which positive impacts can be made in behavioral health. While the Inventory is not an exhaustive listing of behavioral health programs and services in the County, it does include details on certain practices, networks, and partnerships that have made a meaningful impact within the behavioral health system.

Using the inventory tool, the BHWG members could more easily identify assets currently available as well as existing systems-level gaps that need to be addressed. Compiling the identified assets and gaps in Montgomery County helped to inform the direction of the Action Plan as well as highlight and align both potential and existing partner organizations to assist in implementing the Plan once finalized.

The foundational documents reviewed by the BHWG include:

- Inventory of available mental health and substance abuse services, Montgomery County Department of Health and Human Services (DHHS), Behavioral Health and Crisis Services Correspondence, July 2012.
- Mental Health Advisory Committee, Montgomery County Department of Health and Human Services, Recommendations from the Annual Meeting of the Boards, Committees and Commissions with County Executive Isiah Leggett, February 23, 2012.  
(<http://www.healthymontgomery.org/javascript/htmleditor/uploads/MHACAnnualReport.pdf>)
- Alcohol and Other Drug Abuse Advisory Council, *2010-2011 Annual Report*.  
([http://www.healthymontgomery.org/javascript/htmleditor/uploads/AODAAC\\_Annual\\_Report.pdf](http://www.healthymontgomery.org/javascript/htmleditor/uploads/AODAAC_Annual_Report.pdf))

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<sup>2</sup> Inventory of Behavioral Health-Related Programs in Montgomery County available at:  
[http://www.healthymontgomery.org/javascript/htmleditor/uploads/MASTER\\_Inventory\\_Tool\\_Behavioral\\_Health\\_8\\_2012.pdf](http://www.healthymontgomery.org/javascript/htmleditor/uploads/MASTER_Inventory_Tool_Behavioral_Health_8_2012.pdf)

- Health Management Associates. *Accountable Care in the Safety Net* (Terry Conway, MD, Managing Principal & Pat Terrell, Managing Principal) Prepared for the Blue Shield of California Foundation, November 2010.  
([http://www.healthymontgomery.org/javascript/htmleditor/uploads/FINAL\\_Accountable\\_Care\\_in\\_the\\_Safety\\_Net.pdf](http://www.healthymontgomery.org/javascript/htmleditor/uploads/FINAL_Accountable_Care_in_the_Safety_Net.pdf))
- Montgomery County Public Schools, *Mental Health Task Force Report*, May 10, 2005  
([http://www.healthymontgomery.org/javascript/htmleditor/uploads/mentalhealth\\_report\\_2005\\_M\\_CPS1.pdf](http://www.healthymontgomery.org/javascript/htmleditor/uploads/mentalhealth_report_2005_M_CPS1.pdf))
- *Developing a System of Care: Findings and Recommendations on the Public Mental Health System*, Blue Ribbon Task Force on Mental Health (Appointed by the Montgomery County Council), April 2002.  
([http://www.healthymontgomery.org/javascript/htmleditor/uploads/blue\\_ribbon\\_task\\_force\\_on\\_mh\\_2002.pdf](http://www.healthymontgomery.org/javascript/htmleditor/uploads/blue_ribbon_task_force_on_mh_2002.pdf))
- *Public Mental Health Services for Children and Adolescents in Montgomery County*, League of Women Voters of Montgomery County, Inc., Fact Sheet, April 2010.  
(<http://www.lwvmd.org/mont/FS2010-04MentalHealth.pdf>)
- *Enhancing the Delivery of Health Care: Eliminating Health Disparities through a Culturally & Linguistically Centered Integrated Health Care Approach: Consensus Statements and Recommendations*, Hogg Foundation for Mental Health, June 2012.  
(<http://hogg.utexas.edu/uploads/documents/FinalReport%20-ConsensusStatementsRecommendations.pdf>)
- *A Strategic Plan for Public Mental Health Services*, Montgomery County Department of Health and Human Services, July 2002.  
([http://www6.montgomerycountymd.gov/content/hhs/reports/Mental%20HealthSP\\_%20Aug02.pdf](http://www6.montgomerycountymd.gov/content/hhs/reports/Mental%20HealthSP_%20Aug02.pdf))
- *Progress on Building Brighter Futures*, 2009 Annual Report, Montgomery County Collaboration Council for Children, Youth and Families, Inc.  
<http://collaborationcouncil.org/publications/annualreport09.pdf>)

Also, throughout the process of conducting the environmental scan, the BHWG members developed a glossary of terms to provide guidance and consistency in their action planning.<sup>3</sup>

## **Actions Underway, Policies, Regulations and Laws that Affect Behavioral Health in Montgomery County**

There are a number of factors that can influence action planning within a community. Understanding the environment within which community health improvement will occur requires a local-level understanding of policies, regulations, laws, and existing best practices with proven impact. In conducting an environmental scan, the BHWG identified factors at the federal, state and local levels that influence the local health issue areas identified by the group for strategy development and implementation planning.

### ***Federal and State Level Environment***

#### ***Health Care Reform (Affordable Care Act)***

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<sup>3</sup> Healthy Montgomery Glossary available at:

[http://www.healthymontgomery.org/javascript/htmleditor/uploads/Healthy\\_Montgomery\\_Term\\_Glossary\\_8\\_3\\_2012.pdf](http://www.healthymontgomery.org/javascript/htmleditor/uploads/Healthy_Montgomery_Term_Glossary_8_3_2012.pdf)



Federal and state changes required by the Affordable Care Act (ACA) include increased access to health insurance as well as mandates that insurance cover behavioral health issues. These changes are scheduled to take effect January, 2014 and are predicted to reduce the number of uninsured in the County by 50% and begin to increase access to behavioral health. Additionally, the ACA includes measures that require integration of services and quality measures related to behavioral health. Despite increased access there will still be a population of uninsurable in Montgomery County as well as a predicted population that will 'churn' in and out of coverage or different types of coverage. This will lead to new issues for the health and behavioral health care systems in terms of providing continuity of care for this population. Another likely issue will be the capacity of the current behavioral health care system and its ability to provide care to a much larger consumer population in a short period of time.

#### *MD Department of Health and Mental Hygiene Restructuring Services*

The Maryland Department of Health and Mental Hygiene (DHMH) recently finished a major report in 2013 with recommendations on the financing and structure of the integration of mental health, substance abuse, and primary care services for Medicaid and Medicare consumers. The impact of these changes on state and local services and on access to services is not yet known, but it could change financing and delivery models significantly.

#### *Hospital Waivers/Reforms*

Maryland hospitals are adopting measures to prevent readmissions in order to avoid penalties. These measures may affect consumers receiving behavioral health services in hospitals. In addition, there may be opportunities for increased collaboration between hospitals and community based organizations providing case management and other types of services that could decrease readmissions.

#### *Health Homes*

Among the efforts to improve health outcomes is the development of Health Homes. Maryland is in the process of creating health homes for people with behavioral health problems centered on two types of services, psychiatric rehabilitation and methadone maintenance. In each case, providers will receive a PMPM (per member per month) stipend to broaden the scope of services so as to become fully engaged in all aspects of the health of the people engaged in services. Rehabilitation specialists become Care Managers or Care Coordinators in this model and provide assistance beyond the limited construct of a single service. Ultimately, this will be evaluated by looking at the health outcomes of consumers and by measuring cost-effectiveness and improved utilization of health system resources. The Health Home concept requires that providers improve the level of cooperation throughout the system to achieve a common goal.

#### *U.S. Climate Related to Behavioral Health*

In light of recent national events including debates concerning the continuance of the ACA and high-profile violence by mentally ill citizens, behavioral health systems may be under additional scrutiny, which may lead to opportunities for service expansions or system-wide changes.

### ***County Level Environment***

*Diverse Socio-Economic Environment.* Montgomery County is increasingly economically and demographically diverse. It is the most populous County in the state, with an estimated 1,004,709 residents in 2012. An estimated 47.8% of the population is non-Hispanic White, 18.3% are African American/Black; 17.9% are Hispanic/Latino; and 14.7% residents are Asian. In 2010, for the first time, non-Hispanic White residents constituted less than half of the County's residents. In addition, by 2010 foreign-born residents represented almost one-third (31.4%) of the population (in 1990, less than one in five residents were foreign-born). From 2007-2011, an estimated 38.1% spoke a language other than

English at home. Between 2007 and 2010, the number of residents living below the federal poverty level grew by two-thirds. From 2007-2011, an estimated 6.3% of the population (over 63,000 residents) was living below the poverty level. In 2012, over 118,000 residents did not have public or private health insurance (a 10%- increase from 2009) and over 8,000 or 7.0% were children under 18 years. Residents with public health insurance totaled more than 116,000 – more than 54,000 of these residents were under 18 years of age, more than 31,000 residents were 18-64 years of age, and another 31,000 residents were 65 and older.<sup>4</sup>

#### *Confusing System of Behavioral Health, Primary Care and Social Services*

A wealth of County and private non-profit agencies provide behavioral health services and advocacy services to consumers, including the uninsured or publicly insured, but there is lack of shared knowledge about services, access, and information.

#### *Hospital "Diversion "and Discharge Efforts and Conversations*

Various efforts of community hospitals, outpatient providers and the DHHS provide more appropriate behavioral health services at key points of emergency department visits and at discharge from inpatient psychiatric services.

#### *Community and DHHS Jail Diversion Pilot (related to longstanding Criminal Justice Behavioral Health workgroup)*

DHHS is trying to identify incarcerated individuals pre-trial or for brief sentences who are mentally ill and could benefit from community services.

#### *Integration of Behavioral Health into Primary Care Settings*

Twelve private, non-profit primary care clinics provide care to uninsured adults. Several also accept Medicaid. Seven of these clinics now have some form of integrated behavioral health services. Montgomery Cares reimburses for behavioral health visits provided at the Montgomery Cares clinics by specific clinicians. Some clinics are pursuing certification as a Patient Centered Medical Home, and most will become Medicaid providers. Finally, the County is implementing a new pilot project. In two of the clinics, Montgomery County Department of Health and Human Services psychiatrists will provide psychiatric consultation, support, and education to the clinics' primary care providers.

#### *Integration of Primary Care Services into Behavioral Health Settings*

The Family Service, Inc./Community Clinic, Inc./Cornerstone, Inc.(formally Threshold Services, Inc.) Substance Abuse and Mental Health Services (SAMHSA) Health Integration Project (HIP) is a local example of a major step forward in integrating primary care services into behavioral health settings. It brings medical clinics into a behavioral health setting to provide increased access to primary care services and coordination of services for a population experiencing serious mental illness and/or substance abuse.

#### *Multiple Integrated and Non-Integrated County Efforts that Convene Groups Related to Behavioral Health*

- Healthy Montgomery Behavioral Health Action Planning Work Group
- Montgomery County Mental Health Advisory Board

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<sup>2</sup> Confronting Suburban Poverty in America, Montgomery County: A Collaborative Model for Meeting Changing Needs. Accessed on October 31, 2013 at: [http://confrontingsuburbanpoverty.org/wp-content/uploads/2013/05/Brookings\\_ToolKit\\_CaseStudies\\_MoCo.pdf](http://confrontingsuburbanpoverty.org/wp-content/uploads/2013/05/Brookings_ToolKit_CaseStudies_MoCo.pdf); U.S. Census Bureau: State and County QuickFacts. Accessed on September 3, 2013 at <http://quickfacts.census.gov/qfd/states/24/24031.html>; Source: U.S. Census Bureau, 2009-2011 American Community Survey. Accessed on September 3, 2013 at [http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS\\_11\\_3YR\\_DP03&prodType=table](http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_11_3YR_DP03&prodType=table);

- Alcohol and Other Drug Abuse Advisory Council (AODAAC)
- Collaborative Meeting and Interagency Committee on Aging (quarterly meetings to share information across agencies)
- Mental Health and Substance Abuse Provider Councils convened by the Mental Health Core Services Agency
- Montgomery Cares Behavioral Health-Primary Care Workgroup, led by the Primary Care Coalition
- Maryland Addictions Directors Council (MADC). Several organizations have applied for the MADC Integration Learning Collaborative. If selected for the project, this will be another group that will meet to address issues related to behavioral health and service integration

*Shortage of Behavioral Health Professionals and Bi-Lingual Behavioral Health Professionals*

A shortage in Montgomery County of psychiatrists and other medication prescribers limits the capacity of outpatient services to individuals with Medicaid and/or Medicare and also those in need of child and adolescent specialists. There is also a shortage of licensed mental health professionals with certain language skills and/or bi-cultural skills.

*Health Information Technology (HIT) for Behavioral Health in Montgomery County:*

Behavioral health organizations lag behind medical settings in use and access to electronic health records (EHRs) and other technology to assist with improving care. DHHS has selected and is adopting an EHR system for its directly operated services, as are Montgomery Cares clinics and most other local providers. Chesapeake Regional Information System of Partners (CRISP) – the Maryland Health Information Exchange (HIE) anticipates bringing specialties like behavioral health providers into CRISP once it completes building functionality for its primary use phase (primary care providers and consumers).

**Gaps Identified Through the Action Planning Process**

To further characterize the action planning environment, the work group identified gaps during the environmental scan that represent challenges in the action planning process. These gaps, however, also serve as opportunities for improvement in behavioral health outcomes.

**Shortage of behavioral health specialists and bi-lingual behavioral health service providers.**

Psychiatry in particular is limited by the number of individuals willing to work in the public mental health system. The shortage of child and adolescent specialists is especially acute. In addition to prescribers, licensed clinical social workers and counselors who are bi-lingual, most notably in English and Spanish, are in short supply. Growing numbers of other language minorities such as Vietnamese and Korean further illustrate the difficulty of staffing for a diverse community.

**Cultural barriers.** Closely related to the issue of language capability is the need to address cultural barriers. Many cultures have strong resistance to seeking behavioral health care. At the same time, the behavioral health system requires diagnosis of medical need for providers to obtain payment for services, producing a conflicting need for a label that may result in consumers declining to engage in services. Services may also need to occur in more non-traditional settings. The ultimate complication is that many of the immigrants in the County are undocumented and there is little or no funding to support services for them other than those provided by Montgomery County or non-profit organizations.

**Integrated services are limited.** Only recently have behavioral health and primary care providers initiated partnerships to provide integrated care. People suffering from mental illness often get little primary care. Many report having no primary care provider or not having seen one in a period of years. Also, while discussions about the high frequency of dual diagnosis for mental illness and substance abuse

have continued for many years, the level of integration of services remains very limited. This has multiple consequences. Patients do not thrive, with mentally ill adults dying more than 20 years earlier than others. Also, those who drop out of care or who fail to receive regular primary care services often end up in emergency departments and acute care settings that are costly to the system as a whole.

**Inadequate data collection.** The lack of integration and the absence of financing for coordination of care contribute to a fragmented system for providers and one that is difficult for consumers to access. Not surprisingly, this contributes to an overall lack of strong data collection that brings together, mental health, substance abuse, primary care, and hospital use.

**Financing inadequacies.** Reimbursement rates from third party insurers are often woefully inadequate, Medicare co-payment requirements at times have exceeded the capacity of individual consumers, and the failure to factor into the public health mental health system no-show rates among a challenged population affect access, coordination, and sustainability.

### **Other Limitations on Action Planning Efforts (reach of work group, resources, barriers to success, and forces of change)**

Another recognized challenge for action planning is that consumers of behavioral health services need a variety of resources and levels of care available to meet their needs at the type, duration, and intensity required. In addition, the dynamic nature of the behavioral health field provides a continuing challenge. Important current examples of rapid change include the effects of the Affordable Care Act and the impact of the recommendations found in the National Association of Psychiatric Health Systems white paper commissioned by the White House entitled, “Responding to the Newton Tragedy: A White Paper on Behavioral Health as a Partner in the Solution.” Further exploration of recommendations in the white paper is needed.

Also, in exploring the related concerns of some individuals with behavioral health issues, the BHWG sees a need to more extensively engage representatives of law enforcement, public safety and the corrections systems, in order to better define the needs/assets of these additional entities

Until the Healthy Montgomery Steering Committee (HMSC) reviews, revises and approves the recommendations of this report and authorities created, the BHWG remains keenly aware of the lack of authority and resources to implement the Action Plan. Implementation will need the leadership of the HMSC and the commitment of many partners. Additionally, there remain many policy/legal issues and barriers related to access to behavioral health services. These policies and legal issues (e.g., Health Insurance Portability and Accountability Act (HIPAA), Family Educational Rights and Privacy Act (FERPA), the Affordable Care Act, the Maryland Health Benefit Exchange Act and the Maryland Connector Program, and federal and state immigration policies) will have to be further explored and addressed as part of implementing the Action Plan’s strategies.

As stated earlier in this section, the implementation of the Affordable Care Act introduces a plethora of unknowns about the effect on the delivery of direct behavioral health services and the systems delivering those services. Included are the effects of moving 50% of the uninsured into various insurance systems. Among the questions that arise are:

- What percentages will be moved from Montgomery County agencies providing care to indigent and Medicaid/Medicare consumers? What percentages will remain within the current community of providers of indigent care but create new reimbursement opportunities/challenges?
- How will the characteristics of the remaining uninsurable change and how will the patterns of the population that “churns” in and out of health insurance coverage be affected?

- The impact of electronic medical record requirements will be substantial. Will the cost of compliance be wholly or partially reimbursable?

The next Section of this Action Plan describes the Local Health Issue Areas (LHIAs) chosen by the BHWG as priority areas of focus within the context of the complexity of the federal, state and local climate described above, the impending changes to the health insurance and behavioral health delivery systems, and the restrictive charge of the Healthy Montgomery Steering Committee to develop strategies that can be accomplished using existing financial and other resources. The LHIAs, by necessity, represent a systems approach that focuses on the needs of those with the most serious behavioral health problems but which will also result in improved outcomes for other individuals who may have specific needs. Different priority areas may have been chosen if additional funding sources were available to enhance behavioral health in County.

## Section 4: Local Health Issue Area Development

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## Local Health Issue Area Development

### Summary

The Behavioral Health Action Planning Work Group (BHWG) focused on identifying specific issues for which local strategies could be developed. The work involved exploring ways to support existing efforts, assets and collaborations, create efficiencies, and identify opportunities to better serve Montgomery County residents with existing or emerging behavioral health conditions.

The BHWG agreed that the focus of the planning efforts would include:

- Moving to address mental health and substance use problems in an integrated way;
- Considering both prevention and treatment approaches focusing on opportunities to better serve individuals with behavioral health problems, given limited resources;
- Understanding that behavioral health is integrally interrelated with other health and quality of life issues, including housing and employment;
- Assuring efforts address issues related to access to care, health inequities, and unhealthy behaviors.

The group identified three local health issue areas (LHIAs) that aligned with their focus. Goals, objectives, and strategies were articulated for each LHIA to develop action plans which can meaningfully impact behavioral health outcomes for individuals and the community as a whole. The workshop identified three actionable strategies. Below is a summary of the issue areas and recommended strategies.

Addressing the immediately actionable strategies will require the creation of three task forces under the leadership of the Healthy Montgomery Steering Committee (serving as the Advisory Board). The task forces will grapple with a number of important policy and fiscal issues that cut across public/private, institution/community provider sectors and among competing entities. Chartering and populating these task forces with the right leadership and representatives will require the leadership of the Healthy Montgomery Steering Committee (HMSC). Therefore, the BHWG is recommending that the Healthy Montgomery Steering Committee clarify how it wants to charter, convene, and provide administrative support to the task forces created to implement the Plan.

### Recommendations

The group identified three local health issue areas that aligned with their focus and best positioned the behavioral health provider community for action in Montgomery County:

- **LHIA 1.** There is a need for consumers, families, referral agencies, and behavioral health providers to have ready access to basic information about treatment protocols, the full range of available services, payment mechanisms, and how to access services.

- **LHIA 2.** There is a need to develop improved mechanisms for providers to communicate among themselves regarding shared consumers and to create effective linkages for consumers (warm hand-offs) as they move between providers or levels of care.
- **LHIA 3.** There is a need to explore the creation of a coordinated system of care or other formal partnership-based business agreement to meet the needs of individuals with more serious behavioral health conditions.

In order to address these issue areas the following strategies were proposed and developed for implementation in Montgomery County with a goal to achieve a positive impact within 3-5 years.

The Healthy Montgomery Behavioral Health Action Planning Work Group has devised the following strategies to:



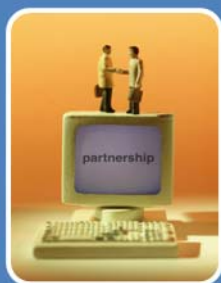
Create a Web-based basic information, communications, and linkage system through which consumers/clients, their families, providers and other social service agency or referral source personnel can easily gain clear, basic information about treatment options, the full range of available services (including payment mechanisms), and how to access services.

Long-term strategies for this effort include the additional media compilation of both paper products and telephone accessible mechanisms to convey the contents of this enhanced resource guide being compiled via infoMontgomery.



Establish protocols to facilitate safe and appropriate transfer of clients from institutional settings (hospitals, emergency rooms, correctional facilities) to community behavioral health organizations.

Long-range strategies include establishing adequate mechanisms for providers to communicate among themselves regarding shared clients and establishing client linkages to enable informed client intakes, coordinated care, and adequately supported discharges. The result will be a system that is conducive to navigating between providers effectively, further contributing to coordinated care and preventing clients being lost to follow-up

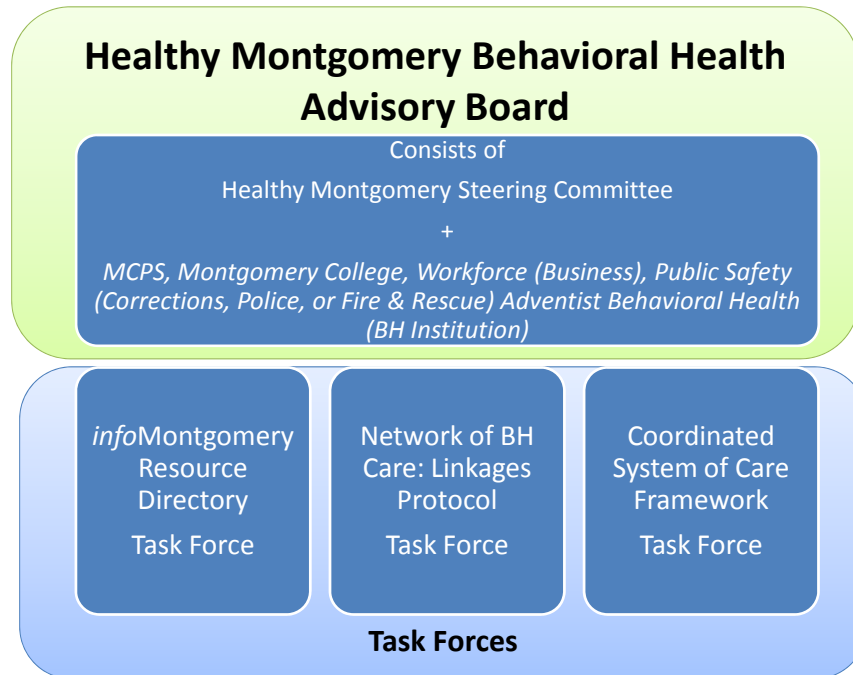


Establish an advisory body to formulate a framework to establish a Behavioral Health Accountable Care System(s) or other formal partnership-based business model to meet the needs of individuals with more serious behavioral health conditions living in Montgomery County.

This strategy will be initiated upon substantial progress and/or completion of the interagency communications and client linkage systems mentioned above.



To manage the ongoing work identified by the BHWG, the following structure is proposed:



To ensure implementation of these actionable strategies, the BHWG is proposing that an advisory board oversee development and management of three task forces that will plan and execute the implementation of the strategies. Existing BHWG members would provide leadership and continuity in the implementation of the strategies by being placed on the advisory board and/or on one or more of the task forces. The Healthy Montgomery Steering Committee will serve as the Advisory Board and, as such, may require some additional affiliations determined to be critical to implementation of the Plan (including representatives of Montgomery County Public Schools, Montgomery College, public safety (police, sheriff, fire rescue, and corrections) and representatives of the workforce and housing fields). Consistent with the existing HMSC membership, representatives from additional affiliations should be in positions that can affect change.

Task force membership would include a sub group of members from the BHWG, along with additional content experts and organizations that expand beyond the membership of the current BHWG. Regarding administrative support, the BHWG recommends that the HMSC work with the task force leadership and task force member organizations to create this support.

The summary table below outlines the three local health issue areas identified for action planning in Montgomery County. The existing County assets and resources that support this effort are provided. Also provided are the short- and long-term outcomes anticipated to result from the implementation of these strategies. Following the table, each local health issue area is discussed in more detail and includes goals, objectives, and plans for action for each strategy.

Local Health Issue Areas Identified for Improvement  
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Strategy	Resources/Assets	Short-Term Outcomes	Long-Term Outcomes
<b>LHIA 1.</b> There is a need for consumers, families, referral agencies, and behavioral health providers to have ready access to basic information about treatment protocols, the full range of available services, payment mechanisms, and how to access services.			
<i>1. Create a Web-based basic information, communications, and linkage system through which consumers, their families, providers and other social service agency or referral source personnel can easily gain clear, basic information about treatment options, the full range of available services payment mechanisms, and how to access services (on infoMontgomery, a collaborative effort of public and private agencies providing information about health, education, and human service resources).</i>	Extensive availability of public, non-profit and private behavioral health services <i>infoMontgomery</i> is operational. <i>infoMontgomery</i> Steering Committee is a broadly representative group of government and non-profit organizations. <i>infoMontgomery</i> is managed by staff at the Montgomery County Collaboration Council for Children, Youth and Families, a member of the HMSC.	Healthy Montgomery Behavioral Health <i>infoMontgomery</i> Task Force is convened under the Collaboration Council auspices; it finalizes policies on scope, content, maintenance and support of the database; identifies resources needed for project. Within 15 months of action plan adoption, the Collaboration Council submits funding proposals and then completes content of database. Within 5 months of data collection and input, the database is launched.	Medicaid and Medicare eligible populations and the uninsured needing behavioral health services, social service and referral agencies readily utilize the behavioral health database to find and easily enroll in care services appropriate to the individual.
<i>2. Create hard copy documents about how to access behavioral health resources in Montgomery County as well as a supply and distribution system for the materials for use by consumers, their families, providers and other social service agency or referral source personnel in environments which do not have access to the Internet.</i>	STRATEGY #1 must be completed first. The database and the knowledge of end user search options requirements established during the development of the database are the basis for properly designing the document-based system. The BHWG did not have resources to research best practices and models for a telephone-based system, including maintaining the accuracy of the information in conjunction with the <i>infoMontgomery</i> database.	<b>Barriers and challenges:</b> Leadership, funding and/or appropriate action steps cannot yet be fully developed. (See Resources/Assets)	This is a long-term strategy which must follow the creation of the <i>infoMontgomery</i> behavioral health database.

Local Health Issue Areas Identified for Improvement  
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Strategy	Resources/Assets	Short-Term Outcomes	Long-Term Outcomes
3. <i>Identify a telephone mechanism through which consumers, their families, providers and other social service agency or referral source personnel can easily gain clear, basic information about treatment options, the full range of available services payment mechanisms, and how to access service for use by consumers, their families, providers and other social service agency or referral source personnel (in environments which do not have access to the Internet).</i>	STRATEGY #1 must be completed first. The database and the knowledge of end user search options are the basis for properly designing the telephone-based system. The BHWG did not have resources to research best practices and models for a telephone-based system, including maintaining the accuracy of the information in conjunction with the <i>info</i> Montgomery database.	<b>Barriers and challenges:</b> Leadership, funding and/or appropriate action steps cannot yet be fully developed. (See Resources/Assets)	This is a long-term strategy which must follow the creation of the <i>info</i> Montgomery behavioral health database.

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Strategy	Resources/Assets	Short-Term Outcomes	Long-Term Outcomes
<b>LHIA 2.</b> There is a need to develop improved mechanisms for providers to communicate among themselves regarding shared consumers and to create effective linkages for consumers (warm hand-offs) as they move between providers or levels of care.			
<i>1. Establish protocols to facilitate safe and appropriate transfer of clients from institutional settings (hospitals, emergency rooms, correctional facilities) to community behavioral health organizations.</i>	This strategy can build on multiple existing efforts by various hospital and community level behavioral health providers collaborating on developing coordinated referrals. Extensive availability of quality public, non-profit and private behavioral health services.	The protocols are adopted and used by the discharging institutional settings (hospitals, emergency rooms, correctional facilities) and the behavioral health providers initiating community level care for the discharged patients.	All Montgomery County behavioral health care institutions and community providers agree on a common policy for transfer/release of patients to the community and adopt and utilize a common transfer protocol.
<i>2. Establish adequate mechanisms for providers communicating among themselves regarding shared consumers and consumer linkages to enable informed client intakes, coordinated care, and adequately supported discharges; establish a system that is conducive to navigating between providers effectively, further contributing to coordinated care and preventing clients being lost to follow-up.</i>	Completed strategy #1 as this (Strategy 2) will build on the protocols and automated system linkages for transferring clients from institutional settings to community behavioral health organizations. This strategy needs further thought in aligning it with the next LHIA (LHIA 3 - Explore the creation of a coordinated system of care) A Task Force with former BHWG members and other experts can work on the further development of this strategy.	<b>Barriers and challenges:</b> Insufficient membership of somatic care providers Further thought needed on this strategy's alignment with the next issue area (LHIA 3.) The BHWG did not have resources to research best practices/models to address a major component (shared electronic interface providing specific consumer information in real time).	TBD

Strategy	Resources/Assets	Short-Term Outcomes	Long-Term Outcomes
<b>LHIA 3.</b> There is a need to explore the creation of a coordinated system of care or other formal partnership-based business agreement to meet the needs of individuals with more serious behavioral health conditions.			
1. <i>Establish a process to explore the creation of a coordinated system of care or other formal partnership-based business agreement to meet the needs of individuals with more serious behavioral health conditions living in Montgomery County.</i>	The national movement toward formal integrated systems, including coordinated systems of care; The Affordable Care Act requires the integration of behavioral health services into the insured health care system. Multiple existing local collaborative efforts among behavioral healthcare providers and hospital/somatic care providers in Montgomery County collaborating on integrating care. Extensive availability of quality public, non-profit and private behavioral health services.	Grant applications are developed by either the HMSC (Advisory Board) or the Coordinated System of Care Task Force to secure funding to implement the Action Plan. The funding application includes funding for a leadership consultant.	Sufficient providers in all categories of care (somatic, mental health, substance abuse) and settings (hospital, emergency departments, somatic, behavioral health and corrections clinics) participate in a partnership based coordinated system of care or similarly organized entity to meet the needs of the target population.

## **Local Health Issue Area Development**

### **Background and Detail**

The initial efforts of the Behavioral Health Action Planning Work Group (BHWG) were to identify and prioritize specific issues within the behavioral health priority area for which local strategies could be developed. To accomplish this, the BHWG considered the results from the 2011 Healthy Montgomery Needs Assessment, the 2012 Behavioral Health Data Profile, and the results of its “Inventory of Community-Based Interventions at the Individual Level, Systems Level, or Environmental Level.” Additional time and consideration were placed on leveraging past successes, building on previous strategic planning efforts, and identifying best practices and strategies that were within the scope and reach of Healthy Montgomery.

While “behavioral health” was determined to be a broad term that encompassed a myriad of health conditions as well as a wide range of programs and services, the BHWG decided to retain the broad focus. The group agreed that the focus of the planning efforts would include:

- Supporting movement towards current prevailing theory and “best practice” measures of addressing both mental health and substance use problems in an integrated way;
- Considering both prevention and treatment approaches focusing on opportunities to better serve individuals with behavioral health problems, given limited resources;
- Understanding that behavioral health is integrally interrelated with other health and quality of life issues, including housing and employment;
- Assuring efforts address issues related to access to care, health inequities, and unhealthy behaviors.

The group identified three local health issue areas (LHIAs) that aligned with their focus:

1. There is a need for consumers, families, referral agencies, and behavioral health providers to have ready access to basic information about treatment protocols, the full range of available services, payment mechanisms, and how to access services;
2. Providers have inadequate mechanisms for communicating among themselves regarding shared consumers and consumer linkages (warm hand-offs);
3. Within the context of the national movement toward formal integrated systems, including coordinated systems of care, there is strong interest in Montgomery County to develop a process to explore the creation of a coordinated system of care or other formal partnership-based business agreement to meet the needs of individuals with more serious behavioral health conditions.

Goals, objectives, and strategies were articulated for each local health issue area to develop action plans that upon implementation will achieve meaningful impact on behavioral health outcomes.

## BEHAVIORAL HEALTH ACTION PLANS

**LHIA 1. There is a need for consumers, families, referral agencies, and behavioral health providers to have ready access to basic information about treatment protocols, the full range of available services, payment mechanisms, and how to access services.**

While Montgomery County can be proud of the overall availability and quality of public and private behavioral health services, basic information, communications, and linkage systems are lacking, particularly for individuals that are uninsured or have Medicaid or Medicare. Providers report that consumers, their families, providers and other social service agency or referral source personnel cannot easily gain clear, basic information about treatment options, the full range of available services, payment mechanisms, and how to access services.

**Goal #1:** *info*Montgomery will host an easily understandable and accessible centralized Internet database of basic information about behavioral health services available in the County that can be sorted by payor, provider, location, specialty, languages spoken, and target population. The primary target audience is people who have Medicare and/or Medicaid or are uninsured, but does not exclude other individuals.

- Objective I.:** Within six months of action plan adoption, the Healthy Montgomery Steering Committee (Advisory Board) with the Behavioral Health and Crisis Services Access (Montgomery County Department of Health and Human Services) and the Montgomery County Collaboration Council for Children, Youth and Families (Collaboration Council) will convene a Behavioral Health Information Task Force (BHITF) of behavioral health and social services providers and consumers to advise the Collaboration Council staff on the development of more detailed search functions in the *info*Montgomery behavioral health database.
- Objective II.:** Within one year of action plan adoption, the BHITF, working with Collaboration Council staff, will finalize and approve the policies on the scope of the database, the content of the database, and the requirements for maintenance and support of the database, taking into consideration changes in the Maryland Medical Assistance financing of services.
- Objective III.:** Within 15 months of action plan adoption, the BHITF and Collaboration Council will identify the resources needed for programming, data collection and input, identify potential funding sources to revise *info*Montgomery, and submit a proposal for funding.
- Objective IV.:** Within 6 months of securing funding, identified staff will complete collection and programming the content of the database and the query functions.
- Objective V.:** Within 5 months of the completion of data collection and input, the Collaboration Council and Healthy Montgomery will launch the behavioral health database.

**Objective VI.:** Within 3 months of the launch of the *info*Montgomery behavioral health database, the Collaboration Council and BHITF will finish training health and social services professional users on how to best use the system for their referral needs and to facilitate consumers' use of the data base to customize their search for behavioral health services.

**Goal #2:** The BHITF will create hard copy documents about how to access behavioral health resources in Montgomery County and a supply and distribution system for the materials so that consumers, their families, providers and other social service agency or referral source personnel can easily gain clear, basic information about treatment options, the full range of available services (including payment mechanisms), and how to access service.

**Goal #3:** The BHITF will implement a telephone-based system for consumers, their families, providers and other social service agency or referral source personnel to easily gain clear, basic information about treatment options, the full range of available services, payment mechanisms, and how to access service.



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**Strategy #1: Create a Web-based basic information, communications, and linkage system through which consumers, their families, providers and other social service agency or referral source personnel can easily gain clear, basic information about treatment options, the full range of available services, payment mechanisms, and how to access services.**

**Funding Status:** Funding required.

**Specify Estimated Amount of Funding Needed:** The HMSC (Advisory Board) will determine the estimated cost involved in carrying out the work of the task force including the time and effort of task force members and needed administrative support. Task force members will determine the estimated cost of the implementation of the Plan's strategies and identify potential sources of funding.

**Specify Anticipated Sources of Funding:** To be determined

ACTION STEPS	COMMUNITY PARTNERS' Roles and Responsibilities	ADDRESSING ACCESS TO CARE, HEALTH INEQUITIES AND UNHEALTHY BEHAVIORS	PLAN HOW YOU WILL EVALUATE EFFECTIVENESS
1. Confirm that the Collaboration Council, Behavioral Health and Crisis Services Access (BHCS Access) and the National Alliance on Mental Illness (NAMI) are willing to lead this effort, including supporting the <i>BHITF</i> .	<p><b>Lead agency:</b> HMSC(Advisory Board)</p> <p><b>List other agencies and what they plan to do:</b> N/A</p> <p><b>Include how you're marketing the intervention/strategy:</b> N/A</p>	<p><b>Specify how you will address access to care issue through this action step, if applicable:</b> N/A</p> <p><b>Specify how you will address inequities through this action step, if applicable:</b> N/A</p> <p><b>Specify how you will address unhealthy behaviors through this action step, if applicable:</b> N/A</p>	<p><b>Quantify what you will do:</b> N/A</p> <p><b>Expected outcomes:</b> Written Memorandum of Understanding among the three agencies.</p>
2. Identify and contact individuals from behavioral and social services organizations and consumers to participate in the <i>BHITF</i> and convene.	<p><b>Lead agency:</b> Collaboration Council/BHCS Access</p> <p><b>List other agencies and what they plan to do:</b> HMSC (Advisory Board) assists with gaining commitments to populate the Task Force.</p> <p><b>Include how you're marketing the intervention/strategy:</b> N/A</p>	<p><b>Specify how you will address access to care issue through this action step, if applicable:</b> N/A</p> <p><b>Specify how you will address inequities through this action step, if applicable:</b> N/A</p> <p><b>Specify how you will address unhealthy behaviors through this action step, if applicable:</b> N/A</p>	<p><b>Quantify what you will do:</b> Contact 15-20 individuals to invite them to participate in the Task Force.</p> <p><b>Expected outcomes:</b> Task Force of approximately 10 individuals from diverse backgrounds and organizations.</p>

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ACTION STEPS	COMMUNITY PARTNERS' Roles and Responsibilities	ADDRESSING ACCESS TO CARE, HEALTH INEQUITIES AND UNHEALTHY BEHAVIORS	PLAN HOW YOU WILL EVALUATE EFFECTIVENESS
<p>3.</p> <p>a. Lead agency staff prepares draft policies on the scope of database, content of database and maintenance and support of the database.</p> <p>b. <i>BHITF</i> reviews and approves policies (may require several revisions.)</p>	<p><b>Lead agency:</b> Collaboration Council/BHCS Access</p> <p><b>List other agencies and what they plan to do:</b> <i>BHITF</i> prepares and reviews policies, provides feedback, and approves final policies.</p> <p><b>Include how you're marketing the intervention/strategy:</b> N/A</p>	<p><b>Specify how you will address access to care issue through this action step, if applicable:</b> N/A</p> <p><b>Specify how you will address inequities through this action step, if applicable:</b> N/A</p> <p><b>Specify how you will address unhealthy behaviors through this action step, if applicable:</b> N/A</p>	<p><b>Quantify what you will do:</b> N/A</p> <p><b>Expected outcomes:</b> Documented policies on the scope of the database, content of database, and maintenance and support of the database.</p>
<p>4.</p> <p>a. Determine the resources needed to revise <i>infoMontgomery</i>.</p> <p>b. Identify sources of funding to include the behavioral health database in <i>infoMontgomery</i>.</p> <p>c. Submit a proposal for funding.</p>	<p><b>Lead agency:</b> 4.a: Collaboration Council 4.b: <i>BHITF</i></p> <p><b>List other agencies and what they plan to do:</b> DHHS Grants Office (recommends funding sources) HMSC/(Advisory Board) (recommends funding sources)</p> <p><b>Include how you're marketing the intervention/strategy:</b> N/A</p>	<p><b>Specify how you will address inequities through this action step, if applicable:</b> N/A</p> <p><b>Specify how you will address unhealthy behaviors through this action step, if applicable:</b> N/A</p>	<p><b>Quantify what you will do:</b> N/A</p> <p><b>Expected outcomes:</b></p> <p>4. a. and b: Budget to modify and maintain <i>infoMontgomery</i> and possible funding sources.</p> <p>4. c: Grant proposal. Desired outcome: grant award.</p>

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ACTION STEPS	COMMUNITY PARTNERS' Roles and Responsibilities	ADDRESSING ACCESS TO CARE, HEALTH INEQUITIES AND UNHEALTHY BEHAVIORS	PLAN HOW YOU WILL EVALUATE EFFECTIVENESS
<p>5.</p> <p>a. Identify staff support from HHS BHCS Access and NAMI to collect information about behavioral health services.</p> <p>b. Conduct an orientation session for staff explaining the type of information needed, and the guidelines for searching viable and reliable information sources to build the content of the database.</p> <p>c. Staff collect data</p> <p>d. Develop and implement pre-implementation survey among participating organizations; collect and analyze survey results.</p>	<p><b>Lead agency:</b> HHS BHCS Access and NAMI</p> <p><b>List other agencies and what they plan to do:</b> N/A</p> <p><b>Include how you're marketing the intervention/strategy:</b> N/A</p>	<p><b>Specify how you will address access to care issue through this action step, if applicable:</b> N/A</p> <p><b>Specify how you will address inequities through this action step, if applicable:</b> N/A</p> <p><b>Specify how you will address unhealthy behaviors through this action step, if applicable:</b> N/A</p>	<p><b>Quantify what you will do:</b> 1-3 potential staff to be assigned to collect information.</p> <p>Pre-implementation survey is developed and implemented; survey data are collected and analyzed.</p> <p><b>Expected outcomes:</b> A confirmed number of staff are able to collect valid and reliable information for the content of the database.</p> <p>Survey data describes baseline ability of participating organizations to gain treatment, service, payment mechanism information and information on access to services.</p>
<p>6. <b>This and subsequent steps are dependent on receiving funding for the programming.</b></p> <p>a. Collaboration Council staff program <i>infoMontgomery</i> behavioral health database.</p> <p>b. <i>BHITF</i> members review and approve content.</p> <p>c. Identified staff inputs information into <i>infoMontgomery</i>.</p> <p>d. <i>BHITF</i> members test the <i>infoMontgomery</i> behavioral health database with staff and clients in their organizations. <i>infoMontgomery</i> staff make changes as necessary.</p> <p>e. Healthy Montgomery and the Collaboration Council launch the <i>infoMontgomery</i> behavioral health database.</p> <p>f. Post-implementation survey is developed and implemented; survey data are collected, analyzed, compared to pre-implementation data and results are shared with the HMSC.</p>	<p><b>Lead agency:</b> Collaboration Council and <i>BHITF</i></p> <p><b>List other agencies and what they plan to do:</b> N/A</p> <p><b>Include how you're marketing the intervention/strategy:</b></p> <p>a. The content of the database will be published on the <i>infoMontgomery</i> website and a link will be added to the Healthy Montgomery website.</p> <p>b. There will be a public launch of the <i>infoMontgomery</i> behavioral health database.</p> <p>c. There will be training for staff of health, behavioral health, social service agencies and other organizations/individuals, such as clergy and school counselors, who refer individuals for behavioral health services.</p>	<p><b>Specify how you will address access to care issue through this action step, if applicable:</b> Having this information available and providing the ability to sort through it, based on the individual's needs, will support access.</p> <p><b>Specify how you will address inequities through this action step, if applicable:</b> Having this information available and providing the ability to sort through it based on the individual's needs will support equitable access</p> <p><b>Specify how you will address unhealthy behaviors through this action step, if applicable:</b> N/A</p>	<p><b>Quantify what you will do:</b> 1 to 3 potential staff are assigned to collect information.</p> <p><b>Expected outcomes:</b> Staff identified to input data (from lead agency, task force member agencies or as funded by grant); database and query functions finalized; database launched</p> <p>Brief report to the HMSC that compares pre- and post- implementation survey results and describes any improvement in ability of participating organizations to gain treatment, service, payment mechanism information and information concerning access to services as well as any needed changes needed to improve the utility of the <i>infoMontgomery</i> database.</p>

## Long-Term Action Planning Considerations for Behavioral Health Strategies

The Behavioral Health Action Planning Work Group developed issues and strategies over the action planning process. Some strategies did not evolve to a place where action could be taken without more planning to resolve barriers, challenges, and resources needed to initiate the work. In some cases, the BHWG did not have adequate time to work through complex issues around approaches, resources, ensuring measurable impact, or other barriers to complete the action plans for strategies proposed.

Below is the long-term strategy to address LHIA 1, Goal 2. It specifies the barriers that prevent immediate implementation. It also provides recommendations for moving forward toward action, so that the Healthy Montgomery Steering Committee (Advisory Board) and community partners can assist the Behavioral Health Information Task Force (BHITF) in overcoming the barriers identified and assist in prioritizing their implementation based on further action planning work.

**LHIA 1: There is a need for consumers, families, referral agencies, and behavioral health providers to have ready access to basic information about treatment protocols, the full range of available services, payment mechanisms, and how to access services.**

**Goal #2:** The Behavioral Health Information Task Force (BHITF) will create hard copy documents about how to access behavioral health resources in Montgomery County and a supply and distribution system for the materials so that consumers, their families, providers and other social service agency or referral source personnel can easily gain clear, basic information about treatment options, the full range of available services, payment mechanisms, and how to access service.

**Strategy #2:** The BHITF will create the hard copy documents described in Goal #2.

**Recommended Approach to Strategy:** Creating a printed document as a companion to the *infoMontgomery* web-based service is considered essential in environments which exclude electronic access to the database. This printed document will utilize the content developed for the *infoMontgomery* database and address the identified needs of the end users to sort the content by provider, location, language, community served, etc. Additionally, the Task Force will design a communication and dissemination strategy for the materials which includes procedures for keeping the distributed documents current and consistent with *infoMontgomery*.

### ***Barriers/challenges to implementation:***

- While creating a printed document as a companion to the *infoMontgomery* web-based service is considered essential, Strategy #1, creating an information, communication and linkage system within *infoMontgomery* must be completed first. The database and the knowledge of end user search option requirements established during the development of the database are the basis for properly designing the printed documents.

- There is no known existing resource/entity that can invest the workforce support and financial resources to compile and update the printed materials once the database is operational within *infoMontgomery*; no cost estimates on this effort were available to apply to the implementation planning of this strategy.
- Also, the BHWG did not have the resources to research best practices for cataloging and tracking the distribution of the documents and the difficult task of maintaining documents distributed widely in the community.

***Next steps recommended by BHWG to HMSC and partners:***

- The HMSC (Advisory Board) should convene the Behavioral Health Information Task Force (BHITF) to develop the database and establish the query (sort by) functions in *infoMontgomery* in partnership with the Collaboration Council for Children, Youth, and Families.
- The HMSC (Advisory Board) should include on the BHITF a representative skilled in communication strategies and database management who has knowledge of designing and maintaining written documents that need regular updates.
- The HMSC (Advisory Board)/ should direct the BHITF to develop a budget for establishing this tool and its related annual maintenance expenses as part of the Task Force's initial work plan.

## Long-Term Action Planning Considerations for Behavioral Health Strategies

Below is the long-term strategy to address LHIA 1, Goal 3. It specifies the barriers that prevent immediate implementation. It also provides recommendations for moving forward toward action, so that the HMSC (Advisory Board) and community partners can assist the Behavioral Health Information Task Force (BHITF) in overcoming the barriers identified and assist in prioritizing their implementation based on further action planning work.

**LHIA 1. There is a need for consumers, families, referral agencies, and behavioral health providers to have ready access to basic information about treatment protocols, the full range of available services, payment mechanisms, and how to access services.**

**Goal #3:** The BHITF will implement a telephone-based system for consumers, their families, providers and other social service agency or referral source personnel to easily gain clear, basic information about treatment options, the full range of available services, payment mechanisms, and how to access service.

**Strategy #3:** The BHITF will create the telephone-based system described in Goal #3.

### Recommended Approach to Strategy:

The BHITF will create a telephone-based system described in Goal #3.

Creating a telephone-based system as a companion to the *info*Montgomery web- based service base is considered essential in environments which exclude electronic access to the data. The telephone system will utilize the content developed for the *info*Montgomery database and address the identified needs of the end users to sort the content by provider, location, language, community served, etc., to create the query “tree” in the telephone system. Additionally, the Task Force will design the telephone system to include procedures for keeping the telephone system current and consistent with *info*Montgomery.

### Barriers/challenges to implementation

- While creating a telephone- based system as a companion to the *info*Montgomery web-based is considered essential, Strategy#1, creating an information, communication and linkage system within *info*Montgomery must be completed first. The database and the knowledge of end user search option requirements established during the development of the database are the basis for properly designing the telephone- based system.
- The BHWG did not have resources to research best practices and models for a telephone-based system, including maintaining the accuracy of the information in conjunction with the *info*Montgomery database.

### Next steps recommended by the BHWG:

- The HMSC (Advisory Board) should convene the Behavioral Health Information Task Force (BHITF) to develop the database and query (sort by) functions in *info*Montgomery in partnership with the Collaboration Council for Children, Youth, and Families.

- The HMSC (Advisory Board)/should include on the BHITF a representative skilled in communication strategies and data base management who has knowledge of designing and maintaining telephone-based information systems.
- The HMSC (Advisory Board)/ should direct the BHITF to develop a budget for establishing this tool and its related annual maintenance expenses as part of the BHITF initial work plan.

**LHIA 2. There is a need to develop improved mechanisms for providers to communicate among themselves regarding shared consumers and to create effective linkages for consumers (warm hand-offs) as they move between providers or levels of care.**

Providers in different agencies have inadequate mechanisms for communicating among themselves regarding shared consumers and consumer linkages. This results in duplicative client intakes, inadequately supported discharges that lead to consumers being lost to follow-up, and uncoordinated care that affects both the quality of consumer care as well as increasing providers' time and cost.

**Goal #1:** Consumers with behavioral health diagnoses who receive services at a local emergency department (ED), the Department of Corrections, Crisis Services or who receive acute care from inpatient behavioral health services will be successfully linked to appropriate community resources for ongoing behavioral health services.

**Objective I:** Within six months of action plan adoption, the Healthy Montgomery Steering Committee (Advisory Board) will convene a Hospital/Community Agency Task Force (HCATF) which includes the Montgomery County hospitals, others providing institutional services, and community agencies that serve as sources of referral for hospital behavioral health consumers.

**Objective II:** Within one year of action plan adoption, the HCATF will define specific protocols that will improve the transfer of patients from a hospital's ED, inpatient services, outpatient Behavioral Health and Crisis Services, Department of Corrections, and school-based counselors to appropriate community resources.

**Objective III:** Within six months after development of the protocols, participating hospitals, others providing institutional services and community agencies that serve as sources of referral for hospital behavioral health consumers will officially adopt and implement the developed protocols.

**Objective IV:** Within 18 months of the adoption of the protocols, the protocols will be disseminated to community providers and social service agencies to serve as a model for communication and linkages within the entire behavioral health system.

**Goal #2:** Providers operate in a network that has immediate communication linkages to ensure information is shared on consumers across an integrated behavioral health system.

**Objective I:** A common "Consent to Share Information with Outside Agencies" system will be established to eliminate the need for duplication of consent processes at different agencies.



**Objective II:** 80% of all identified behavioral health and somatic health care organizations serving the “safety net population” in Montgomery County will have adopted use of the “Consent to Share Information with Outside Agencies” system.

**Objective III:** A shared electronic interface will be established that shares specific consumer information among different providers in real time.

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<b>Strategy #1: Establish protocols to facilitate safe and appropriate transfer of clients from institutional settings (hospitals, emergency rooms, correctional facilities) to community behavioral health organizations.</b>			
<b>Funding Status:</b> Funding required. <b>Specify Estimated Amount of Funding Needed:</b> The HMSC (Advisory Board) will determine the estimated cost involved in carrying out the work of the task force including the time and effort of task force members and needed administrative support. Task force members will determine the estimated cost of the implementation of the Plan's strategies and identify potential sources of funding. <b>Specify Anticipated Sources of Funding:</b> To be determined.			
ACTION STEPS	COMMUNITY PARTNERS' Roles and Responsibilities	ADDRESSING ACCESS TO CARE, HEALTH INEQUITIES AND UNHEALTHY BEHAVIORS	PLAN HOW YOU WILL EVALUATE EFFECTIVENESS
1a. HMSC (Advisory Board) will convene the Hospital/Community Agency Task Force (HCATF) leadership to identify potential members and hold an initial meeting by February 2014.	<b>Lead agency:</b> Suburban Hospital  <b>List other agencies and what they plan to do:</b> Adventist Hospital Family Services, Inc. HMSC(Advisory Board) All will assist in identifying and enrolling members.	<b>Specify how you will address access to care issue through this action step, if applicable:</b> End result will improve access for clients. <b>Specify how you will address inequities through this action step, if applicable:</b> Standard protocols lessen potential for inequities based on a client's demographic information and/or where they receive care. <b>Specify how you will address unhealthy behaviors through this action step, if applicable:</b> N/A	<b>Quantify what you will do:</b> Number of meetings and attendance at workgroup meetings. <b>Expected outcomes:</b> Approved protocols.
2. a. HCATF will identify all the specific agencies in the County that would use the protocols and the specific areas/types of protocols that are needed.  b. Assign members task of developing specific protocols in their area of expertise.  c. HCATF will review and approve all protocols.	<b>Lead agency:</b> Hospital Community Agency Task Force (HCATF)  <b>List other agencies and what they plan to do:</b> HCATF Subcommittee will develop protocols.  <b>Include how you're marketing the intervention/strategy:</b> N/A	<b>Specify how you will address access to care issue through this action step, if applicable:</b> End result will improve access for clients.  <b>Specify how you will address inequities through this action step, if applicable:</b> Standard protocols lessen potential for inequities based on a client's demographic information and/or where they receive care.  <b>Specify how you will address unhealthy behaviors through this action step, if applicable:</b> N/A	<b>Quantify what you will do:</b> Subcommittees created; members assigned  <b>Expected outcomes:</b> Specific protocols ready for adoption.

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ACTION STEPS	COMMUNITY PARTNERS' Roles and Responsibilities	ADDRESSING ACCESS TO CARE, HEALTH INEQUITIES AND UNHEALTHY BEHAVIORS	PLAN HOW YOU WILL EVALUATE EFFECTIVENESS
<p>3. a. Hospital/Community Agency Task Force (HCATF) will identify and recruit additional workgroup members that can assist with implementation and training.</p> <p>b. HCATF will officially ask and invite leadership of every identified agency to adopt the protocols.</p> <p>c. Identified agencies will adopt and incorporate the protocols into their internal protocols.</p> <p>d. HCATF will develop training materials to assist with implementation and offer this training and materials to agencies.</p> <p>e. Protocols will be implemented by front line providers in the agencies and disseminated widely to serve as a model.</p>	<p><b>Lead agency:</b> HCATF</p> <p><b>List other agencies and what they plan to do:</b> N/A</p>	<p><b>Specify how you will address access to care issue through this action step, if applicable:</b> End result will improve access for clients.</p> <p><b>Specify how you will address inequities through this action step, if applicable:</b> Standard protocols lessen potential for inequities based on a client's demographic information and/or where they receive care.</p> <p><b>Specify how you will address unhealthy behaviors through this action step, if applicable:</b> N/A</p>	<p><b>Quantify what you will do:</b> The number of agencies that implement the protocols.</p> <p>The number of people/agencies trained in protocols.</p> <p><b>Expected outcomes:</b> The rate of repeat ED visits and hospitalizations within 30 days of referral will measurably decline for successfully linked Medicaid/Medicare consumers and uninsured.</p>

## Long-Term Action Planning Considerations for Behavioral Health Strategies

The Behavioral Health Action Planning Work Group developed issues and strategies over the action planning process. Some strategies did not evolve to a place where action could be taken without more planning to resolve barriers, challenges, and resources needed to initiate the work. In some cases the BHWG did not have adequate time to work through complex issues around approaches, resources, ensuring measurable impact, or other barriers to completing the action plans for strategies proposed.

Below is the long-term strategy to address LHIA 2, Goal 2. It specifies the barriers that prevent immediate implementation. It also provides recommendations for moving forward toward action, so that the HMSC (Advisory Board) and community partners can assist the Task Force in overcoming the barriers identified and assist in prioritizing their implementation based on further action planning work.

**LHIA 2. There is a need to develop improved mechanisms for providers to communicate among themselves regarding shared consumers and to create effective linkages for consumers (warm hand-offs) as they move between providers or levels of care.**

**GOAL 2:** Providers operate in a network that has immediate communication linkages to ensure information is shared on consumers across an integrated behavioral health system.

**Strategy #2:** Establish adequate mechanisms for providers communicating among themselves regarding shared consumers and consumer linkages to enable informed consumer intakes, coordinated care, and adequately supported discharges; establish a system that is conducive to navigating between providers effectively, further contributing to coordinated care and preventing clients being lost to follow-up.

### ***Barriers/challenges to implementation:***

- This effort is a logical next step to Strategy#1 as it will build on the protocols and automated system creating an improved system to transfer consumers from institutional settings to community behavioral health organizations.
- There was insufficient BHWG membership representing somatic care providers.
- The BHWG did not have resources to research best practices and models for an effort to create a major component (shared electronic interface providing specific consumer information in real time) of an integrated behavioral health system.
- This strategy needs further thought in aligning it with LHIA 3 which requires exploring the creation of a coordinated care system.

### **Recommended Approach to the Long-Term Strategy:**

The HMSC (Advisory Board) will authorize the HCATF to implement the following strategies to ensure continuity and coordination in care:

- Authorize the HCATF to continue meeting to further develop this strategy, create a budget and identify a funding source.

- This HCATF will expand to include a representative sample of all identified behavioral health and somatic health care organizations serving the safety net population in Montgomery County.
- The HCATF will consider this Strategy's relationship to the proposal to create a coordinated system of care.

**LHIA 3. There is a need to explore the creation of a coordinated system of care or other formal partnership-based business agreement to meet the needs of individuals with more serious behavioral health conditions.**

The national movement toward formal integrated systems, including coordinated systems of care, provides Montgomery County with the opportunity to explore significant local systems reform to improve outcomes and reduce costs related to the prevention and treatment of behavioral health issues.

**Goal:** Initiate a process to explore the creation of a coordinated system of care or other formal partnership-based business agreement to meet the needs of individuals with more serious behavioral health conditions who live in Montgomery County.

- Objective I:** By January 2016, the HMSC (Advisory Board) will create a Coordinated System of Care Task Force (CSCTF) to explore the creation of a coordinated system of care in the County to increase cost-effectiveness and improve client outcomes.
- Objective II:** By October 2016, the CSCTF will commission a white paper on viable partnership-based business agreements to meet the needs of individuals with more serious behavioral health conditions who live in Montgomery County.
- Objective III:** By October 2017, the CSCTF will research, identify, and apply for grant funding to aid in the infrastructure and support systems necessary to support the proposed partnership based business agreement.

**Strategy #1: Establish Coordinated System of Care Task Force (CSCTF) to formulate framework to establish a coordinated system of care or other formal partnership-based business agreement to meet the needs of individuals with more serious behavioral health conditions living in Montgomery County.**

**Funding Status:** Funding required.

**Specify estimated amount of Funding Needed:** The HMSC (Advisory Board) will determine the estimated cost involved in carrying out the work of the task force including the time and effort of task force members and needed administrative support. Task force members will determine the estimated cost of the implementation of the Plan's strategies and identify potential sources of funding.

**Specify anticipated Sources of Funding:** To be determined

ACTION STEPS	COMMUNITY PARTNERS' Roles and Responsibilities	ADDRESSING ACCESS TO CARE, HEALTH INEQUITIES AND UNHEALTHY BEHAVIORS	PLAN HOW YOU WILL EVALUATE EFFECTIVENESS
1. HMSC (Advisory Board) recruits and establishes a Coordinated System of Care Task Force (CSCTF) that will inform, formulate and implement the strategic plan to establish a collaborative behavioral health coordinated system of care; CSCTF members will represent major providers of somatic, mental health, and substance abuse services in the County (including emergency departments, hospitals, safety net clinics, and corrections clinics).	<p><b>Lead agency:</b> Healthy Montgomery Steering Committee(Advisory Board)</p> <p><b>List other agencies and what they plan to do:</b> HMSC(Advisory Board) assists in gaining commitments to populate the task force</p> <p><b>Include how you're marketing the intervention/strategy:</b></p>	<p><b>Specify how you will address access to care issue through this action step, if applicable:</b> End result will improve access for clients.</p> <p><b>Specify how you will address inequities through this action step, if applicable:</b> An integrated system will lessen potential for inequities based on a client's demographic information and/or where they receive care.</p> <p><b>Specify how you will address unhealthy behaviors through this action step, if applicable:</b> N/A</p>	<p><b>Quantify what you will do:</b> Recruit and convene CSCTF.</p> <p><b>Expected outcomes:</b> Seat a composition of members to inform consultant on strategic plan for a behavioral health collaborative that follows a coordinated system of care framework.</p>
2. CSCTF through its work with a consultant, commissions white paper to develop a strategic plan to establish a feasible coordinated system of care agreement that links County emergency departments, hospitals, safety net clinics, and corrections clinics in a collaborative network through both technology (emergency medical records), best practices (such as health homes), and systems-wide cost containment measures.	<p><b>Lad agency:</b> CSCTF</p> <p><b>List other agencies and what they plan to do:</b> HMSC(Advisory Board) Providers/Stakeholders, Consultant</p> <p><b>Include how you're marketing the intervention/strategy:</b> N/A</p>	<p><b>Specify how you will address access to care issue through this action step, if applicable:</b> N/A</p> <p><b>Specify how you will address inequities through this action step, if applicable:</b> N/A</p> <p><b>Specify how you will address unhealthy behaviors through this action step, if applicable:</b> N/A</p>	<p><b>Quantify what you will do:</b> Draft White Paper that outlines strategic plan to implement a coordinated system of care in Montgomery County.</p> <p><b>Expected outcomes:</b> Montgomery County will have framework to seek grant funding to actualize a coordinated system of care.</p>

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ACTION STEPS	COMMUNITY PARTNERS' Roles and Responsibilities	ADDRESSING ACCESS TO CARE, HEALTH INEQUITIES AND UNHEALTHY BEHAVIORS	PLAN HOW YOU WILL EVALUATE EFFECTIVENESS
<p>3. CSCTF leverages findings from White Paper's strategic plan framework to develop grant applications to secure funding for implementing the strategic plan through leadership from national consultant who will actualize plan.</p>	<p><b>Lead agency:</b> CSCTF</p> <p><b>List other agencies and what they plan to do:</b> HMSC/(Advisory Board), Providers/Stakeholders, consultant assist with identifying grant sources, developing grant application</p> <p><b>Include how you're marketing the intervention/strategy:</b> N/A</p>	<p><b>Specify how you will address access to care issue through this action step, if applicable:</b> End result will improve access for clients.</p> <p><b>Specify how you will address inequities through this action step, if applicable:</b> An integrated system will lessen potential for inequities based on a client's demographic information and/or where he or she receives care.</p> <p><b>Specify how you will address unhealthy behaviors through this action step, if applicable:</b> N/A</p>	<p><b>Quantify what you will do</b> Apply for grant funding to implement strategic plan.</p> <p><b>Expected outcomes:</b> Grant funding to implement plan; national consultant to lead implementation effort.</p>



## Section 5: Evaluation Planning Using Logic Models

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# Healthy Montgomery Behavioral Health Action Plan

## Logic Model for Local Health Issue Area 1

<b>STRATEGY:</b> Create a Web-based basic information, communications, and linkage system through which consumers, their families, providers and other social service agency or referral source personnel can easily gain clear, basic information about treatment options, the full range of available services, including payment mechanisms, and how to access service.		
There is a need for consumers, families, referral agencies, and behavioral health providers to have ready access to basic information about treatment protocols, the full range of available services, payment mechanisms, and how to access service.		
<b>GOAL:</b> <i>infoMontgomery</i> will host an easily understandable and accessible centralized Internet database of basic information about behavioral health services available in the County that can be sorted by payor, provider, location, specialty, languages spoken, and target population. The primary target audience is people who have Medicare and/or Medicaid or are uninsured, but does not exclude other individuals.		
Logic Model	Description	Possible Evaluation Measures
<b>Target Population</b> <i>Who will directly benefit?</i>	Medicare, Medicaid and uninsured patients and their families and support system Referral agencies and the providers who currently or could potentially serve them	Number of residents uninsured, with Medicare, with Medicaid Number of providers that accept referrals to deliver behavioral health (BH)-related services to Montgomery County residents
<b>Inputs</b> <i>Resources, workforce, costs?</i>	HMSC (Advisory Board)	Meeting schedule, attendance and minutes
	Creation of the Behavioral Health Information Task Force (BHITF) with authority and resources to create and maintain an interactive BH informational database available and easily useable by the target populations	Budget, annual cost, cost per resident Charter of HMSC (Advisory Board); with formal formation of task force in charter
	Existing <i>infoMontgomery</i> database and technical staff to complete revisions	Letter of support from Collaboration Council Director with commitment of <i>infoMontgomery</i> database, technical staff, and anticipated costs for revisions to HMSC
	Task Force members with technical knowledge to support activities	Letter of support from Task Force co-chairs which lists list members interested in providing the necessary technical support to project to HMSC
<b>Activities</b> <i>What we do- quantified terms. (What will produce measureable results?)</i>	Prepare and adopt MOU among the Collaboration Council, MCDHHS BHCS and NAMI to lead the effort	Signed MOU between Collaboration Council, MCDHHS BHCS, and NAMI
	Create and support the HMSC (Advisory Board); HMSC establishes task force to lead implementation of expanded <i>infoMontgomery</i> database development	Charter of HMSC; with formal formation of Task Force in charter
	Task Force implements scope of services from MOU	Quarterly progress reports from task force to HMSC
<b>Outputs</b> <i>Direct products of activities. (How will strategy be counted? What portfolio of services will produce desired change?)</i>	Updated <i>infoMontgomery</i> publicly accessible centralized Internet-based database of basic information about available behavioral health services in Montgomery County, sorted by payor, provider, location, specialty, languages spoken, and target population; Contents of platform will be reviewed and updated to ensure content is on a schedule established by the Task Force and the host agency, the Collaboration Council	Revised data dictionary of portal's data elements that includes: payor, provider, location, specialty, languages spoken, and target population Percent of listed attributes added and maintained within <i>infoMontgomery</i> Stats on use of added elements in search functions Dissemination materials that convey new elements to target audiences
<b>Short Term Outcomes</b> <i>Initial changes in condition, attitude, knowledge beliefs, skills. (Who or what would change and how? Accountable for what outcomes?)</i>	Within six months of action plan adoption, the BHITF s convened under the Collaboration Council auspices, with authority to identify detailed search functions in <i>infoMontgomery</i>	Membership for Task Force, charter/charge of Task Force
	Within one year of action plan adoption, the BHITF finalizes policies on scope, content, maintenance and support of the db; identifies resources needed for project; within 15 months of action plan adoption, resources needed and potential funding source is identified	Agenda, minutes, materials from meetings held, policies on scope, content, maintenance and support of the database; Budget reflecting cost of construction and ongoing maintenance; funding proposal
	Within six months of securing funding content of database is completed.	Budget with sources and amounts identified and scheduled for payment; contracts/MOUs with funding amounts and payment schedule
	Within five months of completing content the database is launched	Dissemination materials promoting launch date Usage statistics on new features upon activation
<b>Intermediate Term Outcomes</b> <i>Resulting behavior change. (Who or what would change and how? Accountable for what outcomes?)</i>	Publicly insured, uninsured people, their advocates, providers and referral agencies become aware of the database and the availability/quality of care available to diverse populations	Website utilization patterns of residents by coverage group to detect improvement over time for Montgomery County residents
	Care will extend to higher percentages of those in need	Designed, administered, and analyzed pre- and post-implementation survey to partnering providers that captures pre/post use of <i>infoMontgomery</i> ; and assessment of HM BH care delivery system's integration defined parameter (TBD) to convey effectiveness, timeliness and monitor over time.
	Also, the behavioral health care services community will acquire elements of a system, which will foster additional linkages, coordination and collaboration (i.e., the field will move toward becoming an integrated system)	
<b>Long Term Outcomes</b> <i>Changes in policies, programs and practices. (What's possible, who cares? Accountable for what outcomes?)</i>	Medicaid, Medicare eligible populations and the uninsured needing behavioral health services, readily utilize the behavioral health <i>infoMontgomery</i> database to find and easily enroll in care services appropriate to the individual	Enrollment patterns for most needed/utilized services and percent improvement
<b>Anticipated Impacts</b> <i>Longer term indicators of impact. "If we got it right, in 10 yrs."</i> 3/18/2014	Usage and feedback data shows that all residents and BH providers have the information they need to easily access care at an early stage and/or immediately upon release from receiving acute care services. ER visits for BH conditions decrease significantly for target population	ER and inpatient utilization rates for preventable BH conditions that directly benefit from successful referrals (TBD by Task Force experts) Reduction in self reports of days of poor mental health in BRFSS and other surveillance systems

# Healthy Montgomery Behavioral Health Action Plan

## Logic Model for Local Health Issue Area 2

**STRATEGY:** Establish protocols to facilitate safe and appropriate transfer of clients from institutional settings (hospitals, emergency rooms, correctional facilities) to community behavioral health organizations.

There is a need to develop improved mechanisms for providers to communicate among themselves regarding shared consumers and to create effective linkages for consumers (warm hand-offs) as they move between providers or levels of care.

Consumers with behavioral health diagnoses who receive services at a local emergency department (ED), the Department of Corrections, Crisis Services or who receive acute care from inpatient behavioral health services will be successfully linked to appropriate community resources for ongoing behavioral health services.

Logic Model	Description	Possible Evaluation Measures
<b>Target Population</b> <i>Who will directly benefit?</i>	Behavioral health consumer community whose care is being transferred from institutional settings (hospitals, emergency rooms, correctional facilities) to community behavioral health organizations.	Number of discharged patients from institutional settings receiving behavioral health (BH) services Number of discharging patients receiving BH services by type of institutional setting Number of community providers enrolling discharged BH clients
<b>Inputs</b> <i>Resources, workforce, costs?</i>	Commitment of institutions and community providers to participate in developing transfer protocols (MOAs/MOUs) Commitment among staff to manage the process Individuals to lead or participate in the process Funding for the process (budget)	#/Kind of institutions participating in developing the discharge protocols MOUs and MOAs in place that enable the effective implementation of discharge protocols #/Kind of community providers participating in developing the discharge protocols Dedicated funding (budget) that supports protocol development, pilot-testing, training, implementation and evaluation of discharge-protocol process
<b>Activities</b> <i>What we do- quantified terms. (What will produce measureable results)</i>	The Hospital/Community Agency Task Force (HCATF) is established The HCATF meets to produce protocols Protocols are pilot-tested and evaluated, revised Final protocols disseminated to participating providers with compliance measured over time	HCATF membership, agendas, minutes Protocols developed by HCATF Evaluation results from pilot-tested protocols Final protocol published and disseminated to participating providers (institutional settings and community)
<b>Outputs</b> <i>Direct products of activities. (How will strategy be counted? What portfolio of services will produce desired change?)</i>	Protocols are distributed with adequate training to assure successful linkage between institutional settings to community BH organizations (re)initiating community level care and are accepted for use by discharging facilities and community providers	Approved Discharge Protocols Number of institutions formally accepting the Discharge protocols
<b>Short Term Outcomes</b> <i>Initial changes in condition, attitude, knowledge beliefs, skills. (Who or what would change and how? Accountable for what outcomes?)</i>	The protocols are adopted and used by the institutional settings (hospitals, emergency rooms, correctional facilities) and the behavioral health providers initiating community level care for the discharged patients.	Number of clients successfully linked from institutional setting to appropriate community BH services Number of patients readmitted without having received community level care
<b>Intermediate Term Outcomes</b> <i>Resulting behavior change. (Who or what would change and how? Accountable for what outcomes?)</i>	Patients successfully continue treatment, comply with behavioral and medication recommendations when released back into the community.	Rate of patients that utilized discharge protocol that were readmitted without receipt of community BH services Rate of discharged patients receiving initial services from participating community provider Protocol Compliance rate by provider/provider type
<b>Long Term Outcomes</b> <i>Changes in policies, programs and practices. (What's possible, who cares? Accountable for what outcomes?)</i>	All Montgomery County behavioral health care institutions and community providers agree on a common policy for transfer/release of patients to the community and adopt and utilize a common transfer protocol.	BH-related ER readmission rates (within 30 days of discharge) BH related ER admission rates Percent of County BH clients appropriately transferred using protocols Percent of County BH providers utilizing discharge protocol
<b>Anticipated Impacts</b> <i>Longer term indicators of impact. "If we got it right, in 10 yrs..."</i>	Residents with Behavioral Health problems are readily aware of the treatment services available among a broad range of community and hospital based services, receive prompt treatment at an appropriate level of care within a provider system effectively sharing and protecting patient information when transferring within system.	The number of agencies that implement the protocols The rate of repeat ED visits and hospitalizations within 30 days of referral will measurably decline for target population Evaluation plan in place by participating providers that adequately measures: clients that are readily aware of the treatment services available among a broad range of community and hospital based services; patients that receive prompt treatment at an appropriate level of care within a provider system; and how compliant providers are in effectively sharing and protecting patient information

# Healthy Montgomery Behavioral Health Action Plan

## Logic Model for Local Health Issue Area 3

**STRATEGY:** Establish Coordinated System of Care Task Force (CSCTF) to formulate framework to establish a coordinated system of care or other formal partnership-based business agreement to meet the needs of individuals with more serious behavioral health conditions living in Montgomery County.

There is a need to explore the creation of a coordinated system of care or other formal partnership-based business agreement to meet the needs of individuals with more serious behavioral health conditions.

**GOAL:** Initiate a process to explore the creation of a coordinated system of care or other formal partnership-based business model to meet the needs of individuals with more serious behavioral health conditions who live in Montgomery County.

Logic Model	Description	Possible Evaluation Measures
<b>Target Population</b> <i>Who will directly benefit?</i>	Montgomery County Residents with serious behavioral health (BH) conditions, focused on the uninsured, Medicaid, and Medicare eligible residents	Number of County residents uninsured, with Medicare, with Medicaid Number of County residents with serious behavioral health conditions by coverage status and type of condition Number of providers that provide BH related services to County residents
<b>Inputs</b> <i>Resources, workforce, costs?</i>	Somatic, mental health, and substance abuse community level treatment providers, along with institutional settings (including Hospitals, EDs) serve on Coordinated System of Care Task Force (CSCTF) Staffing for the CSCTF Funding/budget for contracting with a consultant to participate in a leadership level position to develop the white paper that conveys feasible conceptual framework for a BH a coordinated system of care	Budget and funding for a consultant (financial commitments from each participating entity to support CSCTF work) Membership via commitments to serve on the CSCTF (charter or charge from the HMSC)
<b>Activities</b> <i>What we do- quantified terms. (What will produce measureable results)</i>	HMSC establishes the CSCTF to formulate and implement a strategic plan to establish a coordinated system of care, including somatic, MH and SA, hospitals, EDs, Safety Net, Corrections clinics. Securing a qualified consultant to facilitate White Paper and subsequent funding of concept via grant mechanisms The CSCTF hires consultant and together produces a white paper to develop a strategic plan to establish a feasible coordinated system of care.	Project plan/schedule to recruit consultant Scope of work for consultant that conveys milestones and deliverables to achieve white paper to convey viable strategies for Montgomery County Signed contract with consultant CSCTF agendas, minutes, and deliverables Progress reports approved by CSCTF on consultant performance
<b>Outputs</b> <i>Direct products of activities. (How will strategy be counted? What portfolio of services will produce desired change?)</i>	White Paper that develops a strategic plan to actualize a BH partnership-based coordinated system of care is produced, providing the content for grant applications.	Approved Final White Paper submitted by CSCTF to HMSC Minutes of CSCTF and HMSC meetings
<b>Short Term Outcomes</b> <i>Initial changes in condition, attitude, knowledge beliefs, skills. (Who or what would change and how? Accountable for what outcomes?)</i>	Grant applications are developed by either the HMSC or CSCTF to secure funding to implement the Strategic Plan Applications for funding opportunities submitted Grant application includes funding for a consultant to actualize the plan.	Grant applications compiled and submitted that leverage White Paper concepts for funding Letters of support from BH providers to align with White Paper concept in preparation for funding opportunities
<b>Intermediate Term Outcomes</b> <i>Resulting behavior change. (Who or what would change and how? Accountable for what outcomes?)</i>	The coordinated system of care is funded to create the basis for a BH partnership-based system of delivering care to the target population.	Grant awarded to fund White Paper concept in Montgomery County
<b>Long Term Outcomes</b> <i>Changes in policies, programs and practices. (What's possible, who cares? Accountable for what outcomes?)</i>	Sufficient providers in all categories of care (somatic, MH, SA) and settings (hospital, ED, somatic, BH and Corrections clinics) participate in a partnership-based coordinated system of to meet the needs of the target population.	Deliverables from Grant (progress reports, deliverables, evaluation plans, sustainability plans) Formal partnerships established that actualize model (MOUs/MOAs, contracts, etc.) Number/kind of somatic, MH, SA, community providers and hospital, ED, SBHC, Corrections entering into agreement % of target population served by the entities participating in the coordinated system of care
<b>Anticipated Impacts</b> <i>Longer term indicators of impact. "If we got it right, in 10 yrs..."</i>	Patients in the coordinated system of care receive timely, appropriate care to manage or resolve symptoms and respond positively to instructions on self- care. Providers readily refer patients to partners as needed and coordinated care using treatments which best meet the somatic, mental health and substance abuse cessation/prevention conditions facing the patient.	Systems are implemented to adequately capture the timeliness, quality, effectiveness, short- and long-term improvements of target population (consumers) being served in coordinated system of care ER and inpatient utilization rates for preventable BH conditions that directly benefit from successful referrals (TBD CSCTF experts/consultant)

